2022 Proceedings of the
National Association of Insurance Commissioners

2022 Spring National Meeting
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& Kansas City Convention Center
Kansas City, Missouri
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Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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Important answers to common questions about auto, home, health and life insurance — as well as buyer’s guides on annuities, long-term care insurance and Medicare supplement plans.

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CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation

I. Name

The name of the Corporation is: National Association of Insurance Commissioners (NAIC).

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

The NAIC's Registered Office in the State of Delaware is to be located at: 1209 Orange St., in the City of Wilmington, Zip Code 19801. The registered agent in charge thereof is The Corporation Trust Company.

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

The name and address of the incorporator are as follows:

Catherine J. Weatherford
National Association of Insurance Commissioners
120 W. 12th St., Suite 1100
Kansas City, MO 64106

VI. Purpose

The NAIC is organized exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), including without limitation, to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:

(a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers.

(b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions.

(c) Support and improve state regulation of insurance.

VII. Restrictions

A. No substantial part of the activities of the Corporation shall be the carrying of propaganda, or otherwise attempting to influence legislation except as otherwise permitted by Section 501(h) of the Code and in any corresponding laws of the State of Delaware, and the Corporation shall not participate in or intervene
in including the publishing or distribution of statements concerning any political campaign on behalf of or in opposition to any candidate for public office.

B. For any period for which the Corporation may be considered a private foundation, as defined in Section 509(a), the Corporation shall be subject to the following restrictions and prohibitions:

1. The Corporation shall not engage in any act of self-dealing as defined in section 4941(d) of the Code.

2. The Corporation shall make distributions for each taxable year at such time and in such manner so as not to become subject to the tax on undistributed income imposed by section 4942 of the Code.

3. The Corporation shall not retain any excess business holdings as defined in section 4943(c) of the Code.

4. The Corporation shall not make any investments in such manner as to subject it to tax under section 4944 of the Code.

5. The Corporation shall not make any taxable expenditures as defined in section 4945(d) of the Code.

VIII. Membership

The NAIC shall have one class of members consisting of the Commissioners, Directors, Superintendents, or other officials who by law are charged with the principal responsibility of supervising the business of insurance within each State, territory, or insular possession of the United States. Members only shall be eligible to hold office in and serve on the Executive Committee, Committees and Subcommittees of the NAIC. However, a member may be represented on a Committee or Subcommittee by the member’s duly authorized representative as defined in the Bylaws. Only one official from each State, territory or insular possession shall be a member and each member shall be limited to one vote. Any insurance supervisory official of a foreign government or any subdivision thereof, which has been diplomatically recognized by the United States government, may attend and participate in all meetings of this Congress but shall not be a member and shall not have the power to vote.

IX. Activities

The NAIC is a nonprofit charitable and educational organization and no part of the net earnings or property for the corporation will inure to the benefit of, or be distributable to its members, directors, officers or other private individuals, except that the NAIC shall be authorized and empowered to pay reasonable compensation for services rendered by employees and contractors, and to make payments and distributions in furtherance of the purposes set forth in Article VI hereof.

X. Powers

The NAIC shall have all of the powers conferred by the Delaware General Corporation Law for non-profit corporations, except that, any other provision of the Certificate to the contrary notwithstanding, the NAIC shall neither have nor exercise any power, nor carry on any other activities not permitted: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); or (b) by a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended, (or the corresponding provision of any future United States Internal Revenue law).
XI. Immunity

All officers and members of the Executive Committee shall be immune from personal liability for any civil damages arising from acts performed in their official capacity, and shall not be compensated for their services as an officer or member of the Executive Committee on a salary or a prorated equivalent basis. The immunity shall extend to such actions for which the member of the Executive Committee or officer would not otherwise be liable, but for the Executive Committee member’s or officer’s affiliation with the NAIC. This immunity shall not apply to intentional conduct, wanton or willful conduct or gross negligence. Nothing herein shall be construed to create or abolish an immunity in favor of the NAIC itself. Nothing herein shall be construed to abolish any immunities held by the state officials pursuant to their individual state’s law.

XII. Exculpation and Indemnification

A member of the Executive Committee shall not be liable to the NAIC or its members for monetary damages for breach of fiduciary duty as a member of the Executive Committee, provided that this provision shall not eliminate or limit the liability of a member of the Executive Committee for any breach of the duty of loyalty to the NAIC or its members, for acts or omissions not in good faith, or which involve intentional misconduct or a knowing violation of law, or for any transaction from which the member of the Executive Committee involved derived an improper personal benefit. Any amendment, modification or repeal of the foregoing sentence shall not adversely affect any right or protection of a member of the Executive Committee of the Corporation hereunder in respect of any act or omission occurring prior to the time of such amendment, modification, or repeal. If the Delaware General Corporation Law hereafter is amended to authorize the further elimination or limitation of the liability of the members of the Executive Committee, then the liability of a member of the Executive Committee, in addition to the limitation provided herein, shall be limited to the fullest extent permitted by the amended Delaware General Corporation Law.

The NAIC shall indemnify to the full extent authorized or permitted by the laws of the State of Delaware, as now in effect or as hereafter amended, any person made or threatened to be made a party to any threatened, pending or completed action, suit or proceeding (whether civil, criminal, administrative or investigative, including an action by or in the right of the NAIC) by reason of the fact that the person is or was a member of the Executive Committee, officer, member, committee member, employee or agent of the NAIC or serves any other enterprise as such at the request of the NAIC.

The foregoing right of indemnification shall not be deemed exclusive of any other rights to which such person may be entitled apart from this Article XII. The foregoing right of indemnification shall continue as to a person who has ceased to be a member of the Executive Committee, officer, member, committee member, employee or agent and shall inure to the benefit of the heirs, the executors and administrators of such a person.

XIII. Dissolution

In the event of the dissolution of the NAIC, the Executive Committee shall, after paying or making provision for the payment of all of the liabilities of the NAIC, dispose of all the assets of the NAIC equitably to any state government which is represented as a member of the NAIC at the time of dissolution, provided that the assets are distributed upon the condition that they be used primarily and effectively to implement the public purpose of the NAIC, or to one or more such organizations organized and operated exclusively for religious, charitable, education, scientific, or literary purposes or similar purposes as shall at the time qualify: (a) as an exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); and (b) as an organization contributions to which are deductible under Section 170(c) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), as the Executive Committee shall determine.
XIV. **Bylaws**

The Bylaws of the NAIC may prescribe the powers and duties of the several officers, members of the Executive Committee and members and such rules as may be necessary for the work of the NAIC provided they are in conformity with the Certificate of Incorporation.

XV. **Amendments**

This Certificate of Incorporation may be altered or amended at any meeting of the full membership (Plenary Session) of the NAIC by an affirmative vote of two-thirds of the members qualified to vote, or their authorized representatives, provided that previous notice of the proposed amendment has been mailed to all members by direction of the Executive Committee at least thirty (30) days prior to the meeting.

**IN WITNESS WHEREOF,** this Certificate of Incorporation has been signed this 4th day of October 1999.

/signature/
Catherine J. Weatherford, Incorporator

ADOPTED 1999, Proc. Third Quarter
BYLAWS OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ARTICLE I

Name, Organization and Location

The name of this corporation is NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC). The NAIC is organized under the General Corporation Law of the State of Delaware. The NAIC may have one (1) or more office locations within or without the State of Delaware as the Executive Committee may from time to time determine.

ARTICLE II

Membership

The Membership of the NAIC shall be comprised of those persons designated as members in the Certificate of Incorporation. Each member of the NAIC shall have the power to vote and otherwise participate in the affairs of the NAIC as set forth herein or as required by applicable law. This power may be exercised through a duly authorized representative who shall be a person officially affiliated with the member’s department and who is wholly or principally employed by said department.

The organization may charge members an annual assessment, the amount of which shall be determined by the Executive Committee. Members failing to pay all NAIC assessments on a timely basis shall be placed in an inactive status. Members in an inactive status shall not have any voting rights and shall be denied membership on NAIC committees and task forces, access to mailings and services of the NAIC Offices, as well as access to zone examination processes and other benefits of membership in the NAIC.

The NAIC’s receipt of full payment from the inactive member of all current and past due assessments shall serve to immediately remove them from inactive status.

The Membership of the NAIC shall be subject to a conflict of interest policy and disclosure form as adopted by the members.

The Executive Committee is empowered to reinstate, in part or in whole, an inactive member’s participation on the committees and task forces, access to mailings and services of the NAIC Offices and satellite offices, as well as access to zone examination processes, and other benefits of membership in the NAIC upon good cause shown as determined by the Executive Committee.
ARTICLE III

Officers

The officers of the NAIC shall be a President, a President-Elect, a Vice President, and a Secretary-Treasurer. Annual officer elections shall be held at the last regular National Meeting of each calendar year or at such other plenary session as agreed to by the members. The voting membership, by secret ballot, shall elect officers as provided in these Bylaws. Officers’ terms shall be for one year, beginning on January 1 following their election. The officers shall hold office until their death, resignation, removal or the election and qualification of their successors, whichever occurs first. Any Officer may resign at any time by giving notice thereof in writing to the President of the NAIC. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

If an interim vacancy occurs in the office of President, the President-Elect shall cease to hold his or her office effective immediately and shall assume the office of President. If an interim vacancy occurs in any one or more of the other officer positions, an interim election shall be held to fill the vacancy. No member may hold any office for more than two consecutive years. Notwithstanding the foregoing, at no time shall more than two officer positions be filled by members of the same Zone during the same term. Any officer may be removed from office by the affirmative vote of two-thirds (2/3) of the members, but only after a resolution for removal is adopted by two-thirds (2/3) of the Executive Committee whenever, in their judgment, the best interests of the NAIC would be served thereby.

The President shall serve as Chairman of the Executive Committee and shall preside at all special and regular meetings of the members. The President shall serve as the leader of the organization and its principal spokesperson. The President shall work closely with the Executive Committee to establish and achieve the strategic, business and operational goals of the organization; ensure appropriate policies and procedures for the organization are implemented and followed; and protect the integrity as well as the resources of the organization. After a member completes his or her term or terms as President, he or she shall not be able to hold another officer position for a period of twelve (12) months from the date such member completes his or her term or terms as President, which shall be referred to as a "waiting period"; provided however, the Executive Committee may waive the twelve month waiting period if warranted by exigent circumstances.

The President-Elect shall serve as Vice-Chairman of the Executive Committee. In the absence of the President at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, the President-Elect shall preside over such meeting to the extent of the President’s absence. The President-Elect shall perform such other duties and tasks as may be assigned by the President. Where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office.

The Vice President, in the absence of the President and President-Elect at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, shall preside over such meeting to the extent of the President’s and the President-Elect’s absence; and shall perform such other duties as may be assigned by the President or President-Elect, or in the absence thereof, by the Executive Committee.

The Secretary-Treasurer shall assist the President and, as applicable, the President-Elect or the Vice President in the conduct of meetings of the Executive Committee and members. For member meetings, the Secretary-Treasurer shall call the roll of the membership and certify the presence of a quorum and shall receive, validate and maintain all proxies for elections held at member meetings. The Secretary-Treasurer shall also recommend to the Executive Committee such policies and procedures to maintain the history and continuity of the NAIC. The
Secretary-Treasurer shall also assist the President and President-Elect in all matters relating to the budget, accounting, expenditure and revenue practices of the NAIC; including, but not limited to reviewing the financial information of the organization and consulting with NAIC management, independent auditors, and other necessary parties regarding the financial operations and condition of the organization.

ARTICLE IV

Executive Committee

The business and affairs of the NAIC shall be managed by and under the direction of the Executive Committee. The Executive Committee shall be made up entirely of members of the NAIC. The Executive Committee shall consist of the following members: the officers of the NAIC; the most recent past president; the twelve (12) members of the zones as provided for in Article V of these Bylaws. The members of the Executive Committee shall be subject to a conflict of interest policy as adopted by the members. Any Executive Committee member may resign at any time by giving notice thereof in writing to the members of the NAIC. Resignation as an Executive Committee member also operates as resignation as a Zone officer. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

1. The Executive Committee shall have the authority and responsibility to:

   (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws.

   (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session.

   (c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate.

   (d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone.

   (e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC.

   (f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report.

   (g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.

2. Duties and Operations of the Executive Committee.

   (a) The Executive Committee shall hold at least two (2) regular meetings annually at a designated time and place. Special meetings may be held when called by the President, or by at least three (3) members of the Executive Committee in writing. In any case, the Executive Committee shall meet at least once per calendar month. At least five (5) days notice shall be given of all regular and special meetings. Meetings
may be held in person or by means of conference telephone or other communication equipment by
means of which all persons participating in the meeting can hear each other, and such participation in a
meeting shall constitute presence in person at such meeting in accordance with applicable laws. The
presiding member of the Executive Committee shall only cast his or her vote in order to break a tie
vote. In addition, the Executive Committee may act by written consent as provided by law.

(b) The Executive Committee may, with the concurrence of two-thirds of the members of the Executive
Committee, establish rules for its conduct that shall not conflict with the Certificate of Incorporation and
Bylaws. Such rules may be changed only by a concurrence of two-thirds of the members of the
Executive Committee after twenty-four (24) hours notice to all members of the Executive Committee.

(c) Any action required or permitted to be taken at any meeting of the Executive Committee or any
committee thereof may be taken without a meeting if all members of the Executive Committee or such
committee, as the case may be, consent thereto in writing in accordance with applicable law.

(d) The Executive Committee shall cause to be kept minutes of its meeting and have information of any
action of a general character taken by it published to members qualified to vote.

(e) NAIC OFFICES

(i) The Executive Committee shall oversee an Executive Office and a Central Office with management
and staff personnel and appropriate resources for performance of duties and assigned
responsibilities. Additional satellite offices may be established as needed. The Executive Committee
shall have the authority to select, employ and terminate a Chief Executive Officer who shall not be
a member of the NAIC and who shall have the primary responsibility for the internal management
and functioning of the NAIC Offices within the direction of the Executive Committee, as well as other
duties assigned by the Executive Committee through execution of an Employment Agreement or
other authorization. The Chief Executive Officer appointed by the Executive Committee pursuant to
this section shall not be considered an officer for purposes of Article III hereof and shall not be a
member of the Executive Committee. The Executive Committee, through the Internal Administration
(EX1) Subcommittee, shall provide oversight and direction to the Chief Executive Officer regarding
Office operations.

(ii) Consistent with the purposes of the NAIC, the role of the NAIC Offices is to: (1) provide services to
the NAIC through support to the NAIC Committees, Subcommittees, Task Forces or otherwise; (2)
provide services to individual State insurance departments; and (3) develop recommendations for
consideration as to NAIC policy and administrative decisions of the NAIC.

(iii) In performing its role, subject to the oversight and direction specified in (paragraph i) the NAIC
Offices may engage in a variety of functions including but not limited to the following: research;
analysis; information gathering and dissemination; library services; data collection; data base
building and maintenance; report generation and dissemination; government liaison; non-regulatory
liaison; securities valuation; administration; litigation; legislative and regulatory drafting; and
educational development.

(iv) The Chief Executive Officer shall prepare an annual budget, related to the priorities of the NAIC, for
the NAIC Offices to be submitted through the EX1 Subcommittee to the Executive Committee, which
shall make its recommendations to the members of the NAIC for action at the next Plenary Session
of the NAIC.
3. Internal Administration (EX1) Subcommittee

The Internal Administration (EX1) Subcommittee shall be a Subcommittee reporting to the Executive Committee. Appointments of the Chair and Vice Chair of the Executive Subcommittee and members other than those specifically designated herein shall be made by the President and President-Elect.

This Subcommittee shall be comprised of the President, President-Elect, Vice President, the Secretary-Treasurer, the most recent past President, and three (3) other members of the Executive Committee. The presiding member of the Subcommittee shall only cast his or her vote in order to break a tie vote.

The Internal Administration (EX1) Subcommittee shall:

(a) Exercise such powers and authority as may be delegated to it by the Executive Committee.

(b) Generally oversee the NAIC Offices including, without limitation: (i) periodically monitor operations of the NAIC Offices, (ii) review and revise the budget of the NAIC, hold an annual hearing to receive public comments on the budget of the NAIC, and submit the revised budget to the Executive Committee, (iii) approve emergency expenditures which vary from the adopted budget and promptly certify its action in writing to the Executive Committee, (iv) evaluate the Chief Executive Officer and make appropriate recommendations to the Executive Committee, (v) assist the Chief Executive Officer in resolving competing demands for NAIC resources, (vi) review compensation of all senior management and (vii) quarterly prepare a report containing the current budget and expenditures which the Secretary-Treasurer shall present to the Executive Committee.

4. Audit Committee

The Executive Committee shall appoint an Audit Committee made up of at least four (4) members of the NAIC, including at least one member from each zone, in addition to the NAIC Secretary-Treasurer. The NAIC Secretary-Treasurer shall chair the Audit Committee. The Audit Committee shall report to the Executive Committee without any NAIC employees being present. The Audit Committee shall be directly responsible for the appointment, compensation, and oversight of the independent certified public accountant employed to conduct the audit. The Audit Committee shall also have the power, to the extent permitted by law, to: (i) initiate or review the results of an audit or investigation into the business affairs of the NAIC; (ii) review the NAIC’s financial accounts and reports; (iii) conduct pre-audit and post-audit reviews with NAIC staff, members and independent auditors; and (iv) exercise such other powers and authority as delegated to it by the Executive Committee.

ARTICLE V

Zones

To accomplish the purposes of the NAIC in a timely and efficient manner, the United States, its territories and insular possessions shall be divided into four Zones. Each Zone shall consist of a group of at least eight States, located in the same geographical area, with each State being contiguous to at least one other State in the group so far as practicable, plus any territory or insular possession that may be deemed expedient, all as determined by majority of the Executive Committee. Members of each Zone shall annually elect a Chairman, a Vice Chairman and a Secretary from among themselves prior to or during the last regular National Meeting of each calendar year or at such time as agreed to by the Zone members. The Chairman, Vice Chairman and Secretary of each Zone shall be members of the Executive Committee with terms of office corresponding to that of the officers. Each Zone shall perform such functions as are designated by the Executive Committee of the
NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone.

**ARTICLE VI**

**Standing Committees and Task Forces**

1. **General**

The Standing Committees shall not be subcommittees of the Executive Committee and shall have no power or authority for the management of the business and affairs of the NAIC. Each Standing Committee shall be composed of not more than 15 members, including a Chair and one or more Vice Chairs, appointed by the President and President-Elect, and such appointments shall remain effective until the succeeding President and President-Elect appoint members for the following year. Standing Committees shall meet at least twice a year at National Meetings and may meet more often at the call of the Chair as required to complete its assignments from the Executive Committee in a timely manner.

The Executive Committee shall make all assignments of subject matter to the Standing Committees and shall require coordination between Committees and Task Forces of the subject matter if more than one Committee or Task Force is affected. The format of the Committee reports shall be prescribed by the Executive Committee. All appointments or elections of members of the NAIC to any office or Committee of the NAIC shall be deemed the appointment or election of a particular member and shall not automatically pass to a successor in office.

2. **Specific Duties**

The Standing Committees of the NAIC, their duties and responsibilities shall be as follows:

(a) **Life Insurance and Annuities (A) Committee:** This Standing Committee shall consider issues relating to life insurance and annuities.

(b) **Health Insurance and Managed Care (B) Committee:** This Standing Committee shall consider issues relating to health and accident insurance and managed care.

(c) **Property and Casualty Insurance (C) Committee:** This Standing Committee shall consider issues relating to personal and commercial lines of property and casualty insurance, worker’s compensation insurance, statistical information, surplus lines, and casualty actuarial matters.

(d) **Market Regulation and Consumer Affairs (D) Committee:** This Standing Committee shall consider issues involving market conduct in the insurance industry; competition in insurance markets; the qualifications and conduct of agents and brokers; market conduct examination practices; the control and management of insurance institutions; consumer services of State insurance departments; and consumer participation in NAIC activities.

(e) **Financial Condition (E) Committee:** This Standing Committee shall consider both administrative and substantive issues as they relate to accounting practices and procedures; blanks; valuation of securities; the Insurance Regulatory Information System (IRIS), as it relates to solvency and profitability; the call, monitoring and concluding report of Zone Examinations; and financial examinations and examiner training.

(f) **Financial Regulation Standards and Accreditation (F) Committee:** This Standing Committee shall consider
both administrative and substantive issues as they relate to administration and enforcement of the NAIC Accreditation Program, including without limitation, consideration of standards and revisions of standards for accreditation, interpretation of standards, evaluation and interpretation of states’ laws and regulations, and departments’ practices, procedures and organizations as they relate to compliance with standards, examination of members for compliance with standards, development and oversight of procedures for examination of members for compliance with standards, qualification and selection of individuals to perform the examination of members for compliance with standards, and decisions regarding whether to accredit members.

(g) International Insurance Relations (G) Committee. This Standing Committee shall have the responsibility for issues relating to international insurance.

(h) Innovation, Cybersecurity and Technology (H) Committee. This Standing Committee shall consider issues related to cybersecurity, innovation, data security and privacy, and emerging technology issues.

3. Task Forces

The Executive Committee, its Subcommittee and the Standing Committees may establish one or more Task Forces, subject to approval of the Executive Committee. The parent Committee or Subcommittee, subject to approval of the Executive Committee, may vote to discontinue a Task Force once its charge has been completed.

Vacancies in the positions of Chair or Vice Chair of any Task Force shall be filled by the parent Committee or Subcommittee from within or outside the present Task Force membership; provided, however, that the chief insurance regulatory official of the state of the former Chair or Vice Chair shall become a member of the Task Force. A vacancy in the position of member shall be filled by the chief insurance regulatory official of the vacating member’s state.

If an existing Task Force is dealing with insurance issues that require continuing study, the Executive Committee may adopt the recommendation of the parent Committee or Subcommittee that the Task Force be designated a Standing Task Force. A Standing Task Force shall continue in effect until terminated by the Executive Committee.

ARTICLE VII

Meetings of the Membership

1. Regular Meetings

The NAIC shall hold at least two (2) regular meetings of the members ("National Meetings") each calendar year. Notice, stating the place, day and hour and any special purposes of the National Meeting, shall be delivered by the Executive Committee not less than ten (10) calendar days nor more than sixty (60) calendar days before the date on which the National Meeting is to be held, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

2. Special Meetings

Special meetings of the members may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) but not more than sixty (60) days prior thereto, or by any twenty (20) members of the NAIC by giving all members notice of such meeting at least thirty (30) but not more than sixty (60) days prior thereto. Notice of the special meeting shall state the place, day and hour of the
special meeting and the purpose or purposes for which the special meeting is called, and shall be delivered by
the persons calling the meeting within the applicable time period set forth herein, either personally, by mail or
by other lawful means, to each member entitled to be present and vote at such meeting.

3. Waiver of Notice; Postponement

Member meetings may be held without notice if all members entitled to notice are present (except when
members entitled to notice attend the meeting for the express purpose of objecting, at the beginning of the
meeting, because the meeting is allegedly not lawfully called or convened), or if notice is waived by those not
present. Any previously scheduled meeting of the members may be postponed by the Executive Committee (or
members calling a special meeting, as the case may be) upon notice to members, in person or writing, given at
least two (2) days prior to the date previously scheduled for such meeting.

4. Quorum

Except as otherwise provided by law or by the Certificate of Incorporation, the presence, by person or proxy, of
a majority of the members shall constitute a quorum at a member meeting, a meeting of a Standing Committee,
Task Force or a working group. The chairman of the meeting may adjourn the meeting from time to time,
whether or not there is such a quorum. The members present at a duly called member meeting at which a
quorum is present may continue to transact business until adjournment, notwithstanding the withdrawal of
enough members to leaveless than a quorum.

5. Any meeting of the NAIC may be held in executive session as defined in the NAIC policy on open meetings.
Any member may attend and participate in any meeting of the NAIC or any meeting of a Standing
Committee or Task Force whether or not such member has the right to vote. All National Meetings shall
provide for a Plenary Session of the NAIC as a whole in order to consider and take action upon the matters
submitted to the NAIC.

ARTICLE VIII

Elections

1. The election of officers of the NAIC shall be scheduled for the plenary session of the last National Meeting of
the calendar year or at such other plenary session as agreed to by the members.

2. At the beginning of such Plenary Session, the Secretary-Treasurer shall ascertain and announce the presence
of a quorum.

3. Upon the determination of a quorum, the chair shall briefly review the provisions of the Certificate of
Incorporation and Bylaws in regard to voting.

4. The President shall ask for and announce all proxies. Proxies shall be held by the Secretary-Treasurer or a
designee throughout the election session. Proxies shall be valid, subject to their term, until superseded by
the member and shall be governed by ARTICLE IX of the Bylaws.

5. Every individual voting by proxy must meet the requirements of Article II of the Bylaws of the NAIC which
requires that such a person be “...officially affiliated with the member’s (the member delegating authority to
vote) department, and is wholly or principally employed by said department.”

6. Prior to opening the nominations for office, the Chair shall appoint three (3) members of the NAIC to act as
voting inspectors. The voting inspectors shall distribute, collect, count and/or verify ballots, and report their findings to the Secretary-Treasurer. If a voting inspector is nominated for an office and does not withdraw as a candidate, he or she shall not be a voting inspector for the election of the office to which he or she is nominated and the chair shall appoint another voting inspector in his or her place.

7. The Chair shall announce the opening of nominations for offices in the following order:

(a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office. In those cases where the President runs for re-election or where a vacancy exists because the President–Elect fails or is otherwise unable to assume the Presidency, this office will be subject to an election.

(b) President-Elect.

(c) Vice President.

(d) Secretary-Treasurer.

8. Only members or duly authorized proxyholders may make nominations.

9. One nominating speech, not to exceed three (3) minutes in duration, shall be allowed for each nominee.

10. After nominations are closed for each office, each nominee must indicate whether he or she accepts the nomination and, if he or she accepts, shall be permitted to address the membership for a period of up to seven (7) minutes. Such addresses shall be given in the order by which the nominations were made.

11. The votes of members, in person or by proxy, constituting a majority of the quorum present at the meeting shall be necessary for election to such office. If no candidate receives a majority, the two candidates with the most votes will participate in a run-off election. The candidate with the most votes in the run-off election shall win such election.

12. Voting need not be by written ballot, unless otherwise required by these Bylaws, the Certificate of Incorporation, or applicable law.

ARTICLE IX

Proxies; Waiver of Notice

Where the delegation of power to vote or participate in the membership of the NAIC is required by ARTICLE II of these Bylaws to be in writing, such delegation must be effected by proxy. All proxies must be dated, give specific authority to a named individual who meets the requirements of ARTICLE II for duly authorized representatives, and meet any other applicable legal requirement. Documents such as electronic transmission, telegrams, mailgrams, etc. are acceptable as proxies if they otherwise meet the requirements contained herein and applicable law. Proxies should be maintained by NAIC Central Office staff. Notwithstanding the foregoing, a member may not vote by proxy in a meeting of the Executive Committee, Financial Regulation Standards and Accreditation (F) Committee in a vote concerning a state-specific item, Government Relations Leadership Council, or International Insurance Relations Leadership Group, or any respective subcommittees.

Whenever any notice is required to be given to any member (for a meeting of members or the Executive Committee) under the provisions of the Certificate of Incorporation, these Bylaws or applicable law, a written
waiver, signed by the person entitled to notice, or a waiver by electronic transmission by person entitled to
notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.
Neither the business to be transacted at, nor the purpose of, any annual or special meeting of the members or
any committee, subcommittee or task force need be specified in any waiver of notice of such meeting.

Unless otherwise restricted by the Certificate of Incorporation or these Bylaws, Members may participate in a
meeting by means of conference telephone or by any means by which all persons participating in the meeting
are able to communicate with one another, and such participation shall constitute presence in person at the
meeting.

Any notice required under these Bylaws may be provided by mail, facsimile, or electronic transmission.

**ARTICLE X**

**Procedures; Books and Records**

The Executive Committee shall adopt policies and procedures for the conduct of meetings. In the event such
policies and procedures conflict with the NAIC’s Certificate of Incorporation or Bylaws, the Certificate of
Incorporation and Bylaws shall govern.

The books and records of the NAIC may be kept outside the State of Delaware at such place or places as may
from time to time be designated by the Internal Administration Subcommittee (EX1) of the Executive
Committee.

**ARTICLE XI**

**Amendments**

These Bylaws may be altered or repealed and new Bylaws may be adopted at any regular or special meeting of
the members by an affirmative vote, in person or by proxy, of a majority of the members entitled to vote at such
meeting; provided, however, that any proposed alteration (except to correct typographical or grammatical
errors or article, section or paragraph cross-references caused by other alterations, repeals, or adoptions) or
repeal of, or the adoption of any Bylaw inconsistent with, Article II [Membership], Article VII, Paragraph 2
[Special Meetings of Members] and Paragraph 4 [Quorum], Article VIII [Elections], or this Article XI
[Amendments] of these Bylaws (the “Supermajority Bylaws”) by the members shall require the affirmative vote,
in person or by proxy, of at least two-thirds (2/3) of the members entitled to vote at such meeting and provided,
further, that in the case of any such member action at a special meeting of members, notice of the proposed
alteration, repeal or adoption of the new Bylaw or Bylaws must be contained in the notice of such special
meeting. Corrections for typographical or grammatical errors or to article, section or paragraph cross-
references caused by other alterations, repeals or adoption, shall only be made if approved by the affirmative
vote of at least two-thirds (2/3) of the Executive Committee.

Adopted October 1999, see 1999 Proc., Third Quarter page 7
Amended November 2002, see 2002 Proc., Fourth Quarter page 25
Amended June 2003, see 2003 Proc., Second Quarter page 28
Amended March 2004, see 2004 Proc., First Quarter page 119
Amended December 2004, see 2004 Proc., Fourth Quarter page 58
Amended March 2009, see 2009 Proc., First Quarter page 3–67
Amended September 2009, see 2009 Proc., Third Quarter
Amended October 2011, see Proc., Summer 2011
NAIC Policy Statement on Open Meetings  
Revised: April 1, 2014

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. NAIC members are the elected and appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory. The NAIC is committed to conducting its business openly. This policy statement applies to meetings of NAIC committees, subcommittees, task forces and working groups. It does not apply to Roundtable discussions, zone meetings, commissioners’ conferences, and other like meetings of the members. Applicable meetings will be open unless the discussion or action contemplated will include:

1. Potential or pending litigation or administrative proceedings which may involve the NAIC, any NAIC member, or their staffs, in any capacity involving their official or prescribed duties, requests for briefs of amicus curiae, or legal advice.

2. Pending investigations which may involve either the NAIC or any member in any capacity.

3. Specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis.

4. Internal or administrative matters of the NAIC or any NAIC member, including budget, personnel and contractual matters, and including consideration of internal administration of the NAIC, including, but not limited to, by the Internal Administration (EX1) Subcommittee or any subgroup appointed thereunder.

5. Voting on the election of officers of the NAIC.

6. Consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, Annual and Quarterly Statement Blanks and Instructions, the Accounting Practices and Procedures Manual, and similar materials.

7. Consideration of individual state insurance department’s compliance with NAIC financial regulation standards by the Financial Regulation Standards and Accreditation (F) Committee or any subgroup appointed thereunder.

8. Consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters.

9. Any other subject required to be kept confidential under any Memorandum of Understanding or other agreement, state or federal law or under any judicial or administrative order.

Because not all situations requiring a regulator to regulator discussion can be anticipated at the time a meeting is scheduled, a meeting convened in open session can move into regulator to regulator session on motion by the chair or other member approved by a majority of the members present. Public notice will be provided of all applicable meetings. The reason for holding a meeting in regulator only session will be announced when the meeting notice is published, at the beginning of any regulator only session, and when an open meeting goes into regulator only session.

This revised policy statement shall take effect upon adoption by the membership.
[NOTE: Effective Jan. 1, 1996, conference call meetings are included in the application of the policy statement, by action of the NAIC on June 4, 1995. This policy statement was originally adopted by the NAIC membership during the 1994 Fall National Meeting in Minneapolis, Minnesota, Sept. 18–20, 1994.]

*Revisions Adopted by the NAIC Membership, April 1, 2014*

W:\LEGAL\Bylaws\Open Meetings Policy revised 2014.doc
2022 COMMITTEE AND TASK FORCE STRUCTURE

Plenary

Executive Committee

(EX1) Subcommittee
- Internal Administration
  - Audit Committee

(A) Committee
- Life Insurance and Annuities
  - Life Actuarial Task Force

(C) Committee
- Property and Casualty Insurance
  - Casualty Actuarial and Statistical Task Force
  - Surplus Lines Task Force
  - Title Insurance Task Force
  - Workers’ Compensation Task Force

(E) Committee
- Financial Condition
  - Accounting Practices and Procedures Task Force
  - Capital Adequacy Task Force
  - Examination Oversight Task Force
  - Financial Stability Task Force
  - Receivership and Insolvency Task Force
  - Reinsurance Task Force
  - Risk Retention Group Task Force
  - Valuation of Securities Task Force

Executive Committee

Climate and Resiliency Task Force
- Government Relations Leadership Council
- Long-Term Care Insurance Task Force
- Special Committee on Race and Insurance

(B) Committee
- Health Insurance and Managed Care
  - Health Actuarial Task Force
  - Regulatory Framework Task Force
  - Senior Issues Task Force

(D) Committee
- Market Regulation and Consumer Affairs
  - Antifraud Task Force
  - Market Information Systems Task Force
  - Producer Licensing Task Force

(F) Committee
- Financial Regulation Standards and Accreditation

(G) Committee
- International Insurance Relations

(H) Committee
- Innovation, Cybersecurity, and Technology

NAIC/Consumer Liaison Committee
- NAIC/American Indian and Alaska Native Liaison Committee
# APPOINTED AND DISBANDED GROUPS

## Current and Previous Year

### APPOINTED SINCE JANUARY 2022

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<th>Group Name</th>
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<tr>
<td>Cybersecurity (H) Working Group</td>
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### RENAMED SINCE JANUARY 2022

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<td>Big Data and Artificial Intelligence (H) Working Group</td>
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<td>Tim Mullen</td>
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<td>E-Commerce (H) Working Group</td>
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<td>Casey McGraw</td>
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<td>Innovation, Cybersecurity, and Technology (H) Committee</td>
<td>12/16/2021</td>
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<td>Randy Helder</td>
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<td>Information Systems (EX1) Task Force</td>
<td>01/14/2022</td>
<td>Sherry Stevens</td>
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<td>Long-Term Care Insurance Restructuring (E) Subgroup</td>
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<td>Jennifer Cook</td>
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<td>Biographical Third-Party Review (E) Subgroup</td>
<td>04/13/2021</td>
<td>Crystal Brown</td>
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<td>Life Insurance Illustration Issues (A) Working Group</td>
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<td>Jennifer Cook</td>
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## 2022 Members by Zone

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<thead>
<tr>
<th>Northeast Zone</th>
<th>Southeast Zone</th>
<th>Midwest Zone</th>
<th>Western Zone</th>
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<td>Glen Mulready</td>
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<td>Carter Lawrence</td>
<td>Doug Oommen</td>
<td>Michael Conway</td>
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<td>Trinidad Navarro</td>
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<td>Anita G. Fox</td>
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<td><strong>Vice Chair</strong></td>
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<td>Andrew N. Mais</td>
<td>Jim L. Ridling</td>
<td>Dana Popish Severinghaus</td>
<td>Peni Itula Sapini</td>
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<td>Karima M. Woods</td>
<td>Alan McClain</td>
<td>Amy L. Beard</td>
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<td>Judith L. French</td>
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<td>Guerrero</td>
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<td>Jeff Rude</td>
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© 2022 National Association of Insurance Commissioners
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<th>2022 EXECUTIVE (EX) COMMITTEE</th>
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<tr>
<td>Dean L. Cameron, President</td>
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<td>Chlora Lindley-Myers, President-Elect</td>
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<tr>
<td>Andrew N. Mais, Vice President</td>
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<tr>
<td>Jon Godfread, Secretary-Treasurer</td>
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<td>Most Recent Past President:</td>
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<td>David Altmaier</td>
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Northeast Zone

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<tr>
<th>Gary D. Anderson, Chair</th>
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<tr>
<td>Kathleen A. Birrane, Vice Chair</td>
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<td>Trinidad Navarro, Secretary</td>
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Southeast Zone

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<tr>
<th>Scott A. White, Chair</th>
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<td>Carter Lawrence, Vice Chair</td>
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<td>James J. Donelon, Secretary</td>
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Midwest Zone

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<th>Glen Mulready, Chair</th>
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<td>Doug Ommen, Vice Chair</td>
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<td>Anita G. Fox, Secretary</td>
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Western Zone

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<tr>
<th>Lori K. Wing-Heier, Chair</th>
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<td>Michael Conway, Vice Chair</td>
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<tr>
<td>Andrew R. Stolfi, Secretary</td>
<td>Oregon</td>
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NAIC Support Staff: Andrew J. Beal/Kay Noonan
CLIMATE AND RESILIENCY (EX) TASK FORCE
of the Executive (EX) Committee

Ricardo Lara, Co-Chair California
David Altsmaier, Co-Chair Florida
Colin M. Hayashida, Co-Vice Chair Hawaii
James J. Donelon, Co-Vice Chair Louisiana
Kathleen A. Borrane, Co-Vice Chair Maryland
Barbara D. Richardson, Co-Vice Chair Nevada
Andrew R. Stolfi, Co-Vice Chair Oregon
Elizabeth Kelleher Dwyer, Co-Vice Chair Rhode Island
Raymond G. Farmer, Co-Vice Chair South Carolina
Jim L. Ridling Alabama
Lori K. Wing-Heier Alaska
Peni Itula Sapini Teo American Samoa
Alan McClain Arkansas
Michael Conway Colorado
Andrew N. Mais Connecticut
Trinidad Navarro Delaware
Karima M. Woods District of Columbia
Dana Popish Severinghaus Illinois
Doug Ommen Iowa
Sharon P. Clark Kentucky
(Pending) Maine
Gary D. Anderson Massachusetts
Anita G. Fox Michigan
Grace Arnold Minnesota
Mike Chaney Mississippi
Chlora Lindley-Myers Missouri
Troy Downing Montana
Edward M. DeLeon Guerrero N. Mariana Islands
Eric Dunning Nebraska
Marlene Caride New Jersey
Adrienne A. Harris New York
Mike Causey North Carolina
Jon Godfrey North Dakota
Judith L. French Ohio
Glen Mulready Oklahoma
Michael Humphreys Pennsylvania
Alexander S. Adams Vega Puerto Rico
Carter Lawrence Tennessee
Michael S. Pieciak Vermont
Tregenza A. Roach Virgin Islands
Scott A. White Virginia
Mike Kreidler Washington
Nathan Houdek Wisconsin
Jeff Rude Wyoming

NAIC Support Staff: Jennifer Gardner
**GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL**

_of the Executive (EX) Committee_

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Dean L. Cameron, Chair</td>
<td>Idaho</td>
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<tr>
<td>Chlora Lindley-Myers, Vice Chair</td>
<td>Missouri</td>
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<tr>
<td>Lori K. Wing-Heier</td>
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<td>Mike Kreidler</td>
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Elsie Andy Virginia
Ned Gaines Washington

NAIC Support Staff: David Torian
# Property and Casualty Insurance (C) Committee

<table>
<thead>
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<tr>
<td>Mike Chaney</td>
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<td>Allan L. McVey</td>
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NAIC Support Staff: Aaron Brandenburg/Jennifer Gardner

## Cannabis Insurance (C) Working Group

*of the Property and Casualty Insurance (C) Committee*

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PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (Continued)

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NAIC Support Staff: Sara Robben
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Barbara D. Richardson                                     Nevada
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NAIC Support Staff: Kris DeFrain/Jennifer Gardner
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**Actuarial Opinion (C) Working Group**
*of the Casualty Actuarial and Statistical (C) Task Force*

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<thead>
<tr>
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<tbody>
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<td>New Mexico</td>
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<td>Qing He</td>
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NAIC Support Staff: Kris DeFrain

### Statistical Data (C) Working Group
*of the Casualty Actuarial and Statistical (C) Task Force*

<table>
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<td>Wanchin Chou, Vice-Chair</td>
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<td>Daniel Davis</td>
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<td>Christian Citarella</td>
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<td>David Dahl</td>
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<td>Brian Ryder</td>
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N. Mariana Islands
Nevada
North Carolina
North Dakota
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South Carolina
Tennessee
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Montana  
Nevada  
North Carolina  
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Oklahoma  
Pennsylvania  
Rhode Island  
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Doug Ommen
Vicki Schmidt
James J. Donelon
Gary D. Anderson
Grace Arnold
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NAIC Support Staff: Sara Robben/Aaron Brandenburg
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Vermont

NAIC Support Staff: Sara Robben/Aaron Brandenburg
# MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
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<tbody>
<tr>
<td>Jon Pike, Chair</td>
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<tr>
<td>Trinidad Navarro, Vice Chair</td>
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NAIC Support Staff: Tim Mullen/Randy Helder

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## Advisory Organization Examination Oversight (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee

<table>
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<td>Iowa</td>
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<td>Rebecca Nichols, Vice Chair</td>
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<td>Jimmy Harris</td>
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<td>Kurt Swan</td>
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<thead>
<tr>
<th>Financial Condition (E) Committee (Continued)</th>
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<tr>
<td><strong>NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group</strong></td>
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<tr>
<th>Name</th>
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<tbody>
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<td>Laura Clements</td>
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James J. Donelon
Kathleen A. Birrane
Anita G. Fox
Mike Chaney
Chlora Lindley-Myers
Eric Dunning
Barbara D. Richardson
Chris Nicolopoulos
Adrienne A. Harris
Mike Causey
Jon Godfread
Judith L. French
Michael Humphreys
Cassie Brown
Jon Pike
Scott A. White
Mike Kreidler
Allan L. McVey
Nathan Houdek

Oregon
Minnesota
Alabama
Alaska
American Samoa
Arizona
Arkansas
California
Connecticut
Delaware
District of Columbia
Florida
Hawaii
Idaho
Kansas
Louisiana
Maryland
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New York
North Carolina
North Dakota
Ohio
Pennsylvania
Texas
Utah
Virginia
Washington
West Virginia
Wisconsin

NAIC Support Staff: Lois E. Alexander
NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE
of the NAIC/Consumer Liaison Committee

Troy Downing, Chair
Russell Toal, Vice Chair
Lori K. Wing-Heier
Trinidad Navarro
Dean L. Cameron
Grace Arnold
Edward M. Deleon Guerrero
Mike Causey
Jon Godfread
Glen Mulready
Andrew R. Stolfi
Larry D. Deiter
Mike Kreidler
Jeff Rude

Montana
New Mexico
Alaska
Delaware
Idaho
Minnesota
N. Mariana Islands
North Carolina
North Dakota
Oklahoma
Oregon
South Dakota
Washington
Wyoming

NAIC Support Staff: Lois E. Alexander
## MEMBERS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

<table>
<thead>
<tr>
<th>State/Position</th>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Alabama Commissioner</td>
<td>Jim L. Ridling</td>
<td>Montgomery 36130</td>
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<tr>
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<tr>
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<td>Pago Pago 96799</td>
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<td>Alan McClain</td>
<td>Little Rock 72202</td>
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<td>Ricardo Lara</td>
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<td>Michael Conway</td>
<td>Denver 80202</td>
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<td>Hartford 06103</td>
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<td>Honolulu 96813</td>
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<td>Boise 83720</td>
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<td>Amy L. Beard</td>
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<tr>
<td>Maine Acting Superintendent</td>
<td>Timothy N. Schott</td>
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<td>Jackson 39201</td>
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<td>Chlora Lindley-Myers</td>
<td>Jefferson City 65101</td>
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<td>Montana Commissioner/State Auditor</td>
<td>Troy Downing</td>
<td>Helena 59601</td>
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<td>Russell Toal</td>
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<td>Raleigh 27603</td>
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<td>Bismarck 58505</td>
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<td>Edward M. Deleon Guerrero</td>
<td>Saipan 96950</td>
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<td>St. Thomas 00802</td>
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<tr>
<td>Wyoming Commissioner</td>
<td>Jeff Rude</td>
<td>Cheyenne 82002</td>
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*Updated: 4/1/2022*
# NAIC MEMBER TENURE LIST

**ALABAMA—Appointed, at the pleasure of the Governor; term concurrent with that of the Governor by whom appointed or for the unexpired portion of the term**

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
</table>
| Insurance Commissioner | Jim L. Ridling  
(Appointed Sept. 15, 2008;  
Reappointed Jan. 17, 2011;  
Reappointed November 2017) | 9/15/2008 | incumbent |            |             |
| Acting Insurance Commissioner | D. David Parsons | 9/1/2008 | 9/15/2008 | 0 | 1 |
| Insurance Commissioner | Walter A. Bell | 1/21/2003 | 8/31/2008 | 5 | 7 |
| Insurance Commissioner | D. David Parsons | 12/1/2000 | 1/21/2003 | 2 | 1 |
| Acting Insurance Commissioner | D. David Parsons | 1/20/1999 | 12/1/2000 | 1 | 11 |
| Insurance Commissioner | Richard H. Cater | 2/1/1998 | 1/19/1999 | 0 | 11 |
| Insurance Commissioner | John S. Greeten | 2/6/1987 | 8/16/1988 | 1 | 6 |
| Insurance Commissioner | Michael ‘Mickey’ DeBellis | 1/1/1986 | 1/19/1987 | 1 | 0 |
| Insurance Commissioner | Tharpe Forrester | 6/8/1984 | 1/1/1986 | 1 | 7 |
| Insurance Commissioner | Joseph R. ‘Joe’ Holt | 5/21/1984 | 6/5/1984 | 0 | 1 |
| Insurance Commissioner | Tharpe Forrester, Jr. | 5/19/1980 | 1/17/1983 | 2 | 8 |
| Insurance Commissioner | Haskell H. Sumrall, Jr. | 8/15/1979 | 5/19/1980 | 0 | 9 |
| Acting Insurance Commissioner | Albert Jackson ‘Jack’ Winfield | 2/2/1979 | 8/15/1979 | 0 | 6 |
| Insurance Commissioner | Charles H. Payne | 1/20/1975 | 2/7/1979 | 4 | 0 |
| Insurance Commissioner | John G. Bookout | 1/1/1972 | 1/20/1975 | 3 | 0 |
| Superintendent of Insurance | John G. Bookout | 1/18/1971 | 1/1/1972 | 1 | 0 |
| Superintendent of Insurance | R. Frank Ussery  
(Died Nov. 13, 2021) | 12/14/1968 | 1/18/1971 | 2 | 1 |
| Superintendent of Insurance | Walter S. Houseal | 1/15/1963 | 12/14/1968 | 5 | 11 |
| Superintendent of Insurance | Edmon L. Rinehart | 1/19/1959 | 5/23/1961 | 2 | 4 |
| Superintendent of Insurance | James H. Horn | 10/3/1956 | 1/19/1959 | 2 | 3 |
| Superintendent of Insurance | Leslie Lee Gwaltney, Jr. | 1/18/1955 | 10/3/1956 | 1 | 9 |
| Superintendent of Insurance | Herman A. Longshore | 1/16/1951 | 1/18/1955 | 4 | 0 |
| Superintendent of Insurance | Leslie Lee Gwaltney, Jr. | 1/31/1947 | 1/16/1951 | 4 | 0 |
| Director of Commerce/Superintendent of Insurance | Addie Lee Farish | 12/1/1944 | 1/31/1947 | 2 | 1 |
| Superintendent of Insurance | Frank N. Julian  
(Died Nov. 30, 1944) | 2/1/1935 | 11/30/1944 | 9 | 10 |
| Superintendent of Insurance | Charles C. Greer | 2/1/1931 | 2/1/1935 | 4 | 0 |
| Superintendent of Insurance | George H. Thigpen | 10/1/1927 | 2/1/1931 | 3 | 4 |
| Superintendent of Insurance | Frank N. Julian  
(Died Nov. 30, 1944) | 9/30/1923 | 10/1/1927 | 4 | 0 |
| Commissioner of Insurance | Frank N. Julian  
(Died Nov. 30, 1944) | 3/1/1923 | 9/30/1923 | 0 | 7 |
<p>| Commissioner of Insurance | Russell B. Coleman | 11/2/1922 | 3/1/1923 | 0 | 4 |
| Commissioner of Insurance | Albert Walter Briscoe | 10/1/1919 | 11/2/1922 | 3 | 1 |
| Commissioner of Insurance | Leonard Y. Dean | 7/1/1919 | 10/1/1919 | 0 | 3 |
| Commissioner of Insurance | C. Brooks Smith | 10/1/1915 | 7/1/1919 | 3 | 9 |
| Secretary of State | John Purifoy | 1/19/1915 | 10/1/1915 | 0 | 9 |
| Secretary of State | Cyrus B. Brown | 10/5/1910 | 1/19/1915 | 4 | 3 |</p>
<table>
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<tr>
<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
<th>YRS. SERVED</th>
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<td>ALABAMA—Continued</td>
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<td>Secretary of State</td>
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<td>Edmund R. ‘Ned’ McDavid</td>
<td>5/1/1904</td>
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<td>J. Thomas Heflin</td>
<td>1/22/1903</td>
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<td>Robert P. McDavid</td>
<td>12/1/1898</td>
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<td>James K. Jackson</td>
<td>2/18/1897</td>
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<td>12/1/1896</td>
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<td>Frank A. Boyle (Died Dec. 15, 1950)</td>
<td>4/1/1933</td>
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<td>Cash Cole</td>
<td>12/16/1929</td>
<td>4/1/1933</td>
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<td>Karl Theile</td>
<td>7/22/1921</td>
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**ARKANSAS—Appointed, at the pleasure of the Governor with the advice and consent of the Senate**

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<td>Ricardo Lara (Elected Nov. 6, 2018)</td>
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### NAIC Member Tenure List

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## NAIC Member Tenure List

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### Connecticut—Appointed, at the pleasure of the Governor with the advice and consent of either house of the General Assembly: 4-year term

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## NAIC MEMBER TENURE LIST

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### DISTRICT OF COLUMBIA—Appointed, at the pleasure of the Mayor; confirmed by the Council of District Columbia

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<tr>
<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
<th>BEG. DATE</th>
<th>END DATE</th>
<th>YRS. SERVED</th>
<th>MOS. SERVED</th>
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<tbody>
<tr>
<td>Commissioner, Dept. of Insurance, Securities &amp; Banking (DISB)</td>
<td>Karima M. Woods</td>
<td>7/28/2020</td>
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<tr>
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### NAIC Member Tenure List

#### District of Columbia—Continued

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Lewis A. Griffith</td>
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<td>Lee B. Mosher</td>
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#### Florida—Appointed, at the Pleasure of the Financial Services Commission

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<td>4/29/2016</td>
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# NAIC Member Tenure List

## Florida—Continued

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<th>End Date</th>
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## Florida (Department of Financial Services)—Elected; 4-Year Term

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<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Chief Financial Officer</td>
<td>Jimmy T. Patronis, Jr.</td>
<td>6/30/2017</td>
<td></td>
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<td></td>
<td>(Appointed June 25, 2017;</td>
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<td>Elected Nov. 6, 2018)</td>
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<tr>
<td>Chief Financial Officer</td>
<td>Jeffrey H. ’Jeff’ Atwater</td>
<td>1/4/2011</td>
<td>6/30/2017</td>
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<tr>
<td>Chief Financial Officer</td>
<td>Adelaide Alexander ‘Alex’ Sink</td>
<td>1/2/2007</td>
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## Georgia—Elected; 4-Year Term

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>John F. King</td>
<td>7/1/2019</td>
<td></td>
<td>incumbent</td>
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</tr>
<tr>
<td></td>
<td>(Appointed June 12, 2019)</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Position Vacant</td>
<td>5/16/2019</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Jim Beck</td>
<td>1/14/2019</td>
<td>5/16/2019</td>
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<td>Insurance Commissioner</td>
<td>Ralph T. Hudgens</td>
<td>1/10/2011</td>
<td>1/13/2019</td>
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<td>Insurance Commissioner</td>
<td>John Oxendine</td>
<td>1/20/1995</td>
<td>1/1/2011</td>
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<td>Insurance Commissioner</td>
<td>Tim Ryles</td>
<td>1/20/1991</td>
<td>1/20/1995</td>
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<tr>
<td>Ins. Commissioner/Comptroller General</td>
<td>Zachariah D. ’Zack’ Cravey</td>
<td>1/1/1947</td>
<td>1/1/1963</td>
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<td></td>
<td>(Died June 22, 1946)</td>
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<td>Homer C. Parker</td>
<td>1/14/1941</td>
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<td>C. Downing Musgrove</td>
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<td>Ins. Commissioner/Comptroller General</td>
<td>Glenn B. Carreker</td>
<td>2/24/1936</td>
<td>6/16/1936</td>
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<td>William B. Harrison</td>
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<td>2/24/1936</td>
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<td>Ins. Commissioner/Comptroller General</td>
<td>William A. Wright (Died Sept. 13, 1929)</td>
<td>9/17/1879</td>
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<tr>
<td>Comptroller-General</td>
<td>Washington L. Goldsmith</td>
<td>1/11/1873</td>
<td>9/17/1879</td>
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<tr>
<td>Comptroller-General</td>
<td>Madison Bell</td>
<td>5/24/1871</td>
<td>1/11/1873</td>
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<td><strong>GUAM—Appointed, at the pleasure of the Governor</strong></td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Michelle B. Santos</td>
<td>12/7/2020</td>
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<td>incumbent</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Dafne M. Shimizu</td>
<td>1/7/2019</td>
<td>12/7/2020</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>John P. Camacho</td>
<td>2/5/2018</td>
<td>12/31/2018</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>John P. Camacho</td>
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<td>5/17/2011</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>John P. Camacho</td>
<td>10/29/2008</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Artemio B. ‘Art’ Ilagan</td>
<td>1/1/2008</td>
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<td>6/26/2007</td>
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<tr>
<td>Acting Director of Revenue and Taxation/Acting Insurance Cmsr.</td>
<td>George V. Cruz</td>
<td>9/28/2001</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Joaquin G. Blaz</td>
<td>1/1/1988</td>
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<td>Acting Director of Revenue and Taxation/Acting Insurance Cmsr.</td>
<td>J.C. Carr Bettis</td>
<td>1/1/1987</td>
<td>1/1/1988</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>David J. ‘Dave’ Santos</td>
<td>1/3/1983</td>
<td>1/1/1987</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Jose R. Rivera</td>
<td>1/2/1981</td>
<td>1/3/1983</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Ignacio C. Borja</td>
<td>1/2/1979</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Manuel A. Chaco</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Joaquin G. Blaz</td>
<td>7/20/1969</td>
<td>12/31/1974</td>
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<tr>
<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Joaquin C. Guerrero</td>
<td>10/1/1968</td>
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<tr>
<td>Director of Finance/Insurance Commissioner</td>
<td>Joaquin C. Guerrero</td>
<td>1/4/1965</td>
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<tr>
<td>Acting Director of Finance/Acting Insurance Commissioner</td>
<td>Segundo C. Aguon</td>
<td>6/1/1964</td>
<td>1/4/1965</td>
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<tr>
<td>Acting Director of Finance/Acting Insurance Commissioner</td>
<td>Robert A. Smith</td>
<td>1/1/1964</td>
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<tr>
<td>Director of Finance/Insurance Commissioner</td>
<td>George W. Ingling  (Died March 26, 1979)</td>
<td>3/6/1961</td>
<td>1/1/1964</td>
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### NAIC MEMBER TENURE LIST

**HAWAI'I—Appointed, at the pleasure of the Director of Commerce and Consumer Affairs; approved by the Governor**

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>Colin M. Hayashida</td>
<td>1/1/2019</td>
<td>incumbent</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Gordon I. Ito</td>
<td>12/1/2010</td>
<td>12/31/2018</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Gordon I. Ito</td>
<td>7/20/2010</td>
<td>12/1/2010</td>
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<tr>
<td>Insurance Commissioner</td>
<td>J. P. Schmidt</td>
<td>2/3/2003</td>
<td>7/1/2010</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Rey Graulty</td>
<td>2/4/1997</td>
<td>3/1/1999</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Wayne C. Metcalf</td>
<td>1/1/1995</td>
<td>2/1/1997</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Lawrence M. Reifurth</td>
<td>3/1/1994</td>
<td>1/1/1995</td>
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<td>Insurance Commissioner</td>
<td>Robin Campaniano</td>
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<td>12/16/1991</td>
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<td>Insurance Commissioner</td>
<td>Mario R. Raml</td>
<td>5/1/1984</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Susan Kee-Young Park</td>
<td>7/1/1982</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Mary G. F. Bitterman</td>
<td>2/1/1981</td>
<td>7/1/1982</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Tamy S. Hong</td>
<td>1/1/1979</td>
<td>2/1/1981</td>
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<td>Insurance Commissioner</td>
<td>Wayne Minami</td>
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<td>Sidney I. Hashimoto</td>
<td>1/17/1963</td>
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<td>Insurance Commissioner</td>
<td>Charles H. Silva</td>
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<td>Insurance Commissioner</td>
<td>Raymond Y. C. Ho</td>
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<td>Insurance Commissioner</td>
<td>Kam Tai Lee</td>
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<td>Insurance Commissioner</td>
<td>Sakae Takahashi</td>
<td>1/1/1952</td>
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<td>Insurance Commissioner</td>
<td>Howard H. Adams</td>
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<td>Insurance Commissioner</td>
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<td>12/15/1947</td>
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<td>Walter D. Ackerman, Jr.</td>
<td>2/19/1943</td>
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<td>Insurance Commissioner</td>
<td>Norman D. Godbold, Jr.</td>
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<td>Insurance Commissioner</td>
<td>W. C. McGonagle</td>
<td>6/30/1934</td>
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<td>E. S. Smith</td>
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<td>6/30/1934</td>
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<td>Insurance Commissioner</td>
<td>Henry C. Hapai</td>
<td>11/1/1922</td>
<td>7/15/1929</td>
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<td>A. Lewis, Jr.</td>
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<td>11/1/1922</td>
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<td>Insurance Commissioner</td>
<td>Delbert E. Metzger</td>
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<td>Insurance Commissioner</td>
<td>Charles J. McCarthy</td>
<td>10/31/1914</td>
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<td>Insurance Commissioner</td>
<td>David L. Conkling</td>
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<td>10/31/1914</td>
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<td>A. J. Campbell</td>
<td>1/1/1907</td>
<td>7/1/1909</td>
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<td>Insurance Commissioner</td>
<td>A. N. Keookai</td>
<td>1/1/1903</td>
<td>1/1/1907</td>
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**IDAHO—Appointed; 4-year term, subject to earlier removal by the Governor**

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td>Insurance Director</td>
<td>Dean L. Cameron</td>
<td>6/15/2015</td>
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<td>(Reappointed March 19, 2019)</td>
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<td>Thomas A. 'Tom' Donovan</td>
<td>1/5/2015</td>
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<td>@William W. 'Bill' Deal</td>
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<td>Shad Priest</td>
<td>7/1/2006</td>
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<td>Gary L. Smith</td>
<td>12/1/2004</td>
<td>6/30/2006</td>
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<tr>
<td>Insurance Director</td>
<td>Mary L. Hartung</td>
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<td>11/30/2004</td>
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<td>4/17/1998</td>
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<td>James M. Alcorn</td>
<td>3/1/1996</td>
<td>4/17/1998</td>
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<td>James M. Alcorn</td>
<td>12/1/1995</td>
<td>3/1/1996</td>
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<tr>
<td>Acting Insurance Director</td>
<td>John Michael 'Mike' Brassey</td>
<td>1/16/1995</td>
<td>12/1/1995</td>
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<tr>
<td>Insurance Director</td>
<td>James M. Alcorn</td>
<td>6/1/1994</td>
<td>1/16/1995</td>
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<td>7</td>
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<tr>
<td>Acting Insurance Director</td>
<td>George J. Neumayer</td>
<td>3/1/1991</td>
<td>7/1/1991</td>
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### NAIC MEMBER TENURE LIST

**State/Member Title** | Member Name | Beg. Date | End Date | Yrs. Served | Mos. Served
--- | --- | --- | --- | --- | ---
**IDAHO—Continued**
Insurance Director | Wayne L. Soward | 5/14/1984 | 1/5/1987 | 3 | 5
Insurance Director | Trent M. Woods | 9/12/1980 | 5/14/1984 | 3 | 8
Insurance Director | Monroe C. Gollaher | 1/1/1974 | 9/12/1980 | 6 | 8
Insurance Commissioner | James Hubbard | 7/1/1947 | 7/28/1950 | 3 | 0
Insurance Director | Edward B. McMonigle | 8/1/1945 | 7/1/1947 | 1 | 11
Acting Insurance Director | Laura E. Dewey | 4/5/1945 | 8/1/1945 | 0 | 4
Insurance Director | Howard C. Cullimore | 5/21/1944 | 4/5/1945 | 0 | 11
Insurance Director | James A. Dement | 4/8/1944 | 5/21/1944 | 0 | 1
Insurance Director | Howard C. Cullimore | 1/4/1943 | 4/8/1944 | 1 | 3
Insurance Director | Joel Jenifer | 1/7/1941 | 1/4/1943 | 2 | 0
Insurance Director | Ted M. Walrath | 3/1/1939 | 1/7/1941 | 1 | 10
Insurance Director | Warren H. Bakes | 3/2/1931 | 3/1/1939 | 8 | 0
Insurance Director | David C. Neifert | 6/1/1924 | 3/1/1931 | 6 | 9
Insurance Director | Harry D. Smith | 12/22/1922 | 6/1/1924 | 0 | 6
Insurance Director | Howard J. Brace | 10/18/1919 | 12/22/1922 | 3 | 2
Insurance Director | Willet R. Hyatt | 5/15/1917 | 10/18/1919 | 1 | 11
Insurance Commissioner | George F. Steele | 7/1/1915 | 5/15/1917 | 1 | 10
Insurance Commissioner | Elmer F. Van Valkenberg | 4/1/1913 | 7/1/1915 | 2 | 3
Insurance Commissioner | Isaac C. Hattabaugh | 4/1/1911 | 4/1/1913 | 2 | 0
Insurance Commissioner | Charles D. Goaslind | 8/24/1909 | 4/1/1911 | 1 | 7

**ILLINOIS—Appointed, at the Pleasure of the Governor**

Director of Insurance | Dana Popish Severinghaus | 2/22/2022 | incumbent
Acting Director of Insurance | Dana Popish Severinghaus | 1/19/2021 | 2/22/2022 | 1 | 1
Interim Acting Director of Insurance | Shannon Whalen | 12/11/2020 | 1/18/2021 | 0 | 1
Director of Insurance | Robert H. Muriel | 5/31/2019 | 12/11/2020 | 1 | 7
Acting Director of Insurance | Kevin Fry | 1/25/2019 | 3/8/2019 | 0 | 2
Acting Director of Insurance | Karin Zosel | 12/12/2018 | 1/25/2019 | 0 | 1
Director of Insurance | Jennifer Hammer | 2/15/2017 | 12/10/2018 | 0 | 10
Acting Director of Insurance | Jennifer Hammer | 1/17/2017 | 2/15/2017 | 0 | 1
Acting Director of Insurance | Anne Melissa Dowling | 7/1/2015 | 1/17/2017 | 1 | 6
Acting Director of Insurance | James A. Stephens | 1/12/2015 | 7/1/2015 | 0 | 6
Director of Insurance | Andrew Boron | 1/27/2012 | 1/12/2015 | 3 | 0
Acting Director of Insurance | Robert E. ‘Bob’ Wagner | 1/1/2012 | 1/27/2012 | 0 | 1
Acting Director of Insurance | Andrew R. Stolli | 10/1/2011 | 12/31/2011 | 0 | 2
Acting Director of Insurance | Jack Messmore | 6/1/2011 | 10/1/2011 | 0 | 4
Acting Director of Insurance | Deirdre K. Manna | 2/17/2004 | 3/21/2005 | 1 | 1
Director of Insurance | J. Anthony Clark | 3/31/2003 | 1/31/2004 | 0 | 10
Acting Director of Insurance | Arnold Dutcher | 1/1/2003 | 3/31/2003 | 0 | 2
Director of Insurance | Nathaniel S. ‘Nat’ Shapo | 1/19/1999 | 1/1/2003 | 4 | 0
Acting Director of Insurance | Arnold Dutcher | 2/27/1998 | 1/19/1999 | 0 | 11
Acting Director of Insurance | James W. ‘Jim’ Schacht | 2/1/1994 | 7/1/1995 | 1 | 5

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### ILLINOIS—Continued

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### INDIANA—Appointed, at the Pleasure of the Governor

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## NAIC Member Tenure List

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<tr>
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<td>Interim Commissioner of Insurance</td>
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### NAIC MEMBER TENURE LIST

#### KANSAS—Elected; 4-Year Term

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<td>Vicki Schmidt</td>
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<td>Commissioner of Insurance</td>
<td>Kenneth A. ‘Ken’ Selzer</td>
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<td>Sandra K. ‘Sandy’ Praeger</td>
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<td>George Tobey Anthony</td>
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<td>Simon H. Snider</td>
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<td>Superintendent of Insurance</td>
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<td>Richard D. Morris</td>
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#### KENTUCKY—Appointed, at the Pleasure of the Governor

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<td>Sharon P. Clark</td>
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<td>Nancy G. Atkins</td>
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<td>Brian Maynard</td>
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<td>Glenn Jennings</td>
<td>4/27/2005</td>
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# NAIC MEMBER TENURE LIST

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<td>1/1/1924</td>
<td>4/1/1929</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>A. M. Wash</td>
<td>5/1/1923</td>
<td>1/1/1924</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>James F. Ramey</td>
<td>1/1/1920</td>
<td>5/1/1923</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Charles F. Thomas</td>
<td>3/1/1916</td>
<td>1/1/1920</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>M. C. Clay</td>
<td>3/1/1912</td>
<td>3/1/1916</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Charles W. Bell</td>
<td>9/1/1907</td>
<td>3/1/1912</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Henry R. Prewitt</td>
<td>9/1/1904</td>
<td>9/1/1907</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>John B. Chenault</td>
<td>9/1/1900</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Will H. Stone</td>
<td>9/1/1898</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>David N. Comingore</td>
<td>9/22/1896</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Henry F. Duncan</td>
<td>8/1/1890</td>
<td>9/1/1896</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Leslie C. Norman</td>
<td>9/20/1881</td>
<td>8/1/1890</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Bedford Leslie</td>
<td>9/18/1877</td>
<td>9/1/1881</td>
<td>4</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Gustavus W. Smith</td>
<td>5/24/1871</td>
<td>9/19/1876</td>
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# LOUISIANA—Elected, 4-Year Term

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>James J. ‘Jim’ Donelon</td>
<td>2/15/2006</td>
<td></td>
<td>incumbent</td>
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</tr>
<tr>
<td></td>
<td>(Appointed Feb. 15, 2006;</td>
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<td>Elected Sept. 30, 2006;</td>
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<td>Re-elected Oct. 20, 2007;</td>
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<td>Re-elected Oct. 22, 2011;</td>
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<td>Re-elected Oct. 24, 2015;</td>
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<table>
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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td></td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Darrell Cobb</td>
<td>8/1/1991</td>
<td>12/1/1991</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Dudley A. Guglielmo</td>
<td>5/1/1964</td>
<td>5/1/1972</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Rufus D. Hayes</td>
<td>8/1/1956</td>
<td>5/1/1964</td>
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## NAIC Member Tenure List

### LOUISIANA—Continued

<table>
<thead>
<tr>
<th>State/Member Title</th>
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<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Secretary of State/Insurance Cmsr.</td>
<td>James A. Gremillion</td>
<td>6/24/1940</td>
<td>6/7/1943</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Eugene A. Conway</td>
<td>6/22/1932</td>
<td>2/19/1940</td>
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<tr>
<td>Insurance Commissioner</td>
<td>John D. Saint</td>
<td>9/8/1930</td>
<td>5/11/1932</td>
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<tr>
<td>Insurance Commissioner</td>
<td>James J. Bailey</td>
<td>9/30/1916</td>
<td>12/1/1929</td>
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<tr>
<td>Insurance Commissioner</td>
<td>William E. Millsaps</td>
<td>9/21/1915</td>
<td>9/29/1916</td>
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<tr>
<td>Acting Deputy Insurance Commissioner</td>
<td>Richard Flower</td>
<td>3/10/1915</td>
<td>4/1/1915</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>E. J. O'Brien</td>
<td>5/1/1911</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>Edward Everett</td>
<td>1/1/1911</td>
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<tr>
<td>Assistant Secretary of State/Ins. Commissioner</td>
<td>Eugene J. McGivney</td>
<td>9/29/1903</td>
<td>9/30/1910</td>
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<td>Secretary of State/Ins. Commissioner</td>
<td><em>No Record in NAIC Proceedings</em></td>
<td>9/13/1898</td>
<td>9/25/1902</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>Edward Newman</td>
<td>1897</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>John J. McCann</td>
<td>1896</td>
<td>1897</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>John T. Michel</td>
<td>1896</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>W. B. Spencer</td>
<td>10/1/1895</td>
<td>1896</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>George Spencer</td>
<td>10/1/1894</td>
<td>10/1/1895</td>
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<td>Deputy Insurance Commissioner</td>
<td>W. B. Spencer</td>
<td>10/1/1891</td>
<td>10/1/1894</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>L. F. Mason</td>
<td>10/1/1889</td>
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<tr>
<td>Secretary of State</td>
<td>Simeon Toby</td>
<td>8/6/1888</td>
<td>10/1/1891</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>Oscar Orroyo</td>
<td>10/1/1885</td>
<td>10/1/1889</td>
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<tr>
<td>Deputy Insurance Commissioner</td>
<td>William A. Strong</td>
<td>9/1/1878</td>
<td>9/25/1884</td>
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<tr>
<td>Secretary of State</td>
<td><em>No Record in NAIC Proceedings</em></td>
<td>4/16/1872</td>
<td>8/27/1878</td>
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<tr>
<td>Secretary of State</td>
<td>Richard Gaines</td>
<td>10/18/1871</td>
<td>4/15/1872</td>
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<tr>
<td>Secretary of State</td>
<td>George E. Bovee</td>
<td>5/24/1871</td>
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### MAINE—Appointed; 5-Year Term

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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</thead>
<tbody>
<tr>
<td>Acting Superintendent of Insurance</td>
<td>Timothy N. Schott</td>
<td>4/1/2022</td>
<td>Incumbent</td>
<td></td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Mila Kofman</td>
<td>3/1/2008</td>
<td>5/31/2011</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Eric A. Cioppa</td>
<td>1/14/2007</td>
<td>2/28/2008</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Jeri E. Brown</td>
<td>9/1/1991</td>
<td>10/21/1991</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Everard B. Stevens</td>
<td>11/10/1986</td>
<td>6/1/1987</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Frank M. Hogerty, Jr.</td>
<td>10/3/1973</td>
<td>5/20/1979</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Frank M. Hogerty, Jr.</td>
<td>11/15/1967</td>
<td>10/3/1973</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>George F. Mahoney <em>(Died June 1, 1967)</em></td>
<td>6/18/1951</td>
<td>6/1/1967</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>David B. Soule</td>
<td>6/12/1947</td>
<td>6/18/1951</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Alfred W. Perkins</td>
<td>1/14/1946</td>
<td>3/5/1947</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Guy R. Whitten <em>(Alfred W. Perkins on leave of absence for military service)</em></td>
<td>1/13/1944</td>
<td>1/13/1946</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Alfred W. Perkins</td>
<td>5/1/1942</td>
<td>1/12/1944</td>
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<td>State/Member Title</td>
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<td>Beg. Date</td>
<td>End Date</td>
<td>Yrs. Served</td>
<td>Mos. Served</td>
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<td><em>Maine—Continued</em></td>
<td>Pittsburgh</td>
<td>12/30/1940</td>
<td>2/13/1942</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>C. Waldo Lovejoy</td>
<td>3/23/1937</td>
<td>11/12/1940</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Wilbur D. Spencer</td>
<td>5/3/1923</td>
<td>3/22/1937</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Leon W. Nelson</td>
<td>11/26/1922</td>
<td>5/2/1923</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>G. Waldon Smith</td>
<td>4/24/1918</td>
<td>11/25/1922</td>
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<tr>
<td>Acting Commissioner of Insurance</td>
<td>Ivan E. Lang</td>
<td>1/1/1918</td>
<td>4/24/1918</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Erastus J. Carter</td>
<td>2/1/1915</td>
<td>1/1/1918</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>J. Wallace Blunt</td>
<td>7/1/1913</td>
<td>2/1/1915</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Andrew P. Havey</td>
<td>12/9/1911</td>
<td>7/1/1913</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Beecher Putnam</td>
<td>1/1/1909</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Stephen W. Carr</td>
<td>12/26/1893</td>
<td>1/1/1909</td>
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<td>Commissioner of Insurance</td>
<td>Joseph O. Smith</td>
<td>1/1/1885</td>
<td>12/26/1893</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Frank E. Nye</td>
<td>9/1/1884</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Ormandal Smith</td>
<td>4/1/1883</td>
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<td>Joseph B. Peaks</td>
<td>3/1/1880</td>
<td>4/1/1883</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>William Philbrick</td>
<td>5/5/1879</td>
<td>3/1/1880</td>
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<td>Commissioner of Insurance</td>
<td>Joshua Nye</td>
<td>4/26/1873</td>
<td>5/5/1879</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Albert W. Paine</td>
<td>5/24/1871</td>
<td>4/26/1873</td>
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</table>

| Maryland—Appointed, at the Pleasure of the Governor; 4-Year Term | | | | | |
| Commissioner of Insurance | Kathleen A. Birrane | 5/18/2020 | incumbent |
| Commissioner of Insurance | Alfred W. 'Al' Redmer, Jr. | 1/22/2015 | 5/15/2020 | 5 | 4 |
| Commissioner of Insurance | Therese M. Goldsmith | 6/13/2011 | 1/21/2015 | 3 | 7 |
| Acting Commissioner of Insurance | Elizabeth 'Beth' Sammis | 1/1/2010 | 6/13/2011 | 1 | 5 |
| Commissioner of Insurance | Ralph S. Tyler III | 9/1/2007 | 1/1/2010 | 2 | 4 |
| Interim Commissioner of Insurance | Peggy J. Watson | 6/1/2007 | 9/1/2007 | 0 | 3 |
| Commissioner of Insurance | R. Steven 'Steve' Orr | 1/1/2006 | 5/31/2007 | 1 | 4 |
| Acting Commissioner of Insurance | James V. 'Jim' McMahen | 10/1/2005 | 1/1/2006 | 0 | 3 |
| Commissioner of Insurance | Alfred W. 'Al' Redmer, Jr. | 6/1/2003 | 10/1/2005 | 2 | 4 |
| Commissioner of Insurance | Steven B. 'Steve' Larsen | 6/16/1997 | 6/1/2003 | 6 | 0 |
| Acting Commissioner of Insurance | Charles B. Kelly III | 5/1/1997 | 6/1/1997 | 0 | 1 |
| Commissioner of Insurance | Dwight K. Bartlett III | 5/1/1993 | 5/1/1997 | 4 | 0 |
| Commissioner of Insurance | John A. Donahoe | 5/1/1989 | 5/1/1993 | 4 | 0 |
| Commissioner of Insurance | E. Susan Kellogg | 7/1/1988 | 5/1/1989 | 0 | 10 |
| Acting Commissioner of Insurance | Martha Roach | 1/1/1988 | 7/1/1988 | 0 | 6 |
| Commissioner of Insurance | Edward J. Muhl | 7/1/1982 | 1/1/1988 | 5 | 6 |
| Commissioner of Insurance | Edward J. Birrane, Jr. | 7/1/1976 | 7/1/1982 | 5 | 0 |
| Commissioner of Insurance | Thomas J. Hatem | 7/16/1970 | 7/1/1976 | 6 | 0 |
| Commissioner of Insurance | Newton I. Steers, Jr. | 5/15/1967 | 7/15/1970 | 3 | 2 |
| Commissioner of Insurance | Norman Polovoy | 12/16/1966 | 5/15/1967 | 0 | 5 |
| Commissioner of Insurance | Francis B. 'Bill' Burch | 7/15/1965 | 12/16/1966 | 1 | 5 |
| Acting Commissioner of Insurance | John H. Coppage | 8/18/1952 | 12/17/1952 | 0 | 4 |
| Commissioner of Insurance | Harvey M. Chesney (Died Aug. 17, 1952) | 5/8/1951 | 8/17/1952 | 1 | 3 |
| Commissioner of Insurance | Claude M. Hanley | 5/1/1947 | 5/8/1951 | 4 | 0 |
| Commissioner of Insurance | Lawrence E. Ensor | 9/1/1943 | 5/1/1947 | 3 | 8 |
| Commissioner of Insurance | John B. Gontrum | 5/1/1939 | 9/1/1943 | 4 | 4 |
| Commissioner of Insurance | Wesley S. Hanna | 5/1/1935 | 5/1/1939 | 4 | 0 |
## NAIC Member Tenure List

### Maryland—Continued

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
</tr>
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<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>William C. Walsh</td>
<td>5/1/1931</td>
<td>5/1/1935</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Harrison Rider</td>
<td>3/1/1929</td>
<td>5/1/1931</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Commissioner of Insurance</td>
<td>Carville D. Benson</td>
<td>8/1/1924</td>
<td>2/8/1929</td>
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<td>(Died Feb. 8, 1929)</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Harvey L. Cooper</td>
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<td>8/1/1924</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Thomas J. Keating</td>
<td>4/1/1919</td>
<td>9/1/1922</td>
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<td>William Mason Shehan</td>
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<td>Emerson C. Harrington</td>
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<td>Benjamin F. Crouse</td>
<td>12/1/1905</td>
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<td>(Died Nov. 8, 1910)</td>
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<td>J. Frederick C. Talbott</td>
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<td>Jesse K. Hines (Died Sept. 20, 1889)</td>
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### Massachusetts—Appointed, at the Discretion of the Governor

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<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Timothy H. Gailey</td>
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<td>Dennis E. Sullivan</td>
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### NAIC Member Tenure List

#### Massachusetts—Continued

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<th>State/Member Title</th>
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<td>Arthur E. Linnell</td>
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<td>Wesley E. Monk</td>
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<td>Clarence W. Hobbs</td>
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<td>9/1/1919</td>
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<td>Frederick L. ‘Fred’ Cutting</td>
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<td>Insurance Commissioner</td>
<td>George S. Merrill</td>
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<td>John K. Tarbox (Died May 28, 1887)</td>
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<td>Julius L. Clarke</td>
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#### Michigan—Appointed, at the Pleasure of the Governor; 4-Year Term

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<td>Director, Department of Insurance and Financial Services (DIFS)</td>
<td>Aneta G. Fox</td>
<td>1/14/2019</td>
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<td>Acting Director, DIFS</td>
<td>Judith A. ‘Judy’ Weaver</td>
<td>12/28/2018</td>
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<td>Patrick M. McPharlin</td>
<td>5/18/2015</td>
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<td>Director, DIFS</td>
<td>Annette E. Flood</td>
<td>11/1/2013</td>
<td>5/18/2015</td>
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<td>Director, DIFS</td>
<td>R. Kevin Clinton</td>
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<td>Ronald C. Jones, Jr.</td>
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<td>E. L. Cox</td>
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<tr>
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<td>Herman W. Coleman</td>
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<td>David J. Dykhouse</td>
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<td>John W. Wickstrom</td>
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<tr>
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<td>Allen L. Mayerson</td>
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<td>Sherwood Colburn</td>
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### NAIC Member Tenure List

#### Michigan—Continued

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<th>Member Title</th>
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#### Minnesota—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<th>Member Title</th>
<th>Member Name</th>
<th>Beg Date</th>
<th>End Date</th>
<th>Yrs Served</th>
<th>Mos Served</th>
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<td>Michael J. ‘Mike’ Rothman</td>
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### NAIC MEMBER TENURE LIST

#### MINNESOTA—Continued

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### MISSISSIPPI—Elected; 4-Year Term

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### MISSOURI—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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### NAIC Member Tenure List

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### MISSOURI—Continued

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<th>Mos. Served</th>
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<td>Superintendent of Insurance</td>
<td>Alfred Carr</td>
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<td>Superintendent of Insurance</td>
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<td>Superintendent of Insurance</td>
<td>Francis P. Blair, Jr.</td>
<td>10/1/1873</td>
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<td>William Selby</td>
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<td>Superintendent of Insurance</td>
<td>Wyllis King</td>
<td>5/24/1871</td>
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### MONTANA—Elected; 4-Year Term

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Troy Downing (Elected Nov. 3, 2020)</td>
<td>1/4/2021</td>
<td>incumbent</td>
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<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Matthew M. ‘Matt’ Rosendale (Elected Nov. 8, 2016)</td>
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<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>Monica J. Lindeen (Elected Nov. 4, 2008; Re-elected Nov. 6, 2012)</td>
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<td>1/2/2017</td>
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<td>Cmsr. of Securities and Insurance / State Auditor</td>
<td>John Morrison (Elected Nov. 7, 2000; Re-elected Nov. 2, 2004)</td>
<td>1/1/2001</td>
<td>1/5/2009</td>
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<tr>
<td>Cmsr. of Insurance/State Auditor</td>
<td>Mark D. O’Keefe (Elected Nov. 3, 1992; Re-elected Nov. 5, 1996)</td>
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<td>1/1/2001</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Andrea M. ‘Andy’ Bennett (Elected Nov. 6, 1984 Re-elected Nov. 8, 1988)</td>
<td>1/7/1985</td>
<td>1/4/1993</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Elmer V. ‘Sonny’ Omholt</td>
<td>5/21/1962</td>
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<td>John J. Holmes (Died May 12, 1962)</td>
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<td>5/12/1962</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>William Keating (Died June 23, 1917)</td>
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<td>Cmsr. of Insurance/State Auditor</td>
<td>Charles M. McCoy</td>
<td>12/15/1911</td>
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<tr>
<td>Cmsr. of Insurance/State Auditor</td>
<td>Henry R. Cunningham</td>
<td>1/1/1905</td>
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### NEBRASKA—Appointed, at the Pleasure of the Governor

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td>Director of Insurance</td>
<td>Eric Dunning</td>
<td>4/19/2021</td>
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<td>Director of Insurance</td>
<td>Bruce R. Ramge</td>
<td>11/15/2010</td>
<td>4/18/2021</td>
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<td>Bruce R. Ramge</td>
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<td>Acting Director of Insurance</td>
<td>Ann M. Frohman</td>
<td>10/10/2007</td>
<td>11/28/2007</td>
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<td>L. Timothy 'Tim' Wagner (Died Oct. 9, 2007)</td>
<td>1/7/1999</td>
<td>10/9/2007</td>
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<td>Timothy J. Hall</td>
<td>1/3/1998</td>
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## NAIC MEMBER TENURE LIST

### NEBRASKA—Continued

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<td>Director of Insurance</td>
<td>Michael J. Dugan</td>
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<td>Samuel ‘Sam’ Van Pelt</td>
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<td>4/1/1933</td>
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<td>Joseph L. Kizer</td>
<td>1/3/1931</td>
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<td>1/3/1929</td>
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<td>Acting Chief, Bureau of Insurance</td>
<td>Mary A. Fairchild</td>
<td>1/4/1923</td>
<td>4/10/1925</td>
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<tr>
<td>Chief, Bureau of Insurance</td>
<td>W. Bruce Young</td>
<td>8/23/1919</td>
<td>1/4/1923</td>
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<tr>
<td>Secretary of Insurance Board</td>
<td>William B. Eastham</td>
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<td>8/23/1919</td>
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<tr>
<td>Secretary of Insurance Board</td>
<td>Lawson G. Brian</td>
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<tr>
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<td>Heman A. Babcock</td>
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### NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td>Insurance Commissioner</td>
<td>Barbara D. Richardson</td>
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<tr>
<td>Acting Insurance Commissioner</td>
<td>Amy L. Parks</td>
<td>7/7/2015</td>
<td>3/7/2016</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Scott J. Kipper</td>
<td>10/24/2011</td>
<td>7/2/2015</td>
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</table>
### NAIC Member Tenure List

**State/Member Title** | **Member Name** | **Beg. Date** | **End Date** | **Yrs. Served** | **Mos. Served**
--- | --- | --- | --- | --- | ---
**NEVADA—Continued**<br>Acting Insurance Commissioner | Amy L. Parks | 8/12/2011 | 10/24/2011 | 0 | 2
Insurance Commissioner | Brett J. Barratt | 7/7/2010 | 7/1/2011 | 1 | 0
Acting Insurance Commissioner | Betty Baker | 9/1/2008 | 12/29/2008 | 0 | 3
Insurance Commissioner | Alice Molasky-Arman | 1/6/1995 | 9/1/2008 | 13 | 8
Insurance Commissioner | Alessandro A. 'Al' Iuppa | 1/1/1990 | 2/1/1991 | 1 | 1
Insurance Commissioner | David A. Gates | 7/6/1984 | 1/1/1990 | 5 | 6
Insurance Commissioner | Kevin Sullivan | 1/3/1983 | 7/6/1984 | 1 | 6
Insurance Commissioner | Patsy Redmond | 5/12/1981 | 1/1/1983 | 1 | 8
Insurance Commissioner | Donald W. 'Don' Heath | 1/1/1979 | 5/12/1981 | 2 | 4
Insurance Commissioner | James L. 'Jim' Wadhams | 6/1/1978 | 1/1/1979 | 0 | 7
Insurance Commissioner | Paul A. Hammel (Died April 21, 1965) | 4/1/1951 | 4/21/1965 | 14 | 1
Deputy Controller | Paul A. Hammel (Died April 21, 1965) | 1/1/1951 | 4/1/1951 | 0 | 3
State Comptroller | Jerome P. 'Jerry' Donovan | 12/1/1947 | 1/1/1951 | 3 | 5
State Comptroller | Edward C. Peterson | 1/3/1927 | 1/8/1935 | 8 | 0
State Comptroller | George A. Cole | 1/1/1915 | 1/1/1927 | 12 | 0
State Comptroller | Jacob Eggers | 1/1/1907 | 1/1/1915 | 8 | 0
State Comptroller | Samuel P. Davis | 1/1/1899 | 1/1/1907 | 8 | 0
State Comptroller | C. A. LaGrave | 1/1/1895 | 1/1/1899 | 4 | 0
State Comptroller | Robert L. Horton | 1/1/1891 | 1/1/1895 | 4 | 0
State Comptroller | James F. Hallock | 1/1/1879 | 1/1/1891 | 12 | 0
State Comptroller | William W. Hobart | 5/24/1871 | 1/1/1879 | 7 | 8

**NEW HAMPSHIRE—Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council**

Insurance Commissioner | Christopher R. 'Chris' Nicopolopoulos | 2/19/2020 | incumbent
Acting Insurance Commissioner | Alexander K. 'Alex' Feldvebel | 1/1/2020 | 2/19/2020 | 0 | 1
Insurance Commissioner | Paula T. Rogers | 5/12/1999 | 8/12/2003 | 4 | 3
Insurance Commissioner | Charles N. 'Charlie' Blossom | 8/1/1996 | 5/7/1999 | 2 | 9
Acting Insurance Commissioner | Leo W. Fraser, Jr. | 4/11/1975 | 3/31/1976 | 1 | 0
Insurance Commissioner | Donald 'Don' Knowlton | 6/9/1943 | 7/2/1968 | 25 | 1
Acting Insurance Commissioner | Simon M. Sheldon | 4/30/1943 | 6/9/1943 | 0 | 1
Insurance Commissioner | Arthur J. Rouillard | 9/17/1937 | 4/30/1943 | 5 | 7
Insurance Commissioner | John E. Sullivan (Died Sept. 6, 1937) | 6/16/1931 | 9/6/1937 | 6 | 3
Acting Insurance Commissioner | William N. Johnston | 9/26/1930 | 6/16/1931 | 0 | 9
Insurance Commissioner | John E. Sullivan | 5/17/1923 | 9/26/1930 | 7 | 4

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## NAIC MEMBER TENURE LIST

### NEW HAMPSHIRE—Continued

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>John J. Donahue (Died May 8, 1923)</td>
<td>4/2/1919</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Rufus N. Elwell (Died Feb. 9, 1919)</td>
<td>11/21/1917</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Robert J. Merrill</td>
<td>1/13/1915</td>
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<td>Joseph Warren</td>
<td>12/31/1914</td>
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<td>John C. Linehan (Died Sept. 19, 1905)</td>
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<td>Henry H. Huse</td>
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<td>9/7/1890</td>
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<td>Insurance Commissioner</td>
<td>Oliver Pillsbury (Died Feb. 21, 1888)</td>
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### NEW JERSEY—Appointed, at the Pleasure of the Governor

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<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Marlene Caride</td>
<td>6/27/2018</td>
<td></td>
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<td>incumbent</td>
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<tr>
<td>Acting Cmsr. of Banking and Ins.</td>
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<tr>
<td>Commissioner Designee</td>
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<td>Richard J. Badolato</td>
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<td>Peter L. Hartt</td>
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<td>Holly C. Bakke</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Jaynee LaVecchia</td>
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<td>Elizabeth ‘Lisa’ Randall</td>
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<td>Acting Insurance Commissioner</td>
<td>Anita B. Kartalopoulos</td>
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<td>John G. Foley</td>
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<td>Charles R. Howell</td>
<td>2/1/1955</td>
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## NAIC Member Tenure List

### New Jersey—Continued

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<th>State/Member Title</th>
<th>Member Name</th>
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<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Acting Cmsr. of Banking and Ins.</td>
<td>Jerome B. McKenna</td>
<td>10/1/1954</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>Warren N. Gaffney</td>
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<td>Eugene E. Agger</td>
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<td>Cmsr. of Banking and Insurance</td>
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<td>(Died Feb. 11, 1923)</td>
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<td>(Represented by Actuary David P. Fackler)</td>
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<tr>
<td>Secretary of State</td>
<td>Henry C. Kelsey</td>
<td>5/24/1871</td>
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### New Mexico—Appointed, by the Insurance Nominating Committee; 4-Year Term

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<th>End Date</th>
<th>Yrs. Served</th>
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<tr>
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<td>Russell Toal</td>
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<td>Eric P. Serna</td>
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<td>2/1/1928</td>
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### NEW MEXICO—Continued

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<th>End Date</th>
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<td>H. A. Delgado</td>
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<td>L. B. Gregg</td>
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<td>Cleofas Romero</td>
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<td>Jacobo Chavez</td>
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### NEW YORK—Appointed, at the Pleasure of the Governor

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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Adrienne A. Harris</td>
<td>1/25/2022</td>
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<td>Acting Superintendent of Fin. Svcs.</td>
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### NAIC MEMBER TENURE LIST

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<th>BEG. DATE</th>
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<td>Orlow W. Chapman</td>
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### NORTH CAROLINA—Elected; 4-Year Term

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<th>BEG. DATE</th>
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<th>MOS. SERVED</th>
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<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>Mike Causey (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
<td>1/1/2017</td>
<td>incumbent</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>G. Wayne Goodwin</td>
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<td>1/1/2017</td>
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<td>Commissioner of Insurance</td>
<td>John Randolph Ingram</td>
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<td>C. M. Cooke</td>
<td>8/1/1895</td>
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<td>Secretary of State</td>
<td>Octavius Coke</td>
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## North Dakota—Elected; 4-Year Term

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<th>Mos. Served</th>
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<tbody>
<tr>
<td>Commissioner of Insurance</td>
<td>Jon Godfread (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
<td>1/3/2017</td>
<td>incumbent</td>
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## Northern Mariana Islands—Appointed, Concurrent with Current Governor

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<th>Yrs. Served</th>
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<tr>
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## NAIC Member Tenure List

### Ohio—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
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### Oklahoma—Elected; 4-Year Term

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### Oregon—Appointed, Indefinite

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<td>Andrew R. Stolfi</td>
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### NAIC Member Tenure List

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#### Pennsylvania—Appointed, by the Governor with the Advice and Consent of the Senate

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# NAIC Member Tenure List

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## NAIC MEMBER TENURE LIST

### PUERTO RICO—Appointed, Indefinite

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<th>Mos. Served</th>
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<tr>
<td>Commissioner of Insurance</td>
<td>Alexander S. Adams Vega</td>
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<td>Angela Wayne</td>
<td>1/2/2013</td>
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<td>Ramón L. Cruz-Colón</td>
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### RHODE ISLAND—Appointed, at the Discretion of the Director of Business Regulation

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### SOUTH CAROLINA — Appointed, by the Governor upon the Advice and Consent of the Senate

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<td>Layfayette P. Epton</td>
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## NAIC Member Tenure List

### South Carolina — Continued

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### South Dakota — Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation

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### NAIC Member Tenure List

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#### Tennessee—Appointed, at the Discretion of the Governor

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### NAIC Member Tenure List

#### Tennessee—Continued

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<td>James W. Thomas (Died Oct. 25, 1886)</td>
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#### Texas—Appointed; 2-Year Term

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<td>Cassie Brown</td>
<td>9/8/2021</td>
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<p>| UTAH—Appointed, at the Pleasure of the Governor; Confirmed by the Senate | | | | | |
| Commissioner of Insurance | Jonathan T. ‘Jon’ Pike | 2/4/2021 | incumbent |
| Acting Commissioner of Insurance | Jonathan T. ‘Jon’ Pike | 1/5/2021 | 2/4/2021 | 0 | 1 |
| Interim Commissioner of Insurance | Tanji J. Northrup | 10/1/2020 | 1/5/2021 | 0 | 3 |
| Commissioner of Insurance | Todd E. Kiser | 12/20/2012 | 9/30/2020 | 7 | 9 |
| Commissioner of Insurance | Neal T. Gooch | 5/24/2010 | 12/20/2012 | 2 | 7 |
| Acting Commissioner of Insurance | Neal T. Gooch | 1/19/2010 | 5/24/2010 | 0 | 4 |
| Commissioner of Insurance | D. Kent Michie | 1/5/2005 | 1/19/2010 | 5 | 0 |
| Commissioner of Insurance | Merwin U. Stewart | 2/7/1997 | 12/31/2004 | 7 | 11 |
| Commissioner of Insurance | Robert E. Wilcox | 1/27/1993 | 2/7/1997 | 4 | 1 |
| Commissioner of Insurance | Harold C. Yancey | 7/1/1985 | 1/27/1993 | 7 | 7 |</p>
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<tr>
<th>STATE/MEMBER TITLE</th>
<th>MEMBER NAME</th>
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<th>END DATE</th>
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<td>Commissioner of Insurance</td>
<td>Roger C. Day (Died July 18, 2019)</td>
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<td>Commissioner of Insurance</td>
<td>Lewis M. Terry</td>
<td>5/1/1949</td>
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<td>Rulon S. Wells</td>
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<td>John James</td>
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<td>10/10/1910</td>
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<td>Commissioner of Insurance</td>
<td>George B. Squires (Died Sept. 30, 1910)</td>
<td>4/8/1909</td>
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<td>Secretary of State</td>
<td>Charles S. Tingley</td>
<td>1/2/1905</td>
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<td>Secretary of State</td>
<td>James T. Hammond</td>
<td>1/6/1896</td>
<td>1/2/1905</td>
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<td>Secretary of Territory</td>
<td>Elijah Sells</td>
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<td>5/6/1893</td>
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<td>4/6/1887</td>
<td>5/16/1889</td>
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<tr>
<td>Secretary of Territory</td>
<td>Arthur L. Thomas</td>
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<td>4/6/1887</td>
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| VERMONT—Appointed, Biennially by the Governor with the Advice and Consent of the Senate | | | | | |
| Commissioner, DFR | Susan L. Donegan | 1/10/2013 | 6/30/2016 | 3 | 5 |
| Commissioner, DFR | Stephen W. ‘Steve’ Kimbell | 4/4/2012 | 1/9/2013 | 0 | 9 |
| Commissioner, Department of Banking, Insurance, Securities, & Health Care Administration (BISHCA) | Stephen W. ‘Steve’ Kimbell | 1/7/2011 | 4/3/2012 | 1 | 3 |
| Commissioner, BISHCA | Michael F. ‘Mike’ Bertrand | 6/18/2010 | 1/6/2011 | 0 | 7 |
| Commissioner, BISHCA | Paulette L. Thabault | 1/22/2007 | 6/18/2010 | 3 | 5 |
| Commissioner, BISHCA | John P. Crowley | 1/9/2003 | 1/5/2007 | 4 | 0 |
| Commissioner of Banking and Insurance | Jeffery P. Johnson | 1/13/1990 | 8/14/1992 | 2 | 7 |
| Commissioner of Banking and Insurance | Gretchen Babcock | 7/10/1987 | 1/13/1990 | 2 | 6 |
| Commissioner of Banking and Insurance | Thomas P. Menson | 3/30/1986 | 7/11/1987 | 1 | 3 |
| Commissioner of Banking and Insurance | George A. Chaffee | 3/24/1980 | 11/16/1984 | 4 | 8 |
| Commissioner of Banking and Insurance | Stewart M. Ledbetter | 2/16/1977 | 2/22/1980 | 3 | 0 |
| Acting Cmrs. of Banking and Insurance | Jean B. Baldwin | 6/23/1976 | 2/16/1977 | 0 | 8 |
| Commissioner of Banking and Insurance | James A. Guest | 7/16/1973 | 6/23/1976 | 2 | 11 |
| Acting Cmrs. of Banking and Insurance | Eugene R. Lemke | 1/3/1973 | 7/16/1973 | 0 | 6 |
| Commissioner of Banking and Insurance | Charles F. Black | 1/9/1969 | 1/3/1973 | 4 | 0 |
| Commissioner of Banking and Insurance | James H. Hunt | 7/20/1965 | 1/8/1969 | 3 | 6 |
| Commissioner of Banking and Insurance | Robert E. Cummings, Jr. | 6/7/1963 | 7/19/1965 | 2 | 1 |
### NAIC Member Tenure List

#### Vermont—Continued

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<td>Commissioner of Banking and Insurance</td>
<td>Alexander H. Miller</td>
<td>3/1/1951</td>
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<td>Acting Cmsr. of Banking and Insurance</td>
<td>Albert D. Pingree</td>
<td>11/15/1950</td>
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<td>Donald A. Hemenway</td>
<td>12/1/1947</td>
<td>11/15/1950</td>
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<td>Commissioner of Banking and Insurance</td>
<td>Charles E. Burns</td>
<td>7/1/1943</td>
<td>12/1/1947</td>
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<td>Acting Cmsr. of Banking and Insurance</td>
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<td>4/29/1943</td>
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<td>Reginald T. Cole</td>
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<td>Commissioner of Banking and Insurance</td>
<td>L. Douglas Meredith</td>
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<td>Robert C. Clark</td>
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<td>Insurance Commissioner</td>
<td>Laurence A. Kelty</td>
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<td>4/15/1923</td>
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<td>Secretary of State</td>
<td>Guy W. Bailey</td>
<td>10/1/1915</td>
<td>4/11/1917</td>
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<td>State Treasurer</td>
<td>Walter F. Scott</td>
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<td>Secretary of State</td>
<td>F. L. Fleetwood</td>
<td>10/1/1902</td>
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<td>State Treasurer</td>
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<td>Secretary of State</td>
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#### Virgin Islands—Elected; 4-Year Term

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<td>Lt. Governor/Ins. Commissioner</td>
<td>Tregenza A. Roach (Elected Nov. 20, 2018)</td>
<td>1/7/2019</td>
<td>incumbent</td>
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<td>Lt. Governor/Ins. Commissioner</td>
<td>Osbert E. Potter</td>
<td>1/5/2015</td>
<td>1/7/2019</td>
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<td>Gregory R. Francis</td>
<td>1/1/2007</td>
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<td>Director, Banking &amp; Insurance</td>
<td>Gwendolyn &quot;Gwen&quot; Hall Brady</td>
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<td>Director, Banking &amp; Insurance</td>
<td>Larry Diehl</td>
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<td>Derek M. Hodge</td>
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<td>1/2/1995</td>
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<td>Lt. Governor/Ins. Commissioner</td>
<td>Juan Francisco Luis</td>
<td>1/6/1975</td>
<td>1/2/1978</td>
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<td>Cyril E. King</td>
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<td>Govt. Secretary/Ins. Commissioner</td>
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<td>1879</td>
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<tr>
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<td>Edward M. Alfriend</td>
<td>10/18/1871</td>
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<td>WASHINGTON—Elected; 4-Year Term</td>
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<td>Insurance Commissioner</td>
<td>Mike Kreidler (Elected Nov. 7, 2000; Re-elected Nov. 2, 2004; Re-elected Nov. 4, 2008; Re-elected Nov. 6, 2012; Re-elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
<td>1/10/2001</td>
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<td>Insurance Commissioner</td>
<td>Deborah M. Senn</td>
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<td>Richard G. ‘Dick’ Marquardt</td>
<td>1/12/1977</td>
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<td>Karl V. Herrmann</td>
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<td>Insurance Commissioner</td>
<td>Lee L. Kueckelhan</td>
<td>1/1/1961</td>
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### NAIC Member Tenure List

#### West Virginia — Appointed, at the Pleasure of the Governor

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#### Wisconsin — Appointed, at the Pleasure of the Governor

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### NAIC MEMBER TENURE LIST

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#### WYOMING—Appointed, at the Pleasure of the Governor

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Updated: 7/9/2022

https://naiconline.sharepoint.com/teams/memberservicesexecutive/shared documents/commissioner/tenure/_tenure_list_master.docx
The following is a record of officers and list of national meeting locations at which the NAIC has met since its organization.

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<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary / Secretary-Treasurer</th>
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Sept. 23, 1886: John K. Tarbox (MA) was elected President for the 1887 Convention; Samuel H. Cross (RI) was elected Vice-President; and Robert B. Brinkerhoff (Ohio chief clerk) was elected Secretary. Commissioner Tarbox died May 28, 1887. Auditor Cross was out of office effective June 1, 1887. Mr. Brinkerhoff was out of office effective June 3, 1887. Oliver Pillsbury (NH) was chosen to preside over the 1887 Convention. It is unknown who acted as Vice-President. Jacob A. McEwen (Ohio chief clerk) was chosen to act as Secretary.

Aug. 21, 1890: Charles B. Allan (Nebraska deputy auditor) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1891 Convention.
3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Superintendent Hahn was out of office effective June 3, 1886. Sept. 22, 1896: Superintendent Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.

4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office effective March 1, 1897. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.

5. Sept. 23, 1896: Frederick L. ‘Fred’ Cutting (MA) was elected Secretary for the 1897 Convention; however, he was out of office at the date of the Convention. Sept. 7, 1897: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1897 Convention.

6. Sept. 7, 1897: Frederick L. ‘Fred’ Cutting (MA) was elected Secretary for the 1898 Convention; however, he declined the offer. Sept. 13, 1898: Edward T. Orear (MO) was elected President for the 1898 Convention.

7. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.

8. Sept. 20, 1900: John A. O’Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.

9. Sept. 29, 1910: Theodore H. Macdonald (CT) was elected Vice-President for the 1911 Convention; however, he was out of office at the date of the Convention. It is unknown who acted as Vice-President.

10. Aug. 25, 1911: Harry R. Cunningham (MT) was elected Secretary for the 1912 Convention; however, he resigned before the Convention assembled. March 1912: Fitz Hugh McMaster (SC) was elected Secretary for the 1912 Convention.

11. Aug. 1, 1913: Willard Done (UT) was elected First Vice-President for the 1914 Convention; however, he resigned before the Convention assembled. It is unknown who acted as First Vice-President.

12. Aug. 31, 1917: Emory H. English (IA) was elected President for the 1918 Convention; Robert J. Merrill (NH) was elected First Vice-President; and Michael J. Cleary (WI) was elected Second Vice-President. November 1917: Mr. Merrill resigned as First Vice-President. Dec. 6, 1917: Mr. Cleary was elected First Vice-President for the 1918 Convention and Walter K. Chorn (MO) was elected Second Vice-President. Jan. 1, 1918: Mr. English resigned as President and Mr. Cleary was elected President for the 1918 Convention by the Executive (EX) Committee. It is unknown who acted as First Vice-President.

13. Aug. 31, 1917: Fitz Hugh McMaster (SC) was elected Secretary for the 1918 Convention; however, he resigned before the Convention assembled. Dec. 6, 1917: Joseph L. Button (VA) was elected Secretary for the 1918 Convention.

14. Sept. 12, 1919: John B. Sanborn (MN) was elected Second Vice-President for the 1920 Convention; however, he resigned before the Convention assembled. June 1920: Alfred L. Harty (MO) was chosen to act as Second Vice-President for the 1920 Convention.

15. Sept. 3, 1920: Frank H. Ellsworth (MI) was elected President for the 1921 Convention; Alfred L. Harty (MO) was elected First Vice-President; and Thomas B. Donaldson (PA) was elected Second Vice-President. Commissioner Ellsworth resigned effective April 30, 1921, as NAIC President and Michigan Insurance Commissioner. June 27, 1921: Superintendent Harty was elected President for the 1921 Convention by the Executive (EX) Committee; Commissioner Donaldson was elected First Vice-President; and Platt Whitman (WI) was elected Second Vice-President.

16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; Herbert O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.
17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.

18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.

19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as NAIC First Vice-President and New York Insurance Superintendent. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 24, 1929: Commissioner Detrick resigned as NAIC President and California Insurance Commissioner. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.

20. Sept. 19, 1929: Joseph L. Button (VA) was elected Secretary for the 1930 Convention; however, he resigned effective Oct. 15, 1929, as NAIC Secretary and Virginia Commissioner of Insurance and Banking. Dec. 10, 1929: Albert S. Caldwell (TN) was elected Secretary for the 1930 Convention.

21. Sept. 9, 1930: Clarence C. Wysong (IN) was elected President for the 1931 Convention; Jess G. Read (OK) was elected First Vice-President; and Clare A. Lee (OR) was elected Second Vice-President. January 1931: Commissioner Wysong resigned effective Jan. 1, 1931, as NAIC President and Indiana Insurance Commissioner; Commissioner Lee was no longer serving as Second Vice-President; and Commissioner Read was elected President by the Executive (EX) Committee for the 1931 Convention. June 17, 1931: Charles D. Livingston (MI) was elected First Vice-President by the Executive (EX) Committee for the 1931 Convention and William A. Tarver (TX) was elected Second Vice-President by the Executive (EX) Committee.

22. Oct. 20, 1932: William A. Tarver (TX) was elected President for the 1933 Convention; Garfield W. Brown (MN) was elected First Vice-President; and Daniel C. ‘Dan’ Boney (NC) was elected Second Vice-President. Commissioner Tarver resigned effective Feb. 10, 1933, as NAIC President and Texas Life Insurance Commissioner. Commissioner Brown was elected President for the 1933 Convention; Commissioner Boney was chosen to act as First Vice-President and George S. Van Schaick (NY) was chosen to act as Second Vice-President.

23. July 1935: It is unclear why no one acted as First Vice-President or Second Vice-President for the 1935 Convention.

24. June 23, 1939: J. Balch Moor (DC) was elected Vice-President; however, he died July 22, 1939, before the 1940 Convention assembled. John C. Blackall (CT) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

25. June 6, 1945: Edward L. Scheufler (MO) was elected Vice-President for the 1946 Convention; however, he resigned effective Oct. 15, 1945, as NAIC Vice-President and Missouri Insurance Superintendent. Dec. 3, 1945: Robert E. Dineen (NY) was elected Vice-President by the Executive (EX) Committee for the 1946 Convention.

26. June 11, 1946: Jess G. Read (OK) was elected Secretary for the 1947 Convention; however, he died July 20, 1946. Sept. 4, 1946: Nellis P. Parkinson (IL) was elected Secretary by the Executive (EX) Committee to fill the unexpired term.

27. June 1953: George B. Butler (TX) was elected Vice-President; however, he died Sept. 28, 1953. It is unknown who acted as Vice-President for the November 1953 Convention. Nov. 30, 1953: Donald Knowlton (NH) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

28. May 1956: George A. Bowles (VA) was elected Secretary; however, he died June 1, 1956. Paul A. Hammel (NV) was elected Secretary to fill the unexpired term.

29. June 1958: Arch E. Northington (TN) was elected President; however, he resigned effective Dec. 23, 1958, as NAIC President and Tennessee Insurance Commissioner. January 1959: Paul A. Hammel (NV) was elected President and Sam N. Beery (CO) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned effective Jan. 29, 1963, as NAIC Vice-President and Illinois Insurance Director. The office of Vice-President was vacant for the June 1963 Convention.
31. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969, as NAIC President and New Jersey Commissioner of Banking and Insurance. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.


33. A constitutional amendment moved NAIC officer elections from June to December (commencing December 1974), President Johnnie L. Caldwell (GA) served a six-month term.

34. Kenneth E. ‘Ken’ DeShetler (OH) was elected President; however, he resigned effective Jan. 13, 1975, as NAIC President and Ohio Insurance Director. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.

35. H. Peter ‘Pete’ Hudson (IN) was elected President; however, he resigned as NAIC President and Indiana Insurance Commissioner effective Nov. 15, 1979. It is unknown who presided over the December 1979 Convention.

36. John W. Lindsay resigned effective Sept. 3, 1981, as NAIC Vice-President and South Carolina Insurance Commissioner. Johnnie L. Caldwell (GA) was elected by the Executive (EX) Committee to fill the unexpired term.

37. David J. Lyons resigned effective June 17, 1994, as NAIC Vice President but remained as Iowa Insurance Commissioner until July 31, 1994. A special interim Plenary election was held June 12, 1994: Arkansas Insurance Commissioner Lee Douglass was elected Vice President to serve June 17, 1994, to Dec. 31, 1994.

38. September 2001: NAIC members unanimously agreed that the 2001 Fall National Meeting should be canceled in the wake of the tragic events that occurred Sept. 11, 2001. The meeting had been scheduled for Sept. 22–25, 2001, at the Marriott and Westin Copley Place hotels in Boston, Massachusetts.

39. Ernst N. ‘Ernie’ Csiszar resigned effective Aug. 18, 2004, as NAIC President and South Carolina Director of Insurance. Approximately two weeks later, James A. ‘Jim’ Poolman resigned as NAIC Vice President but remained as North Dakota Insurance Commissioner. A special interim Plenary election was held Sept. 13, 2004, during the Fall National Meeting in Anchorage, Alaska: Pennsylvania Insurance Commissioner M. Diane Koken was elected President; Oregon Insurance Administrator Joel S. Ario was elected Vice President; and Maine Insurance Superintendent Alessandro A. ‘Al’ Iuppa was elected Secretary-Treasurer to serve from Sept. 13, 2004, to Dec. 31, 2004.

40. December 2004: NAIC members voted at its 2004 Winter National Meeting to adopt amendments to the NAIC Bylaws, which included the creation of a President-Elect position as an NAIC officer.

41. September 2005: NAIC members agreed to cancel the 2005 Fall National Meeting due to the devastation caused by Hurricane Katrina on Aug. 29, 2005. The meeting had been scheduled for Sept. 10–13, 2005, at the Sheraton hotel in New Orleans, Louisiana.

42. Eric P. Serna resigned effective June 14, 2006, as NAIC Secretary-Treasurer and New Mexico Superintendent of Insurance. A special Plenary interim election was held during the 2006 Summer National Meeting: New Hampshire Insurance Commissioner Roger A. Sevigny was elected Secretary-Treasurer to serve from June 14, 2006, to Dec. 31, 2006.

43. Michael T. McRaith resigned effective May 31, 2011, as NAIC Secretary-Treasurer and Illinois Director of Insurance. A special Plenary interim election was held via conference call May 16, 2011: North Dakota Insurance Commissioner Adam Hamm was elected Secretary-Treasurer to serve from May 31, 2011, to Dec. 31, 2011.


45. Michael F. ‘Mike’ Consedine resigned effective Jan. 20, 2015, as NAIC President-Elect and Pennsylvania Insurance Commissioner. A special Plenary interim election was held via conference call Feb. 8, 2015: Missouri Insurance Director John M. Huff was elected President-Elect to serve from Feb. 8, 2015, to Dec. 31, 2015.
46. Sharon P. Clark resigned effective Jan. 11, 2016, as NAIC President-Elect and Kentucky Insurance Commissioner. A special Plenary interim election was held in Bonita Springs, Florida, on Feb. 7, 2016: Wisconsin Insurance Commissioner Theodore K. ‘Ted’ Nickel was elected President-Elect; Tennessee Insurance Commissioner Julie Mix McPeak was elected Vice President; and Maine Insurance Superintendent Eric A. Cioppa was elected Secretary-Treasurer to serve from Feb. 7, 2016, to Dec. 31, 2017.

47. David C. Mattax, NAIC Secretary-Treasurer and Texas Insurance Commissioner, died in office April 13, 2017. A special Plenary interim election was held via conference call on May 12, 2017: South Carolina Insurance Director Raymond G. Farmer was elected Secretary-Treasurer to serve from May 12, 2017, to Dec. 31, 2017.

48. Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.

49. March 11, 2020: Due to concerns about the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Spring National Meeting in a virtual format. However, on March 23, 2020, the NAIC officers decided to suspend holding any further sessions of the virtual Spring National Meeting to allow NAIC members and staff more time to focus on the health emergency. The meeting had been scheduled for March 21–24, 2020, at the Phoenix Convention Center and the Sheraton Grand and Hyatt Regency hotels in Phoenix, Arizona.

50. June 10, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Summer National Meeting in a virtual format. The meeting had been scheduled for Aug. 8–11, 2020, at the Minneapolis Convention Center and the Hilton and Hyatt Regency hotels in Minneapolis, Minnesota.

51. Sept. 21, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Fall National Meeting in a virtual format. The meeting had been scheduled for Nov. 14–17, 2020, at the JW Marriott hotel in Indianapolis, Indiana.

52. Feb. 24, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Spring National Meeting in a virtual format. The meeting had been scheduled for April 10–13, 2021, at the Gaylord Texan Hotel and Convention Center in Grapevine, Texas.

53. June 1, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Summer National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

54. Oct. 27, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Fall National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

Updated: 3/1/2022

https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared Documents/Commissioner/Meeting_Officer_Record/08-Meeting_Officer_Record.docx
NAIC MODEL LAWS, REGULATIONS AND GUIDELINES

The following is a listing of NAIC model laws, regulations, and guidelines referenced in the Proceedings of the 2022 Spring National Meeting.

Annual Financial Reporting Model Regulation (#205)
10-9

Annuity Disclosure Model Regulation (#245)
3-48

Assumption Reinsurance Model Act (#803)
9-41

Corporate Governance Annual Disclosure Model Act (#305)
8-9, 8-23

Corporate Governance Annual Disclosure Model Regulation (#306)
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Credit for Reinsurance Model Law (#785)
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Credit for Reinsurance Model Regulation (#786)
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Health Benefit Plan Network Access and Adequacy Model Act (#74)
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Health Insurance Reserves Model Regulation (#10)
3-29, 10-30

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3-48

Insurance Data Security Model Law (#668)
2-24, 3-7, 5-23, 5-35, 12-7, 12-9, 12-11

Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)
2-22, 3-6, 3-48, 10-1, 10-3, 10-28

Insurance Holding Company System Regulatory Act (#440)
2-22, 3-6, 3-48, 8-6, 8-25, 8-26, 8-27, 9-60, 9-61, 9-97, 9-155, 9-218, 9-542, 9-543, 9-556, 9-587, 9-604, 9-607, 10-1, 10-3, 10-28

Investments of Insurers Model Act (Defined Limits Version) (#280)
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Life and Health Insurance Guaranty Association Model Act (#520)
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Life and Health Reinsurance Agreements Model Regulation (#791)  
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Life Insurance Illustrations Model Regulation (#582)  
5-137

Long-Term Care Insurance Model Regulation (#641)  
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Medicare Supplement Insurance Minimum Standards Model Act (#650)  
9-193, 9-195

Model Law on Examinations (#390)  
9-587, 9-604, 9-610

Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)  
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Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)  
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Modified Guaranteed Annuity Model Regulation (#255)  
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Nonadmitted Insurance Model Act (#870)  
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Pet Insurance Model Act (proposed)  
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Privacy of Consumer Financial and Health Information Regulation (#672)  
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Property and Casualty Insurance Guaranty Association Model Act (#540)  

Protected Cell Company Model Act (#290)  
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Real Property Lender-Placed Insurance Model Act (#631)  
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CALL TO ORDER

Dean L. Cameron, NAIC President

The 234th session of the National Association of Insurance Commissioners (NAIC) will now come to order. Good morning, my name is Dean Cameron. I am Idaho’s Insurance Commissioner and President of the NAIC. I am pleased to be here with you today and would like to welcome you to the 2022 NAIC Spring National Meeting.

INTRODUCTION OF HEAD TABLE

Dean L. Cameron, NAIC President

I am honored to introduce the members of our head table.

Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner
Honorable Raymond G. Farmer, NAIC Past President and South Carolina Insurance Director
Honorable David Altmaier, NAIC Most Recent Past President and Florida Insurance Commissioner
Honorable Chlora Lindley-Myers, NAIC President-Elect, Missouri Insurance Director, and Meeting Host
Honorable Andrew N. Mais, NAIC Vice President and Connecticut Insurance Commissioner
Honorable Jon Godfread, NAIC Secretary-Treasurer and North Dakota Insurance Commissioner
Andrew J. Beal, NAIC Chief Operating Officer (COO) and Chief Legal Officer (CLO)
Michael F. Consedine, NAIC Chief Executive Officer (CEO)

Please welcome the members of our NAIC Spring National Meeting head table.

New Member Video

I would also like to recognize our newest members in this short video, which will be followed by a message from Missouri Governor Mike Parson. [New Member Video Plays.]

Missouri Governor Video

[Missouri Governor Video Plays.]

Introduction of Missouri Director

Dean L. Cameron, NAIC President

It is my pleasure to welcome NAIC President-Elect, Director of the Missouri Department of Commerce and Insurance, and our Meeting Host Chlora Lindley-Myers to share some thoughts.

Missouri Director of Insurance Speech

Welcome to Missouri! I am overjoyed to welcome you as guests here in Kansas City, and I am hoping for beautiful weather this week so you will stay around awhile and enjoy some of the great things we have to offer here in the Show Me State.

If you love BBQ, you are in the right place. There are well-known BBQ establishments all over Kansas City, including Jack Stack, Gates, and Q39, as well as the always changing landscape of new BBQ royalty you just have to try. In fact, this city is the home of the American Royal World Series of Barbecue, and it is the largest barbecue contest
in the world! While I am on the subject of “royal,” this is the home of the Kansas City Royals baseball team; or if football is more your thing, the Kansas City Chiefs are based here as well. Kansas City has the Sporting Kansas City major league soccer club; the Kansas City T-Bones; the American Association of Professional Baseball; and the Missouri Mavericks, our central hockey league team. Whatever sporting event you may like, we have them here.

Beyond BBQ and sports, Kansas City is a beautiful place to explore culture. It has anything you can imagine from the Kemper Museum of Contemporary Art to the Arabia Steamboat Museum. There is the Negro Leagues Baseball Museum, as well as the American Jazz Museum. Bear in mind, Missouri is the only state with two Federal Reserve Banks, one in St. Louis and one here in Kansas City; you will be glad to know Kansas City also has a Money Museum!

While Kansas City is certainly a place you could stay for days and never get bored, Missouri has a lot more to offer. From the eastern side of the state, St. Louis’ iconic Gateway Arch welcomes you to its historic downtown and riverfront entertainments. If you are an outdoor lover, Missouri is full of beautiful attractions to explore, including the Lake of the Ozarks, miles of trails and streams, and many opportunities for cave exploration for those of you who are not afraid of the dark! Please note, there is ALWAYS Branson with its many music shows and Silver Dollar City.

It is always wonderful to have an NAIC national meeting in Kansas City, and I hope we get to do it more often in the future. After all, when you have the meeting at the NAIC home base, it is sure to save a little bit of money for the organization!

I know we have a very busy week ahead, so let us roll up our sleeves and get ready.

While I am hopeful for great weather in Missouri this week during your stay here, I also want to be mindful of the states who are battling severe weather. Our thoughts are with you, your citizens, and your staff who we know are working hard to provide the help they need.

Thank you for coming, enjoy Missouri, and welcome to the Spring National Meeting!

PRESIDENTIAL ADDRESS

Dean L. Cameron, NAIC President

I wish you all could see the vision that I get to see from here. It is so good to be back in a room with all of you. Standing room only, traditional NAIC format. Grateful to have you in attendance and participating, and as I look out in the audience, I see the most important person in my life, my beautiful bride. Grateful to have her support. Thank you for your attendance and your participation. I am confident that you will find our meeting to be full of information and opportunity.

I would like to start by acknowledging what has been taking place the last few weeks in Ukraine. Our thoughts and prayers go out to the people in Ukraine. We pray for their safety, for their peace. We pray for their success in defending their homeland. We pray for those who are providing shelter and clothing and services, like Poland and other countries. We pray for the wisdom of our leaders to help bring an end to this suffering. I would like to take a moment of pause, a moment of silence and prayer, if you will, as you consider the plight of the individuals, the families, the elderly, the children, and yes, even the elected officials of our country and their country, as well as those men and women in particular fighting for and defending their country. We pray for their safety. Join with me in a moment of silence.

Thank you. Our world has changed dramatically, changed by the pandemic, the war, inflation, supply chain issues, and the lack of civil discourse. Our world is not the same, and frankly, neither are the challenges facing the NAIC. Recently, I reached out to some of our leaders and experienced members of our association, and I asked them what they believed and what the largest challenges and the current challenges are facing the NAIC. It will not
surprise you, some of the challenges that are identified, but it might surprise you on some others, and it may cause some contemplation. Here is a partial list of their thoughts:

1. Partisanship and political divisiveness, where there is an all-or-nothing approach, losing the ability to acknowledge that there is more than one side to an issue.

2. The inability to reach solutions in a timely manner on the issues of today.

3. The ability to attract and retain critical employees.

4. Enhanced communications between all related parties.

5. Attention deficit disorder, forgetting that our primary focus is consumer protection and financial solvency.

6. The accurate collection of appropriate and meaningful data.

7. The NAIC’s role, our influence, and our collaboration with other standard-setters both within our continent and abroad.

8. A growing concern about the growing coverage gap, especially among those that are in the low-to-moderate income levels and those of different races, ethnicities, or genders.

9. The NAIC’s credibility as a thought leader in insurance.

In my career as a legislator, I have heard the phrase, "Don't let the perfect be the enemy of the good" uttered many times, usually uttered in acknowledgment that despite our best efforts, we are unable to obtain the perfect legislation or solution. Perfectionism in today's world has become a real challenge in life. Just ask any parent who is trying to raise a teenager. It is not, however, just teenagers who are struggling with this view as they compare themselves on social media, but it is also adults who demonstrate, demand, and seek perfection at every facet. On occasion, we unrealistically believe we can have our cake and eat it too, as my mother used to say. We continue to look only through our own perspective and unsuccessfully fight for the perfect solution. When I first ran for the legislature, the expectation was to find compromise, to find solutions, and to look for the win-win. The solutions, the compromises, and the win-wins are still here today. We just need to look for them, and I am not just speaking to those of us as members. I am speaking to everybody in the room. In my 25 years of legislative service, I never voted for a perfect bill. That includes the ones I wrote. Think about that for a minute. I will let you do the math. Twenty-five years, with an average of 1,200 to 1,500 pieces of legislation a year. That is somewhere around 35,000 pieces of legislation; never a perfect bill. If we waited for a perfect bill, we would still be waiting. My legislative service taught me that you do not get a perfect solution, but you have to decide: is the compromise good enough to advance the ball? Is it good enough to accomplish most of the goal? Is three-fourths of a loaf still success?

I remember in my second year in the U.S. Senate (Senate), we had a newly elected governor, and I had been newly selected as the chair of the newly created Senate Committee on Commerce, Science, and Transportation, which handles all insurance and banking issues. Gov. Phil Batt (R-ID), an onion farmer from western Idaho, proposed workers’ compensation coverage for farm workers. This had been proposed before, mostly by the minority party, and never received a hearing or had a governor’s endorsement. I listened to my colleagues bemoan the proposal after he delivered his State of the State message. Some even declared his proposal dead on arrival. Legislators saw this proposal as burdensome, costly, and difficult for farmers and their communities, who are often struggling to survive. After hearing the naysayers, and as the chairman of the newly formed Senate Committee on Commerce, Science, and Transportation, of which the legislation would likely come through, and with the belief
that the U.S. House of Representatives (House) would not take the issue up, the proposal was landing on my plate.

With the knowledge that it might be putting my re-election in jeopardy, I approached Senate leadership with a plan, and they reluctantly agreed. I am sure they thought, "He's new. He's naïve. Let him try. In that way, we can show the governor that we made an attempt.” What they did not understand or comprehend was that I had a conviction that this was the right thing to do, and I had just finished a book called “7 Habits of Highly Effective People” by Stephen Covey. In that book, it taught me how to obtain “win-win” solutions.

Following that guidance, I invited interested parties, anybody who had a stake in the issue, but especially those who were opposed, to an evening meeting. At that meeting, I asked each of them to give me the reasons why we should not pass workers’ compensation to farm workers. I filled a chalkboard full of objections, concerns, and obstacles. I pushed to make sure we had every objection on the board. I asked over and over again, "Is there any other concern?" I am sure the opposition simply thought this thing is going to die by the sheer weight of their objections. I questioned to make sure I fully understood each objection and truly understood their perspective.

After I was convinced that I had every objection on the table, I invited them back to a meeting the next night. At that meeting, we started with the least difficult issue, and we took each objection one by one and discussed each. We worked to overcome each individual objection, whether we eliminated it as no longer being an objection, and we all agreed that it was not, or we put it on hold to discuss later. If we found an objection that we could not eliminate, we discussed ways to minimize the impact or mitigate the effects of those concerns. Mitigation might look like a change in the law modifying the rule or asking the state insurance fund for some accommodation. We met every night, excluding weekends, for three straight weeks, and we eliminated or mitigated each and every objection. The legislation was drafted, introduced, and to the surprise of many, all those concerned were now either supporting or neutral. There was no negative testimony in the committee, and I carried the bill on the Senate floor to a unanimous vote. Then, because of the momentum, the listening, and the collaboration, a few weeks later, the House, who said it would not entertain the issue, passed the legislation nearly unanimously, and it was signed into law.

Now, you should know this was not a perfect bill. It is what we had consensus on at the time to pass. In fact, just this last year, we repealed some provisions of minimum premium requirements that were put in place as part of mitigation to those concerned in the farm community. Now, I do not share this with you to pat myself on the back or to say this is about me, because it is not. I was simply a small part. I share it with you because of the lessons learned that might help us as we deal with even similar contentious issues.

Often, I hear challenges that we face, or the industry face, or our team faces. Honestly, at times, it feels like we are talking past each other, if we are talking at all. Sometimes, the concerns are thought about privately, without sharing them or putting them on the table to discuss. No resolution can be achieved if the other side does not even know a concern exists.

Then there is the situation where concerns or objections are presented but not fully understood, perhaps without the other side completely listening to the objection. Sometimes, even after concerns and objections are expressed or listened to, there is no attempt to mitigate or find the solution. What makes things even a little more difficult? As we send our wonderful staff to meetings to represent us without any authority to reach compromise, our staff are carrying our desires and at times do not have the ability to reach consensus. My friends, we cannot be the thought leader or maintain our state-based authority position if we are unable to find solutions. Our ability to find consensus is and will be used against us. Our inability leaves the door wide open for others to step into that void. We cannot completely protect consumers if we let others step into our role. We know for certain that consumers are better protected with our state-based system. We cannot help others participate in the industry or purchase affordable coverage or advance opportunities in life-saving careers and life-changing careers unless we are willing to listen and address the concerns and issues and find solutions.

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At our Spring National Meeting, we discuss sharing our thoughts and our concerns respectfully, thoughtfully, and professionally. I renew that reminder. When we discuss an item, we should feel, especially in our regulator-to-regulator sessions, that this is a safe place to share thoughts, concerns, and ideas. When we hear concerns of others, let us seek to understand, especially when we disagree. When we disagree, let us do so civilly and professionally.

We acknowledge that we have differences, different communities, different challenges, and even different philosophies. Those differences, however, if handled appropriately, are also a strength to our state-based system. The NAIC has a reputation of being thoughtful, deliberate, and nonpartisan.

I remember just five years ago, Idaho was attempting some creative approaches to get more Idahoans insured. Because of the rural nature of Idaho, we had several farmers and ranchers and families working from the land who could not qualify for the subsidy offered to others. We took a lot of heat for that approach, and we learned a lot.

I will never forget the many commissioners who said publicly, “We may not try Idaho’s approach in our state, but we defend their right to try it in his state.” The states can be and should be the laboratories of creativity and innovation. Insurance is not partisan, nor should it be. Insurance is principle-based, and we all have things we can agree on. The application of those principles might look slightly different in each of our states, but that is okay.

My friends, the NAIC has a 150-year rich history of leadership. Looking back at our founders in 1871, you will see the NAIC coming together in a fragile country, where the image of brother fighting brother on the battlefield was still fresh and vivid. Only months after our first meeting, the Great Chicago Fire raged; and on the same day it broke out, fires in Michigan and Wisconsin also broke out. The wildfire in and around Peshtigo, WI, is still the deadliest in U.S. history. In that year, and across 15 decades since, NAIC members and the insurance sector have risen to meet the challenges of that day, taking them head-on.

We have many good examples recently where we are making progress and a few where it is easy for us to get caught in the snares of divisiveness. Let us talk about the creation of the Innovation, Cybersecurity, and Technology (H) Committee. It is a great example of seeing the need and finding a solution. The challenge, and we are up to the challenge, is to find consensus in a timely manner on the many issues that the Committee will address. Remember, our answers need not be engraved in stone. The goal is progress, and I look forward to Commissioner Birrane’s leadership on that committee.

Long-term care (LTC) is another area where good strides have been made; yet, there is work to be done. Under Commissioner Scott A. White (VA) and Commissioner Michael Conway’s (CO) leadership, the multi-state review process should be a success, but it will only be a success if we support it. No, I am not saying we must agree on every review or adopt every review as recommended, but let us give the review careful consideration. Other concerns still plague us in LTC. We must carefully and thoughtfully consider these difficult issues; and yes, we can question whether the insurance industry can survive. Rather, rehabilitation is possible; and if it is possible, what does that look like?

On climate and resiliency, under Commissioner Ricardo Lara (CA), Commissioner David Altmaier (FL), and Director Raymond G. Farmer’s (SC) leadership, we have made good strides. In the past, they have been able to effectively remove the politics out of this politically charged issue. Resiliency and disaster mitigation seem to be an area where we can all agree and collaborate.

Then, there is race and insurance, another area that requires skilled navigation. Without question, we all oppose any unfair discrimination; and without question, we are opposed to the barriers that keep different races, ethnicities, and genders from accessing affordable coverage. We must identify those barriers this year and begin
removing them. That certainly includes ramping up our efforts in financial literacy. We believe, regardless of race, ethnicity, or gender, all should have the opportunity to participate in life-changing careers in the insurance field and the regulatory community. We know firsthand the difficulty of attracting and retaining skilled positions in our insurance departments. We need to promote better career opportunities for those of different races, ethnicities, and genders.

That is why I am especially proud to announce that the NAIC has taken steps to create the New Avenues in Insurance Careers (NAIC) Foundation, which will provide scholarships for specific careers in our departments. The foundation will be made up of a board of past members, past presidents, and others who are no longer serving as insurance commissioners. I have requested as inaugural officers our Past President and South Carolina Director Farmer; our former Past President and Kentucky Commissioner George Nichols III; and our former NAIC Chief Executive Officer (CEO), Past President, and Iowa Commissioner Terry Vaughan to serve as our inaugural officers.

While this will take a few months to get established, our goal is to award scholarships this year. We invite all the industry and interested parties to join with us in this lofty but life-changing endeavor. Per Executive (EX) Committee action yesterday, the NAIC will start with a contribution of $200,000 into the foundation.

Throughout our history, our membership has often been the best when our situations are the most difficult. Our commitment to the task at hand has withstood two world wars, 9/11, and countless natural disasters; and we have done this across political and geographic boundaries, striving to set an example of what can be accomplished in a world too often defined in divisiveness and discord. It is the NAIC way. Collaboration, collegiality, and communication position us to honor our commitment to consumers, as well as drawing on each other’s strengths and lifting one another up.

My grandfather used to say to me, "If you're not part of the solution, you're part of the problem." Therefore, I respectfully ask of you, are you part of the solution? Are you sharing your concerns? Are you listening to the concerns of others? Are you trying to find solutions and ways to mitigate those concerns?

This year, we commit ourselves in defining our future, our next 150 years. With your help, I will endeavor to follow in the footsteps of great NAIC leaders like Superintendent Eric A. Cioppa (ME), Director Farmer, and countless others that I could name. As we turn to the remainder of our 151st year, the future starts today, with the rest of our Spring National Meeting. I am honored and humbled to be part of you, to get to rub shoulders with you, and to be your president as we kick off the next 150 years. I am grateful to each of you as you endeavor to find solutions on these difficult issues.

Thank you for joining us today, both in-person and virtually. Let us avoid having the perfect be the enemy of the good. Rather, let us have the good be the friend of our success. Thank you. The meeting is adjourned.

ADJOURNMENT

Dean L. Cameron, NAIC President

Thank you. I look forward to meeting with state insurance regulators, industry leaders, and interested parties as we discuss the work being done at the NAIC. With that, I officially conclude this opening session of the 234th meeting of the NAIC.
Synopsis of the NAIC Committee, Subcommittee, and Task Force Meetings
2022 Spring National Meeting
April 4–8, 2022

TO: Members of the NAIC and Interested Parties
FROM: The Staff of the NAIC

Committee Action
NAIC staff have reviewed the committee, subcommittee, and task force reports and highlighted the actions taken by the committee groups during the 2022 Spring National Meeting. The purpose of this report is to provide NAIC members, state insurance regulators, and interested parties with a summary of these meeting reports.

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)
April 8, 2022
1. Adopted the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework).
2. Ratified the selection of Superintendent Elizabeth Kelleher Dwyer (RI) as the state insurance regulator representative on the Financial Stability Oversight Council (FSOC).
3. Received the April 6 report of the Executive (EX) Committee. See the Committee listing for details.
4. Adopted by consent the committee, subcommittee, and task force minutes of the 2021 Fall National Meeting.
5. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
6. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
7. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
8. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
9. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
10. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
11. Received the report of the International Insurance Relations (G) Committee. See the Committee listing for details.
12. Received the report of the Innovation, Cybersecurity, and Technology (H) Committee. See the Committee listing for details.
13. Received a status report on the state implementation of NAIC-adopted model laws and regulations.

EXECUTIVE (EX) COMMITTEE
April 6, 2022
1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met April 4 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Adopted its March 21, 2022; Feb. 3, 2022; Jan. 14, 2022; and Oct. 12, 2021, minutes. During these meetings, the Committee took the following action:
      i. Approved an amicus brief In Re: Penn Treaty Network America Insurance Company.
iii. Approved the creation of the New Avenues in Insurance Careers (NAIC) Foundation to help individuals obtain skills relevant to the regulation and business of insurance. Scholarships will be awarded to students to fund college education, internships, and apprenticeships.
iv. Approved the release of the SERFF Modernization – 2022 Transition Stages Fiscal for public exposure.
v. Appointed Director Evan G. Daniels (AZ) to the National Insurance Producer Registry (NIPR) Board of Directors.
vi. Selected Los Angeles, CA, as the location of the 2026 Spring National Meeting.
vii. Reappointed Commissioner Andrew N. Mais (CT) to the International Association of Insurance Supervisors (IAIS) Executive Committee.

C. Adopted the March 30 report of the Audit Committee, including the 2021 Financial Audit Report.
D. Adopted the March 8 report of the Internal Administration (EX1) Subcommittee, including its amended 2022 charges to disband the Information Systems (EX1) Task Force.
E. Appointed Director Dean L. Cameron (ID) to the IAIS Executive Committee.
F. Approved initial funding from the NAIC for the creation of the New Avenues in Insurance Careers (NAIC) Foundation to help individuals obtain skills relevant to the regulation and business of insurance. Scholarships will be awarded to students to fund college education, internships, and apprenticeships.

2. Adopted the report of the Executive (EX) Committee, which met March 21, Feb. 3, and Jan. 14 pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.
3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.
5. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Committee listing for details.
7. Adopted a proposal to establish a Catastrophe Modeling Center of Excellence (COE) within the NAIC Center for Insurance Policy and Research (CIPR).
8. Adopted a proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use.
9. Approved disbanding the SERFF Advisory Board.
10. Received the 2021 Annual Report of the NAIC Designation Program Advisory Board.
11. Received a status report on the NAIC State Ahead strategic plan implementation.
12. Received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Mortgage Guaranty Insurance Model Act (#630); 3) the Nonadmitted Insurance Model Act (#870); and 4) the Pet Insurance Model Act.
13. Heard reports from NIPR and the Interstate Insurance Product Regulation Commission (Compact).

Climate and Resiliency (EX) Task Force

April 6, 2022

1. Adopted its March 21 minutes, which included the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Heard updates from its Innovation, Pre-Disaster Mitigation, and Solvency workstreams.
   C. Adopted a proposal to establish a Catastrophe Modeling Center of Excellence (COE) within the NAIC Center for Insurance Policy and Research (CIPR).
   D. Adopted a proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use.
2. Heard a presentation from Zurich North America and Resilient Cities Network on their partnership to improve community resilience.
3. Heard a presentation from Munich Re on solutions to improve flood resilience through community insurance and nature-based mitigation.
4. Heard a federal update.
Government Relations (EX) Leadership Council
The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting.

Long-Term Care Insurance (EX) Task Force
April 6, 2022
1. Adopted its 2021 Fall National Meeting minutes.
2. Received a report on the implementation plans for the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). If adopted by the Executive (EX) Committee and Plenary, the LTCI MSA Framework is expected to be implemented by September. Implementation will involve tasks including, but not limited to: 1) drafting instructions for insurers and multistate actuarial (MSA) team members; 2) making technical updates to NAIC systems and processes to facilitate the MSA process; 3) developing a more detailed feedback process; and 4) initiating the MSA Associate Program.
3. Heard feedback from the American Council of Life Insurers (ACLI) on encouraging participation in the MSA process.
4. Heard an update on industry trends that could have an impact on the solvency of long-term care insurance (LTCI) companies and reserves. The Task Force will continue to monitor the impacts of COVID-19 and cost-of-care inflation.
5. Received a report on the development of the MSA Associate Program. A kick-off meeting was held with 16 state insurance department regulator volunteers. Future meetings will be scheduled. State insurance actuaries or other staff who are interested in joining may contact NAIC support staff.
6. Disbanded the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. If any new topics related to reduced benefit options (RBOs) arise in the future, the Task Force will discuss them. At the request of consumer representatives, at a future meeting, the Task Force will discuss the topic of guidance for policyholders to better understand RBOs.
7. Adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to regulatory matters) of the NAIC Policy Statement on Open Meetings.

Special (EX) Committee on Race and Insurance
April 6, 2022
1. Adopted its 2021 Fall National Meeting minutes.
2. Received a status report from the following workstreams:
   A. Workstream One: Research/analyze the level of diversity and inclusion within the insurance industry.
   B. Workstream Two: Research/analyze the level of diversity and inclusion within the NAIC and state insurance regulator community.
   C. Workstream Three: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the property/casualty (P/C) line of business.
   D. Workstream Four: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the life insurance and annuities line of business.
   E. Workstream Five: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the health insurance line of business.

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
See the Executive (EX) Committee listing for details.
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

April 7, 2022

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted the report of the Accelerated Underwriting (A) Working Group, including its March 24 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 23 minutes, which included the following action:
      i. Discussed comments received on the Jan. 25 draft of the educational report about accelerated underwriting (AU) in life insurance.
   B. Discussed comments received on the March 4 draft of the educational report about AU in life insurance.
   C. Adopted the March 4 draft of the educational report about AU in life insurance.
3. Adopted the educational report about AU in life insurance as referred by the Accelerated Underwriting (A) Working Group.
5. Received an update from the Annuity Suitability (A) Working Group and learned that although 21 states have adopted the best interest revisions to the Suitability in Annuity Transactions Model Regulation (#275) and seven states have state insurance regulations pending, adoption by the remaining states remains a priority. The Working Group plans to meet in May to continue work on a frequently asked questions (FAQ) document to promote greater uniformity in the adoption of Model #275.
6. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
7. Discussed having the Life Insurance Online Guide (A) Working Group focus on updating life insurance information on the NAIC website.
8. Heard a brief update from Workstream Four of the Special (EX) Committee on Race and Insurance that it hopes to focus on marketing and distribution in underserved communities.

Life Actuarial (A) Task Force

March 31, 2022 (in lieu of the Spring National Meeting)

1. Adopted its March 17, March 10, March 3, Feb. 24, Feb. 17, Feb. 10, Feb. 3, and Jan. 27 minutes. During these meetings, the Task Force took the following action:
   A. Exposed recommended models for economic scenario generator (ESG) field testing for a 21-day public comment period ending April 7.
   B. Heard an update from the American Academy of Actuaries (Academy) on the ESG model office testing. The Academy has developed separate model offices for universal life with secondary guarantees (ULSG) and variable annuities (VA).
   C. Exposed amendment proposal 2022-04—which proposes updates to the VM-20 prescribed swap spreads guidance considering the London Interbank Offered Rate (LIBOR) transition to the Secured Overnight Financing Rate (SOFR)—for a 44-day public comment period ending April 22.
   D. Adopted amendment proposal 2022-01, which clarifies the treatment of the pre-reinsurance ceded reserve and the reserve credit for retrocessions. This amendment proposal was previously exposed for a 21-day public comment period ending March 3.
   E. Agreed to forward a proposal to the Blanks (E) Working Group for changes to the VM-20 Reserves Supplement. This proposal was previously exposed for a seven-day public comment period ending March 2.
   F. Exposed amendment proposal 2022-02—which revises language and adds an explicit cross-reference to the VM-21 section—for a 21-day public comment period ending March 23.
   G. Exposed amendment proposal 2022-03—which updates cross-references and improves consistency between VM-20, Requirements for Principle-Based Reserves for Life Products, and VM-21—for a 21-day public comment period ending March 23.
H. Heard comments on the indexed universal life (IUL) exposure, which was designed as a step to potentially address IUL illustration issues. The IUL Illustration (A) Subgroup will consider the comments and appropriately revise the exposure.

I. Disbanded the Guaranteed Issue (GI) Life Valuation (A) Subgroup.

J. Exposed a proposed asset adequacy testing (AAT) actuarial guideline for a 35-day public comment period ending March 18.

K. Adopted its 2021 Fall National Meeting minutes.

L. Adopted amendment proposal 2021-11, which adds a section for other guidance and requirements for assumptions to VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

M. Re-exposed amendment proposal 2020-12—which revises hedge modeling when future hedging strategies are not clearly defined—for a 47-day public comment period ending March 12.

2. Exposed recommended models for field testing the ESG for a public comment period ending April 7.

3. Adopted the report of the Experience Reporting (A) Subgroup, which has not met since the 2021 Fall National Meeting.

4. Adopted the report of the Index-Linked Variable Annuity (A) Subgroup, including its March 9, March 2, and Feb. 16 minutes. During these meetings, the Subgroup took the following action:
   A. Heard a presentation from the American Council of Life Insurers (ACLI) on interim nonforfeiture values.
   B. Heard comments on the index-linked variable annuity (ILVA) actuarial guideline.

5. Adopted the report of the IUL Illustration (A) Subgroup, which has not met since the 2021 Fall National Meeting.

6. Adopted the report of the Longevity Risk (E/A) Subgroup, which has not met since the 2021 Fall National Meeting.

7. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, which has not met since the 2021 Fall National Meeting.

8. Adopted the report of the Variable Annuities Capital and Reserve (E/A) Subgroup, which has not met since the 2021 Fall National Meeting.


10. Adopted amendment proposal 2022-03.

11. Re-exposed amendment proposal 2020-12—which revises hedge modeling when future hedging strategies are not clearly defined—for a public comment period ending April 29.

12. Heard comments on the exposure of the proposed AAT actuarial guideline and discussed Task Force members’ recommended revisions. The document was then re-exposed for a public comment period ending May 2.

13. Heard an update on the key GEMS Equity Model considerations for the ESG and an update on the Academy model office results.

14. Heard an update from the Society of Actuaries (SOA) on research and education.

15. Heard an update on the activities of the Academy Life Practice Council.

**HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE**

**April 7, 2022**

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted the report of the Consumer Information (B) Subgroup, including its March 22 minutes. During this meeting, the Subgroup took the following action:
   A. Discussed potential work for 2022.
   B. Heard a presentation on consumer understanding of surprise medical bills.

3. Adopted the report of the Health Innovations (B) Working Group, which met April 4 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on its approach to the expected end of the COVID-19 public health emergency.
C. Heard presentations from the Oregon Health Authority (OHA) and the Massachusetts Health Connector about state preparations for the expected end of the COVID-19 public health emergency.

D. Heard a presentation from consumer representatives on suggested priorities to protect underserved consumers after the expected end of the COVID-19 public health emergency.

E. Heard a presentation from the NAIC Center for Insurance Policy and Research (CIPR) on updates to its research on the health disparity impacts of telehealth services and alternative payment models.

4. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.

5. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.

6. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.

7. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the implementation of the federal No Surprises Act (NSA) since its Jan. 1 launch date. The update highlighted the CMS’ activities supporting the implementation and enforcement of the NSA, including a No Surprises Help Desk and other web resources, such as frequently asked questions (FAQ) documents.

8. Adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

Health Actuarial (B) Task Force
March 29, 2022 (in lieu of the Spring National Meeting)

1. Adopted its March 2 and Feb. 1 minutes, which included the following action:
   A. Adopted its proposal to revise the instructions for the health Statement of Actuarial Opinion (SAO).
   B. Discussed its proposal to revise the instructions for the health SAO.

2. Adopted the report of the Long-Term Care Actuarial (B) Working Group, including its March 9 minutes. During this meeting, the Working Group took the following action:
   A. Discussed the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s final Long-Term Care Insurance Mortality and Lapse Study.

3. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on Uniform Rate Review Template (URRT) submissions via the System for Electronic Rates & Forms Filing (SERFF).

4. Heard an update on SOA research.

5. Heard an update from the Academy Health Practice Council.

6. Discussed a referral letter from the Health Risk-Based Capital (E) Working Group regarding asset adequacy testing (AAT) for long-term care insurance (LTCI) companies.

Regulatory Framework (B) Task Force
March 23, 2022 (in lieu of the Spring National Meeting)

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 21, March 7, and Feb. 14 minutes. During these meetings, the Subgroup took the following action:
   A. Continued discussion of revisions to Sections 1–7 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) based on the comments received by the July 2, 2021, public comment deadline.
   B. Discussed its approach for reviewing and considering revisions to Model #171, including whether to begin its review of potential revisions for supplemental products first and then consider potential revisions for short-term, limited-duration (STLD) plans.
   C. Discussed how to address indemnity products in Model #171 given the different plan designs for this product, differing state approaches to regulating this product, and complex federal law and regulations related to the product.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its March 22 minutes. During this meeting, the Working Group took the following action:
   B. Agreed to continue the discussion of potential updates and issues to consider, including within the ERISA Handbook.
   C. Adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.

4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which met March 1 and Jan. 25 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which met March 16 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Heard an update from Montana on its pharmacy benefit manager (PBM) law and steps it is taking to implement its provisions.
   C. Heard an update from the ERISA (B) Working Group on its work to revise the ERISA Handbook to add a case analysis of the Rutledge decision. The update included a commitment to work with the Subgroup as it begins work on its 2022 charge to develop a white paper that will include a discussion of state laws regulating PBM business practices, including the implications of the Rutledge decision—i.e., its progeny and impact—if any, on the state regulation of PBM business practices.
   D. Heard an update on work to compile state PBM laws and regulations to support the Subgroup’s 2022 charge to develop a white paper.

6. Heard an update from the Center on Health Insurance Reforms (CHIR) on its work on various projects of interest to the Task Force. The CHIR has developed an interactive map on the roles of federal and state officials on various aspects of the federal No Surprises Act (NSA). The CHIR is working on an issue brief based on interviews with 12 state departments of insurance (DOIs) on their approaches to NSA implementation. The CHIR is also studying the impacts of the COVID-19 public health emergency (PHE), including assessing preparations by the states for the end of the PHE and the impact of COVID-19 on small business health insurance. The CHIR also examined issues related to alternative types of coverage in lieu of federal Affordable Care Act (ACA)-compliant coverage. One issue focused on the misleading marketing of non-ACA compliant coverage during the COVID-19 special enrollment period (SEP). The CHIR’s future work includes: 1) studying state-based marketplace (SBM) outreach and advertising efforts during the most recent open enrollment period; 2) comparing network adequacy rules across the marketplaces and Medicaid managed care organizations (MCOs); 3) state efforts to improve compliance with the MHPAEA; and 4) SBM efforts to improve health equity.

7. Heard a discussion of the issue of health savings accounts (HSAs), high-deductible health plans (HDHPs), and prescription drug copayment accumulators. The discussion provided background information on prescription copayment assistance and its role in lowering patient out-of-pocket costs for prescription drugs. The speakers also discussed state laws with copayment accumulator policies, including states that ban copayment accumulators. The speakers discussed potential conflicts of state copayment accumulator ban laws with federal requirements related to HSA-qualified HDHP plans and continued eligibility to contribute to an HSA in light of such a law. The speakers discussed potential solutions and options to address this issue, including a suggestion that the Task Force consider developing a model bulletin that state DOIs can use to educate consumers on the issue. The speakers also suggested model language for those states that may be contemplating enacting legislation banning copayment accumulator use as a carve out for HSA-qualified HDHP plans to address any potential conflict with federal HSA-qualified HDHP plan requirements.
Senior Issues (B) Task Force

March 17, 2022 *(in lieu of the Spring National Meeting)*

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted its Feb. 25 and Feb. 8 minutes, which included the following action:
   A. Adopted a letter in support of the federal Centers for Medicare & Medicaid Services’ (CMS) proposed rule on stricter marketing guidelines for Medicare Advantage plans and Medicare Part D plans.
   B. Discussed the CMS’ proposed rule on stricter marketing guidelines for Medicare Advantage plans and Medicare Part D plans.
3. Adopted a letter to the CMS regarding the treatment of nonparticipating durable medical equipment (DME) suppliers under Medicare’s “Limitation on Beneficiary Liability.”
4. Discussed Medicare Part D beneficiaries being “crosswalked” from one Medicare prescription drug plan (PDP) to another.
5. Discussed the sale of access to home care masquerading as insurance.
6. Heard a federal legislative update report.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

April 7, 2022

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers’ Compensation (C) Task Force. See the Task Force listing for details.
6. Adopted the report of the Cannabis Insurance (C) Working Group, which met March 24 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Heard a presentation on the state of the union in the cannabis insurance industry from Jencap Specialty Insurance Services and Miller Nash. The presenters discussed the fast growth in the cannabis market, the need for greater depth of coverage options on certain insurance products, and legal implications on coverage concerns.
   C. Heard a report on federal cannabis-related legislative activities from NAIC staff.
   D. Requested that feedback on its 2022 work plan be sent to NAIC staff. The work plan includes: 1) monitoring cannabis-related federal legislation; 2) finishing updates on and moving for adoption of the *Understanding the Market for Cannabis Insurance* white paper by the Fall National Meeting; and 3) hearing presentations and panel discussions on emerging issues.
7. Adopted the report of the Catastrophe Insurance (C) Working Group, which met April 4 in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group and took the following action:
   A. Adopted the Catastrophe Insurance (C) Working Group’s March 4 minutes, which included the following action:
      i. Adopted its 2021 Fall National Meeting minutes.
      ii. Heard a presentation on a survey sent to the states about the *Catastrophe Computer Modeling Handbook* (Handbook). Twenty-two states responded to the survey, and NAIC staff indicated that the purpose of the survey was to help the Working Group determine what information to include in the Handbook to make it a useful tool for state insurance regulators.
      iii. Discussed next steps on the Handbook. The Working Group created a drafting group to begin discussions and drafting updates to the Handbook. The drafting group will add updates to the Handbook addressing the perils of flood, and possibly convective storms and wildfire. The Handbook will address similarities and differences regarding state approaches to the use of catastrophe models, and the drafting group will consider adding a chart to the appendix that compiles a list of bulletins and regulations used around the country.
B. Adopted the NAIC/FEMA (C) Advisory Group’s March 25 minutes, which included the following action:
   i. Heard a presentation on the status of the National Flood Insurance Program (NFIP) Risk Rating 2.0. FEMA began rating existing policyholders under the new methodology April 1.
   ii. Heard a presentation from FEMA on the NFIP’s Community Rating System (CRS). The CRS provides NFIP premium discounts to communities that achieve specific metrics.
C. Heard an update on federal legislation. The NFIP is operating under an extension through Sept. 30, and the NAIC continues to support a long-term reauthorization. Some of the key bills regarding reauthorization of the NFIP include: 1) the NFIP Reauthorization and Reform Act of 2021; and 2) the Continuous Coverage for Flood Insurance Act. Risk Rating 2.0 began phase two of its implementation on April 1. A bipartisan group of coastal senators have tried unsuccessfully to urge FEMA to postpone Risk Rating 2.0 due to concern regarding premium hikes. The following bills have been introduced in the U.S. Senate: the Flood Insurance Pricing Transparency Act and the Community Disaster Resilience Zones Act of 2022.
D. Discussed Handbook updates. A drafting group of several state insurance regulators has been formed. The state insurance regulators who are members of the drafting group met March 29 to begin discussions regarding the drafting of the Handbook’s updates. Future drafting group meetings will include interested parties that have asked to be a part of the drafting group meetings.
E. Received an update from the Iowa Insurance Department on recent tornadoes. Iowa has had several recent catastrophic events in the past year. These events included a derecho, severe convective storms, and, most recently, tornadoes.
F. Received an update from the Tennessee Department of Commerce and Insurance on recent catastrophic events. Tennessee has experienced several catastrophic events in the past few months. These catastrophic events have included flooding, tornadoes, and wildfires.
G. Received an overview of FEMA regional meetings. The most recent FEMA regional meeting was held virtually in 2021 with FEMA Region 8, FEMA Region 9, and FEMA Region 10. FEMA Region 4 formed a Working Group following its regional meeting and is meeting every other month with FEMA colleagues to discuss issues related to disasters. FEMA Region 6 will hold a workshop on May 3 and May 4 in Oklahoma City; the event will be held virtually for those who are unable to attend in person.
H. Received an update on the NAIC Catastrophe Resource Center. NAIC staff are going to send a survey to the states soliciting feedback from state insurance regulators to help better meet their needs.
8. Adopted the report of the NAIC/FEMA (C) Advisory Group, which met April 4 in joint session with the Catastrophe Insurance (C) Working Group. See the Catastrophe Insurance (C) Working Group listing for details.
9. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met since the 2021 Fall National Meeting.
10. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, which has not met since the 2021 Fall National Meeting.
11. Adopted revised charges reappointing the Pet Insurance (C) Working Group with the charge to: “Complete the development of a model law to establish appropriate regulatory standards for the pet insurance industry.”
13. Heard a presentation from NAIC staff on private passenger auto (PPA) insurance results over the past 10 years.
14. Heard a presentation from CCC Intelligent Solutions and the University of South Carolina on pressures in the property/casualty (P/C) insurance industry.
15. Heard a federal update.
16. Heard a presentation from the University of Connecticut School of Law on a recent ordinance in San Jose, CA, requiring liability insurance for gun owners.
Casualty Actuarial and Statistical (C) Task Force
March 8, 2022 (in lieu of the Spring National Meeting)

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted its Feb. 18, Feb. 8, Jan. 24, and Jan. 10 minutes. During these meetings, the Task Force took the following action:
   A. Adopted the Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report).
   B. Received a report on its 2022 charges.
   C. Adopted the report of the Actuarial Opinion (C) Working Group.
   D. Adopted the report of the Statistical Data (C) Working Group.
   E. Heard comments on referral Project #2019-49: Retroactive Reinsurance Exception.
   F. Discussed the regulatory review of random forest rate models.
3. Reported that it met Feb. 15 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.
4. Reported that it held a Predictive Analytics Book Club meeting on Feb. 22. Willis Towers Watson (WTW) presented on the evaluation of models built in Emblem.
5. Adopted the report of the Actuarial Opinion (C) Working Group, including its March 1, Feb. 1, and Jan. 18 minutes. During these meetings, the Working Group took the following action:
   A. Adopted proposed property/casualty (P/C) Statement of Actuarial Opinion (SAO) instructions and referred them to the Blanks (E) Working Group for consideration.
6. Adopted the report of the Statistical Data (C) Working Group, including its Jan. 27 minutes. During this meeting, the Working Group took the following action:
   A. Adopted a plan to speed up the timeline of the Homeowners Report by collecting data from the most recent data year and collecting two years of data in 2022 to catch up to the new timeline.
   B. Decided to begin a review of the Statistical Handbook of Data Available to Insurance Regulators.
8. Adopted regulatory guidelines for the review of random forest rate models and an associated terminology document.
9. Heard a report about coordination with the Innovation, Cybersecurity, and Technology (H) Committee and Workstream Three of the Special (EX) Committee on Race and Insurance regarding potential bias issues in P/C rating.
10. Heard a presentation from the American Academy of Actuaries (Academy) about its P/C projects.
11. Discussed workers’ compensation loss cost multiplier forms. A small group will draft proposed revisions for future Task Force consideration.

Surplus Lines (C) Task Force
The Surplus Lines (C) Task Force did not meet at the Spring National Meeting

Title Insurance (C) Task Force
April 5, 2022
1. Adopted its 2021 Fall National Meeting minutes.
2. Received a report on how cyber-wire fraud cases referred by title agents are handled at the Virginia Bureau of Insurance. Discussion included an overview of requirements under Virginia Code § 38.2-625 Notice to Commissioner.
3. Heard a presentation on closing protection letter (CPL) language. The presentation included examples of state-specific information and how language differs in states with various exclusions.

4. Received a report on how CPLs are used in Louisiana and Ohio from a statutory and regulatory framework. Discussion included an overview of their purpose, relevant statues, and observations as to other jurisprudence.

5. Held a question-and-answer session on the cyber-wire fraud report and presentations.

6. Discussed its 2022 work plan. In the interest of time, comments were asked to be submitted to NAIC staff. The work plan includes:
   A. Holding a regulator-only meeting with the Consumer Financial Protection Bureau (CFPB).
   B. Discussing how use and language of CPLs vary by state.
   C. Hearing a presentation on the post-pandemic future of the title insurance industry.
   D. Having a roundtable discussion on rate regulation.
   E. Hearing a presentation from the industry on complications that arise from the required use of plans by some states that include rules or forms tailored to other lines of insurance.
   F. Reviewing Section 15C of the Title Insurers Model Act to determine if there is a need to make a recommendation to remove the requirement for on-site review of underwriting and claims practices.

**Workers’ Compensation (C) Task Force**

March 21, 2022 (in lieu of the Spring National Meeting)

1. Received a federal update regarding the monitoring of state workers’ compensation programs. There was language included in the original federal Build Back Better Act that provided for funding to the U.S. Department of Labor (DOL) Office of Workers’ Compensation Programs (OWCP) for “monitoring of state workers’ compensation programs.” The language in the bill that passed in the U.S. House of Representatives in November 2021 was an updated bill that did not include a specific reference to the oversight of state workers’ compensation programs. The outcome of the bill in the U.S. Senate remains uncertain.

2. Heard updates on cannabis, independent contractor, and single-payer health care state and federal legislation, as related to workers’ compensation. There has been legislation in each of these areas at both the state and federal levels, and the National Council on Compensation Insurance (NCCI) tracked more than 1,000 state and federal bills.

**MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE**

April 7, 2022

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted its revised 2022 charges. The Privacy Protections (D) Working Group will be reporting to the Innovation, Cybersecurity, and Technology (H) Committee; the Speed to Market (H) Working Group will be reporting to the Market Regulation and Consumer Affairs (D) Committee; the Advisory Organization Examination Oversight (D) Working Group’s name was shortened to the Advisory Organization (D) Working Group; and the Antifraud Education Enhancement (D) Working Group was disbanded.

3. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.


5. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.

6. Adopted the report of the Advisory Organization (D) Working Group, which met March 22 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.

7. Adopted the report of the Market Analysis Procedures (D) Working Group, including its March 3 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Reviewed its 2022 charges.
   C. Discussed the proposed standard ratios for the travel and short-term, limited-duration (STLD) Market Conduct Annual Statement (MCAS) blanks. Comments on the proposed ratios were requested by April 15.
D. Adopted a motion to add the disability insurance and lender-placed insurance MCAS data into the NAIC Market Analysis Review System (MARS).

8. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, including its March 17 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Nov. 22, 2021, minutes.
   B. Received an update on the life MCAS draft edits for accelerated underwriting (AU).
   C. Received an update on the “other health” MCAS drafting group. The data elements are close to conclusion, and another meeting will take place for a review of some additional definitions. The goal is for this to be completed by the end of April for the Working Group’s review.
   D. Adopted a proposal for home and auto digital claims interrogatories to be included in the 2023 MCAS reporting, which will be collected in 2024.
   E. Discussed the proposed lawsuit definitions and the placement of lawsuit data elements for the home and auto MCAS.
   F. Received guidance regarding the new “number of lawsuits closed with consideration for the consumer” data element for the home and auto MCAS.

9. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, including its March 10 minutes. During this meeting, the Working Group took the following action:
   A. Discussed its potential 2022 tasks.
   B. Discussed draft revisions to the Oct. 27, 2021, draft Chapter 21 of the Market Regulation Handbook. The comment deadline for this exposure was extended to April 15.
   C. Discussed draft revisions to the Oct. 27, 2021, draft Chapter 20 of the Market Regulation Handbook. The comment deadline for this exposure was extended to April 15

10. Adopted the report of the Market Regulation Certification (D) Working Group, including its March 22 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed its 2022 charges and discussed the status of the Voluntary Market Regulation Certification Program.
   B. Heard an update on the Certification Program Scoring Matrix. The drafting group met March 9 to resume its work on a scoring matrix that would enable jurisdictions to do self-assessments, as well as provide a framework for scoring jurisdictions seeking certification under the Voluntary Market Regulation Certification Program. The drafting group plans to have the scoring matrix ready for the Working Group’s consideration by the Summer National Meeting.
   C. Reported that it plans to provide the Voluntary Market Regulation Certification Program, the implementation plan, and the scoring matrix to the Market Regulation and Consumer Affairs (D) Committee for consideration by the Fall National Meeting.
   D. Requested comments on any portion of the Voluntary Market Regulation Certification Program by April 15.

11. Adopted the report of the Privacy Protections (D) Working Group, which met April 4 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Reported that it met March 23 and March 9 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to draft its work plan.
   C. Reported that a group of subject matter experts (SMEs) met to draft revisions to the Preamble and the first three sections of the NAIC Insurance Information and Privacy Protection Model Act (#670) for the Working Group’s consideration.
   D. Heard updates on state and federal privacy legislation.
   E. Adopted its work plan.
   F. Received an update from the workstream team drafting the white paper on data ownership and use rights.

12. Adopted the report of the Speed to Market (D) Working Group, which has not met since the 2021 Fall National Meeting.
Antifraud (D) Task Force  
March 28, 2022 (in lieu of the Spring National Meeting)  
1. Adopted its 2021 Fall National Meeting minutes.  
2. Discussed a letter sent to the Task Force concerning racial bias and discrimination. The Task Force discussed the letter and asked for comments from any members or interested state insurance regulators. The Task Force heard comments from the Center for Economic Justice (CEJ). The Task Force advised that it would continue to monitor this potential topic and schedule additional meetings to discuss, if warranted.  
3. Disbanded the Antifraud Education Enhancement (D) Working Group. The Task Force determined that this Working Group’s current charge would be moved under the Task Force.  
4. Received an update from the Antifraud Technology (D) Working Group. The Working Group formed a subject matter expert (SME) group in 2021 to create a template for industry to use when creating the Antifraud Plan. It will expose the final draft of the template for comment. The Working Group will meet to discuss these comments and consider adoption of the template. Once adopted by the Working Group, the template will be presented to the Task Force for consideration of adoption.  
5. Received an update from the Improper Marketing of Health Insurance (D) Working Group. The Working Group has continued to meet monthly in regulator-to-regulator session.  
6. Heard a report on antifraud activity from the Coalition Against Insurance Fraud (Coalition).  
7. Heard an update from the National Health Care Anti-Fraud Association (NHCAA).

Market Information Systems (D) Task Force  
March 25, 2022 (in lieu of the Spring National Meeting)  
1. Adopted its 2021 Fall National Meeting minutes.  
2. Adopted its Dec. 3, 2021, minutes, which included the following action:  
   A. Revised its 2022 proposed charges to continue work on developing recommendations for the incorporation of artificial intelligence (AI) abilities in the NAIC Market Information Systems (MIS).  
3. Considered the Market Information Systems Research and Development (D) Working Group recommendations regarding the incorporation of AI in the NAIC MIS.  
4. Adopted the report of the Market Information Systems Research and Development (D) Working Group, which met March 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, and took the following action:  
   A. Accepted a request to create or enhance a Market Conduct Annual Statement (MCAS) Personalized Information Capture System (PICS) event to notify subscribers on a recurring basis of outstanding waiver and extension requests.  
   B. Accepted a request to add a new Complaints Database System (CDS) coverage type code for telehealth.  
   C. Completed is review of the 2020 MIS data analysis metrics results.  
5. Heard a report on outstanding Uniform System Enhancement Request (USER) forms.  
6. Adopted the Market Information Systems Research and Development (D) Working Group’s MIS data analysis metrics and recommendations. Detailed reports were sent to each jurisdiction’s market analysis chief (MAC).

Producer Licensing (D) Task Force  
The Producer Licensing (D) Task Force did not meet at the Spring National Meeting.
FINANCIAL CONDITION (E) COMMITTEE

April 5, 2022

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted its Jan. 12 minutes. During this meeting, which was held in joint session with the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, the Committee took the following action:
   A. Discussed Phase II of a bond factor proposal for structured and asset-backed securities (ABS).
   B. Discussed residual interests and the informal coordination that has already taken place among the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, and the various risk-based capital (RBC) formulas and RBC working groups.


5. Adopted the report of the Examination Oversight (E) Task Force. See the Task Force listing for details.


7. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.

8. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.


10. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.

11. Adopted the report of the Financial Analysis (E) Working Group, which met April 4, Feb. 23, and Jan. 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results.

12. Adopted the report of the Group Capital Calculation (E) Working Group, including its Feb. 9 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Discussed comments received on possible changes to the 2022 group capital calculation.

13. Adopted the report of the Restructuring Mechanisms (E) Working Group, including its March 28 minutes. During this meeting, the Working Group took the following action:
   A. Adopted a referral to the Receivership and Insolvency (E) Task Force to consider a proposed new Request for NAIC Model Law Development related to the Property and Casualty Insurance Guaranty Association Model Act (#540).
   B. Discussed comments received on the previously exposed draft white paper.
   C. Exposed the draft white paper for a 30-day public comment period ending April 29.

14. Adopted the report of the National Treatment and Coordination (E) Working Group, including its March 9 minutes. During this meeting, the Working Group took the following action:
   A. Tabled proposal 2021-07 (Instructions Regarding Company Responses).
   B. Approved a response to the Chief Financial Regulator Forum, as recommended by the Domestic Surplus Lines Insurers Drafting Group.
   C. Heard an update on the Biographical Affidavit Database Project. During the development phase, industry and state insurance regulator user input is imperative to the development of the electronic application functionality. Interested parties should contact Jane Barr (NAIC).

15. Adopted the report of the Valuation Analysis (E) Working Group, which met March 23, Feb. 8, and Jan. 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.


17. Received an update on certain committee-supported initiatives related to low interest rates and asset risk.
Accounting Practices and Procedures (E) Task Force
April 5, 2022
1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted the report of the Statutory Accounting Principles (E) Working Group, which met April 4 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Adopted its March 2 and Jan. 27 minutes. During these meetings, the Task Force took the following action:
      i. During its March 2 meeting, the Working Group exposed agenda item 2021-19: Proposed Bond Definition, a revised principle-based bond definition, and a draft issue paper for a public comment period ending May 6. In addition, the motion directed NAIC staff to continue discussions with industry on the bond definition and develop proposed reporting changes and potential statutory accounting revisions for a subsequent exposure.
      ii. During its Jan. 27 meeting, the Working Group adopted the following statutory accounting principles (SAP) clarifications, which were effective for year-end 2021 reporting:
         a. Revisions reflect clarifications to life and health reinsurance disclosures and provide guidance to address audit inquiries. (Ref #2021-31)
         b. Revisions to Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees remove reference to the “standard scenario” to ensure consistency with VM-21, Requirements for Principle-Based Reserves for Variable Annuities. The revisions were effective for year-end 2021 reporting. (Ref #2021-18)
   C. Adopted the following clarifications to statutory accounting guidance:
      i. Revisions rejecting the following:
         a. Accounting Standards Update (ASU) 2021-05, Leases (Topic 842), Lessor s—Certain Leases with Variable Lease Payments for statutory accounting. (Ref #2021-29)
         b. ASU 2021-03, Intangibles — Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting. (Ref #2021-28)
         c. ASU 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options for statutory accounting while incorporating guidance on how to account for changes in fair values for written call options. (Ref #2021-27)
         d. ASU 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants as not applicable for statutory accounting. (Ref #2021-30)
      ii. Revisions reflect updated NAIC designation and designation category guidance adopted by the Valuation of Securities (E) Task Force to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). (Ref #2021-23)
      iii. Adopted editorial revisions to update various terminology references of “substantive” and “nonsubstantive” to reflect “new SAP concept” and “SAP clarification.” (Ref #2021-26EP)
iv. Adopted agenda items resulting in blanks proposals without statutory revisions:

a. Adopted an agenda item supporting supplemental reporting of subsidiary, controlled, and affiliated (SCA) entities investments reported in Schedule D, Part 6, Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Companies. The adoption reflects support for blanks proposal 2022-02BWG and did not result in statutory revisions. (Ref #2021-22)

b. Adopted an agenda item proposing to add a new general interrogatory to require disclosure pertaining to cryptocurrencies directly held or permitted for the remittance of premiums. This agenda item did not result in statutory revisions. However, adoption reflects support for the blanks proposal 2022-01BWG. (Ref #2021-24)

D. Exposed the following SAP clarifications:

i. Revisions incorporate: 1) updates from Financial Accounting Standards Board (FASB) Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 7, Presentation, which identifies factors to consider when deciding how items should be displayed on the financial statements; and 2) Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements, which updates the definitions of an asset and a liability. The Working Group exposed two draft issue papers for historical documentation of these SAP clarifications SSAP No. 4—Assets and Nonadmitted Assets and SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. (Ref #2022-01)

ii. Revisions reject ASU 2021-09, Leases (Topic 842), Discount Rate for Lessees That Are Not Public Business Entities for statutory accounting. (Ref #2022-05)

iii. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items: Revisions incorporate certain disclosures from ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance of terms and provisions of assistance received. (Ref #2022-04)

iv. SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 43R—Loan-Backed and Structured Securities: Revisions clarify the identification and reporting requirements for affiliated transactions and incorporate new reporting codes in the investment schedules to identify investments held that involve related parties. The new reporting requirements will identify investments acquired through, or in, related parties, regardless of if they meet the definition of an affiliate. (Ref #2021-21)

v. Revisions reject ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers for statutory accounting. Revisions in SSAP No. 68—Business Combinations and Goodwill also note that the intent is not to modify any U.S. generally accepted accounting principles (GAAP) for U.S. GAAP book value. (Ref #2022-07)

vi. SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies: Revisions propose to either eliminate the audited U.S. tax basis equity valuation exception or clarify that the U.S. tax basis equity audit shall occur at the investee level. (Ref #2022-02)

vii. SSAP No. 86—Derivatives: Revisions propose: 1) a new Exhibit A, which will replace both Exhibit A and Exhibit B of SSAP No. 86 that adopts with modification U.S. GAAP guidance in determining hedge effectiveness; and 2) revised measurement methods for excluded components in hedging instruments. The Working Group directed NAIC staff to continue to work with industry representatives on other elements within ASU 2017-12: Derivatives and Hedging: Targeted Improvements to Accounting for Hedging Activities. (Ref #2021-20)

viii. Revisions incorporate the practical expedient from ASU 2021-07, Compensation – Stock Compensation (Topic 718), Determining the Current Price of an Underlying Share for Equity-Classified Share-Based Awards for the current price input, a required component for option-pricing models used in determining fair value for share-based payments. (Ref #2022-06)

ix. Interpretation (INT) 22-01: Freddie Mac When-Issued K-Deal (WI Trust) Certificates: Revisions support a draft interpretation to clarify that investments in the Freddie Mac “When Issued K-Deal” (WI) Program are in scope of SSAP No. 43R. (Ref #2022-08)
x. Blanks Proposal: Exposed an agenda item that expressed support for a blanks proposal with instructional changes to Schedule T, the State Page, and Accident and Health Policy Experience Exhibit (AHPEE) to clarify guidance for premium adjustments. The instructions clarify that all premium adjustments, including but not limited to federal Affordable Care Act (ACA) premium adjustments related to the risk adjustment program, shall be allocated as premium in the respective jurisdiction. This agenda item does not result in statutory revisions. (Ref #2022-03)

xi. The comment period for items exposed is June 3, except for agenda items 2021-21, 2022-03, and 2022-08, which have a May 6 comment deadline to allow for adoption consideration during an interim meeting anticipated for May.

E. Reviewed comments and directed NAIC staff on the following items:
   i. Bond Proposal Project: Received comments and an update regarding potential reporting options to revise Schedule D, Part 1: Long-Term Bonds. The update included preliminary responses to certain aspects of those comments. The Working Group directed NAIC staff to proceed with developing an illustration of reporting revisions for subsequent exposure. (Ref #2019-21)
   ii. SSAP No. 22R—Leases: Reviewed comments on prior exposed revisions intending to clarify that in any scenario in which a lease terminates early, all remaining leasehold improvements shall be immediately expensed. The Working Group directed NAIC staff to continue to work with interested parties to refine the guidance for subsequent consideration. (Ref #2021-25)
   iii. Received an update that the Working Group and the Valuation of Securities (E) Task Force received a comment letter from the American Council of Life Insurers (ACLI) regarding a proposed amendment to the P&P Manual to permit unguaranteed and unrated subsidiary obligors in working capital finance investment (WCFI) transactions. As the Working Group does not have an exposure on this topic, the Working Group noted receipt but does not plan to address comments at this time; the comment letter will be included in the Valuation of Securities (E) Task Force minutes.

F. Received an update on U.S. GAAP exposures.

G. Received an update on the Working Group referral of agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in companies applying the retroactive reinsurance exception, which allows prospective reporting. The Casualty Actuarial and Statistical (C) Task Force discussed this item on March 8. The Task Force directed and formed a small group to further work on this, including drafting instructional revisions to Schedule P — Analysis of Losses and Loss Expenses.

3. Adopted the report of the Blanks (E) Working Group, which met March 29 and took the following action:
   A. Adopted its Nov. 16, 2021, minutes, which included the following action:
      i. Adopted proposal 2021-14BWG – Expand the number of lines of business reported on Schedule H to match the lines of business reported on the health statement. Modify the instructions so they will be uniform between life/fraternal and property.
      ii. Adopted its editorial listing and approved the State Filing Checklists content.
      iii. Rejected proposal 2021-11BWG requesting to add a new annual statement supplement to the property/casualty (P/C) statement to capture exposure data for annual statement lines 4, 19.1, 19.2, and 21.2 of the Exhibit of Premiums and Losses.
      iv. Deferred proposal 2021-13BWG, which adds a new supplement to capture premium and loss data for annual statement lines 17.1, 17.2, and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business for a public comment period ending March 4.
      v. Exposed seven new proposals for a public comment period ending March 4.
B. Adopted its editorial listing and the following proposals:
   i. **2021-15BWG** – Add a footnote to Exhibit 7 in the life/fraternal statement and the health statement (life supplement) to capture the amount of Federal Home Loan Bank (FHLB) funding agreements reported in Column 1 through Column 6 of the exhibit (2021-16 SAPWG).
   ii. **2021-16BWG Modified** – For Note 9 – Income Taxes, remove the 9C illustration instructions for the deferred tax asset (DTA) and deferred tax liability (DTL) components, which state, “reporting entities should disclose those items included as ‘Other’ (Lines 2a13, 2e4, 3a5 and 3b3) as additional lines for those items greater than 5% in the printed/PDF filing document,” as the illustration is not set up to accommodate variable lines. Add formulas for calculation of total and subtotal on the illustration for 9C. For Note 15 – Leases, modify the illustrations to add a “Thereafter” line and add a “Total” formula.
   iii. **2021-17BWG Modified** – Modify the Analysis of Operations by Lines of Business in the health blank to include all of health lines of business included in the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health. Add instructions for the new columns and adjust the column references. Add the health blank Analysis of Operations by Lines of Business as a supplement to the life/fraternal blank with instructions and crosschecks. Add crosscheck to the health blank Analysis of Operations by Lines of Business to the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health instructions.
   iv. **2021-19BWG Modified** – Add columns and lines to U&I (Parts 1, 2, 2A, 2B, and 2D) and the Exhibit of Premiums, Enrollment and Utilization in the annual statement to bring the lines of business reporting in line with Life/Fraternal and Property. Add columns and lines to the Exhibit of Premiums, Enrollment and Utilization and U&I Analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made.
   v. **2021-20BWG Modified** – Starting at Line 72 of the Life/Fraternal Five-Year Historical, add or delete lines that do not capture the specific lines of business reported on the Life/Fraternal Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and accident and health (A&H) for Line 33 of those pages.
   vi. **2021-21BWG Modified** – Add instruction to the Investment Schedules General Instructions to exclude non-rated residual tranches or interests from being reported as bonds on Schedule D, Part 1, and add lines to Schedule BA for the reporting those investments (2021-15 SAPWG).
   vii. **2021-23BWG Modified** – Add a line category for Residual Tranches or Interests in the Asset Valuation Reserve Equity and Other Invested Asset Component blank, and renumber the lines below the addition. Modify instructions as appropriate for the added lines.

**Capital Adequacy (E) Task Force**

March 28, 2022 (in lieu of the Spring National Meeting)

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted its Jan. 27, 2022; and Dec. 20, 2021, minutes. During these meetings, the Task Force took the following action:
   A. Adopted the 2021 Catastrophe Event List.
   B. Discussed the appointment of a new risk-based capital (RBC) working group and solicited membership for the Risk-Based Capital Investment Risk and Evaluation (E) Working Group.
3. Adopted the report of the Health Risk-Based Capital (E) Working Group, including its March 18 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 25, 2022; Jan. 28, 2022; and Dec. 16, 2021, minutes, which included the following action:
      i. Referred the Health Test Language Proposal to the Blanks (E) Working Group.
      ii. Referred a memorandum to the Health Actuarial (B) Task Force.
      iii. Adopted proposal 2021-18-H as modified for instructions in evaluating the investment yield adjustment in the underwriting risk factors.
   iv. Received the American Academy of Actuaries (Academy) report on the H2 – Underwriting Risk Review.
v. Reviewed the investment yields of the six-month U.S. Treasury bonds for the investment income adjustment.
B. Discussed next steps in moving forward on the H2 – Underwriting Review project with the Academy.
C. Adopted its 2022 working agenda.

4. Adopted the report of the Life Risk-Based Capital (E) Working Group, including its March 23 minutes. During this meeting, the Working Group took the following action:
A. Adopted its 2021 Fall National Meeting minutes.
B. Adopted its March 10, 2022; Jan. 20, 2022; and Dec. 16, 2021; minutes. During these meetings, the Working Group took the following action:
i. Discussed the Academy’s C2 Work Group recommendation on mortality.
ii. Discussed the asset valuation reserve (AVR) and bond factor changes.
iii. Adopted guidance on bond factor changes.
C. Adopted its working agenda
D. Discussed reinsurance and comfort trusts.
E. Discussed bond funds.

5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, including its March 23 minutes. During this meeting, the Working Group took the following action:
A. Adopted the report of the Catastrophe Risk (E) Subgroup, including its March 22 minutes. During this meeting, the Subgroup took the following action:
i. Adopted its 2021 Fall National Meeting minutes.
ii. Adopted its Feb. 22 and Jan. 25 minutes. During these meetings, the Working Group took the following action:
b. Adopted proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only), which the Subgroup exposed for a 60-day public comment period ending Feb. 13, 2022.
c. Received an update from the Catastrophe Model Technical Review Ad Hoc Group. The update included the discussion of the survey questions created by the members within the group, which was based on Actuarial Standard of Practice (ASOP) No. 38—Catastrophe Modeling (for All Practice Areas).
d. Discussed three different kinds of catastrophe models that deviate from the vendor models. The Subgroup will focus on discussing the vendor catastrophe models with adjustments or different weight first.
e. Discussed the issue of double-counting in the R5 component. The Subgroup asked the interested parties to review the current methodology and provide comments in the upcoming meetings.
f. Discussed the possibility of adding flood peril in the Rcat component. The industry asked the Subgroup to consider the materiality issue with respect to whether the flood peril is warranted, given the exposure of the industry.
g. Heard a presentation from Milliman on the private flood market.
iii. Discussed its 2022 working agenda.
iv. Discussed the insured loss threshold for wildfire peril. The Subgroup considered following the same minimum 25 million insured losses per event threshold as the other perils.
v. Exposed proposal 2021-17-CR MOD (Wildfire Information-Only Reporting Exemption) for a 14-day public comment period ending April 5. This proposal allows an exemption for those companies where the modeling requirements would impose a cost and compliance burden during the for informational purposes only period.
vi. Discussed the independent model review instruction in the Rcat component. The Subgroup heard comments from the Missouri Department of Commerce and Insurance regarding the Rcat instructions.
vii. Discussed the issue of double counting in the R5 component.
C. Adopted proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only).
D. Adopted proposal 2021-14-P (R3 Factor Adjustment).
E. Exposed proposal 2022-01-P (Removing Trend Test for Informational Purposes Only Footnote) for a 30-day public comment period ending April 22.
F. Heard an update on current property/casualty (P/C) risk-based capital (RBC) projects from the Academy.
6. Adopted the report of the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, including its March 22 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Feb. 22 minutes, which included the following action:
      i. Discussed its appointment, charges, and the Financial Condition (E) Committee’s direction.
      ii. Heard a high-level overview of investment development from NAIC staff.
      iii. Discussed desired outcomes investment reporting perspectives and next steps.
   B. Adopted its working agenda.
   C. Discussed comments received on its request to solicit feedback.
   D. Discussed next steps.
10. Adopted proposal 2021-14-P (Re Factor Adjustment).
11. Adopted its working agenda.

Examination Oversight (E) Task Force
The Examination Oversight (E) Task Force did not meet at the Spring National Meeting.

Financial Stability (E) Task Force
April 5, 2022 (joint session with the Macroprudential (E) Working Group)
1. Adopted its Feb. 22 minutes, which included the following action:
   A. Received an update from the Macroprudential (E) Working Group.
   B. Adopted the “Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers” document.
   D. Adopted the Working Group’s Feb. 1 minutes, which included the following action:
      i. Adopted the “Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers” document.
      ii. Received an update on the 2021 LST Framework, including scope criteria.
      iii. Received an update on the NAIC macroprudential risk assessment system.
2. Adopted the Working Group’s March 2 minutes, which included the following action:
   A. Received an update on the NAIC macroprudential risk assessment system.
   B. Exposed the NAIC macroprudential risk assessment process for a public comment period ending March 21.
3. Received an update from the Working Group.
4. Adopted the NAIC macroprudential risk assessment system.
5. Heard an international update, which included an update on the International Association of Insurance Supervisors’ global monitoring exercise and the consultation on liquidity stress testing (LST).
Receivership and Insolvency (E) Task Force
April 6, 2022
1. Adopted its 2021 Fall National Meeting minutes.
2. Received a report from the Receiver’s Handbook (E) Subgroup on the progress of the development of revisions to the Receiver’s Handbook for Insurance Company Insolvencies. The drafting group is currently working on Chapter 5. The Subgroup expects to meet to expose revisions to several chapters for public comment.
3. Received a referral from the Restructuring Mechanisms (E) Working Group and exposed a draft Request for NAIC Model Law Development for the Property and Casualty Insurance Guaranty Association Model Act (#540) for a 30-day public comment period ending May 6. The request focuses on addressing potential gaps in Model #540 provisions to ensure guaranty fund coverage for policies after insurance business transfer (IBT) or corporate division (CD) transactions.
4. Heard a presentation from the National Conference of Insurance Guaranty Funds (NCIGF), including recommendations to improve pre-receivership coordination and information sharing between state insurance departments and guaranty funds. The Task Force agreed to refer the issue to the Receivership Law (E) Working Group for further consideration.
5. Heard an update on federal activities. The NAIC’s proposed State Insurance Receivership Priority (SIRP) Act establishes a time limit in the Federal Priority Act (FPA) for the U.S. Department of Justice (DOJ) to file claims of the U.S. to insolvent insurance company estates and ensure state insurance regulators are not held personally liable if claims of the government are not paid first. Several members of the Task Force and NAIC staff are working with U.S. Rep. Madeleine Dean’s (D-PA) office to finalize the SIRP Act. It is expected to be introduced to the U.S. House of Representatives in 2022.
6. Heard an update on international activities. The International Association of Insurance Supervisors (IAIS) is conducting a survey of member jurisdictions to gather information to inform the development of an application paper on policyholder protection schemes. The U.S. recently completed its in-person meetings for the IAIS-targeted jurisdictional assessments regarding the holistic framework, which included an assessment of insurance resolution.

Reinsurance (E) Task Force
March 22, 2022 (in lieu of the Spring National Meeting)
1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met March 3, 2022, and Dec. 20, 2021, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   A. Approved proposed revisions to the Uniform Checklist for Reciprocal Jurisdiction Reinsurers.
   C. Completed the reviews of certified reinsurers and reciprocal jurisdiction reinsurers.
3. Exposed revisions to the Uniform Checklist for Reciprocal Jurisdiction Reinsurers.
4. Received a status report on the reinsurance activities of the Mutual Recognition of Jurisdictions (E) Working Group.
5. Received a status report on the states’ implementation of the 2019 revisions to the Credit for Reinsurance Model Law (#785), the Credit for Reinsurance Model Regulation (#786), and the implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

Risk Retention Group (E) Task Force
The Risk Retention Group (E) Task Force did not meet at the Spring National Meeting.
Valuation of Securities (E) Task Force

April 5, 2022 (in lieu of the Spring National Meeting)

1. Adopted its 2021 Fall National Meeting minutes.
2. Discussed comments received on a proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to update the definition of “principal protected securities” (PPS), which was exposed for a 60-day public comment period ending Feb. 11.
3. Discussed comments received on a proposed amendment to the P&P Manual to update the definition of “other non-payment risk assigned a subscript “S,” which was exposed for a 60-day public comment period ending Feb. 11.
4. Exposed a proposed referral to the Blanks (E) Working Group to add fixed income analytical risk measures to investments reported on Schedule D, Part 1 for a 45-day public comment period ending May 20.
5. Discussed comments received on a proposed amendment to the P&P Manual to add guidance on the designation of Schedule BA assets with fixed income characteristics, which was exposed for a 60-day public comment period ending Feb. 11.
6. Adopted a proposed amendment to the P&P Manual to permit unguaranteed and unrated subsidiary obligors in working capital finance investments (WCFI) transactions, with Securities Valuation Office (SVO) discretion, which was exposed for a 60-day public comment period ending Feb. 11.
7. Discussed comments received on an NAIC staff report on the use of NAIC designations by other jurisdictions in the regulation of insurers, which was exposed for a 60-day public comment period ending Feb. 11.
8. Received a report from SVO staff on the 2021 year-end carry-over filings.
9. Received a staff report on projects of the Statutory Accounting Principles (E) Working Group.
10. Received a staff update on new residential mortgage-backed securities (RMBS)/commercial mortgage-backed securities (CMBS) thresholds and price breakpoints.
11. Received a staff update on the ad hoc credit rating provide study group.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

April 5, 2022

1. Adopted its 2021 Summer National Meeting minutes.
2. Adopted, immediately by reference, revisions made during 2021 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual [AP&P Manual]) and were deemed insignificant.
4. Exposed the 2021 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to be acceptable for accreditation but not required for a 30-day public comment period ending May 6. The revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership.
5. Exposed the proposed updates to the Preamble of the Accreditation Program Manual to reference VM-21, Requirements for Principle-Based Reserves for Variable Annuities, for a 30-day public comment period ending May 6. The proposed revisions serve as a reference for how captives that reinsure variable annuity business are addressed in the accreditation standards.
6. Reported that it met April 4 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, and took the following action: 1) discussed state-specific accreditation issues; and 2) awarded continued accreditation to the insurance departments of Alabama, Mississippi, and North Carolina.
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE
April 7, 2022

1. Adopted its 2021 Fall National Meeting minutes.
2. Adopted its Jan. 18 minutes, which included the following action:
   A. Approved the submission of the NAIC comments on the International Association of Insurance Supervisors (IAIS) draft Application Paper on Macroprudential Supervision.
3. Discussed international efforts on sustainability and climate, including a presentation by the Sustainable Insurance Forum (SIF) on its mission and workstreams and by Liberty Mutual on how it is addressing these issues.
4. Heard an update on recent activities and priorities of the IAIS, including: 1) the comparability assessment process for the aggregation method (AM); 2) an update on the targeted jurisdictional assessments (TJAs) as part of the implementation of the holistic framework; 3) recommendations from the Climate Risk Steering Group; and 4) a survey of membership on diversity, equity, and inclusion (DE&I) initiatives.
5. Heard an update on international activities, including: 1) recent and upcoming meetings, events, and speaking engagements with international regulators; 2) the Spring 2022 International Fellows Virtual Program; and 3) upcoming meetings and participation in workstreams at the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee.

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE
April 5, 2022

1. Adopted structural and charge revisions, which included the following action:
   A. Moved the Speed to Market (H) Working Group to the Market Regulation and Consumer Affairs (D) Committee.
   B. Moved the Privacy Protections (D) Working Group from the Market Regulation and Consumer Affairs (D) Committee to the Innovation, Cybersecurity, and Technology (H) Committee.
   C. Modified the charge to the Privacy Protections (H) Working Group to add the words “data ownership and use rights” to the charge.
   D. Appointed a new working group, the Innovation in Technology and Regulation (H) Working Group, and adopted its proposed charges.
2. Adopted the report of the Big Data and Artificial Intelligence (H) Working Group, which met April 5 and took the following action:
   A. Discussed its 2022 work plan, which includes the following four workstreams:
      i. The first workstream will continue the survey work regarding industry’s use of artificial intelligence (AI)/machine learning (ML). The subject matter experts (SMEs) involved in this workstream will continue the analysis of the AI/ML private personal auto (PPA) survey data, use PPA survey data and experience to inform the development of an AI/ML homeowners survey, and develop an AI/ML life insurance survey. The homeowners survey will be issued in June, and the life insurance survey will be issued in August. Company responses will be collected on a confidential basis. All the survey results will culminate in the publication of a white paper to provide insights on the industry’s use of data and AI/ML in these three lines of business. This white paper will not identify specific company practices. The Working Group intends to publish the white paper by the Fall National Meeting.
      ii. The second workstream will focus on the review of third-party data and model vendors to determine the appropriate regulatory framework for monitoring and overseeing industry’s use of third-party data and model vendors. This work will be completed by the Fall National Meeting with suggestions for implementation of deliverables to be considered by the Committee.
      iii. The third workstream will gather data and evaluate information on governance models/frameworks and software tools/resources from various sources, including: vendors; academics; industry; and international supervisory authorities, which could assist state insurance regulators in overseeing and monitoring industry’s use of data and AI/ML and eliminate unintended bias in such use. This work will involve coordination with other NAIC committees engaged in similar efforts.
iv. The fourth workstream is focused on how to implement the expectations outlined in the “NAIC Principles on Artificial Intelligence (AI)” and provide suggestions on next steps, which could include regulatory guidance such as model governance. The other workstreams will help inform the recommendations for this workstream. Because of this, the final deliverable of this workstream is not anticipated to be presented to the Committee until fall 2023.

B. Received an update on the PPA AI/ML preliminary survey results. The update provided a summary of the company response regarding the use of AI/ML broken down by the functional areas of claims, fraud detection, marketing, rating, underwriting, and loss prevention. The preliminary analysis reflects that 155 of the 193 companies that responded to the survey are or will be using AI/ML within claims operations; 111 companies are or will be using AI/ML within fraud detection; 103 companies are or will be using AI/ML within marketing; 77 companies are or will be using AI/ML within rating; 59 companies are or will be using AI/ML within underwriting; and only three companies have AI/ML implemented in production for loss prevention. The preliminary results also reflected that 82% of rate models are developed internally, while 18% are developed by a third party. The NAIC will continue to work with state insurance regulators to analyze the results of the PPA AI/ML survey.

3. Adopted the report of the Cybersecurity (H) Working Group, including its March 23 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed its charges and discussed potential projects, including:
      i. The development of a cybersecurity response plan to aid state insurance regulators in situations where cybersecurity events take place within the insurance industry.
      ii. The development of a cybersecurity survey to better understand cybersecurity practices by insurers.
      iii. The development of cybersecurity-related training that would be beneficial to state insurance regulators.
   B. Heard a report on state, federal, and international cybersecurity efforts.

4. Adopted the report of the E-Commerce (H) Working Group, including its March 30 minutes. During this meeting, the Working Group took the following action:
   A. Heard a summary of the recent state and industry surveys regarding the federal Uniform Electronic Transactions Act (UETA), actions taken by states regarding e-commerce both during and because of the COVID-19 pandemic, and industry concerns and recommendations moving forward with e-commerce.
   B. Discussed its overall work plan and timelines moving forward.

5. Received a report on the Casualty Actuarial and Statistical (C) Task Force predictive model review process. The report included an update on the Task Force’s meetings on rate filing issues and its predictive analytics webinars called the “Book Club.” The Task Force has reviewed 54 rate models and produced 127 reports to assist state insurance regulators with model reviews.

6. Received a report from the Privacy Protections (D) Working Group, which met April 4 and took the following action:
   A. Heard updates on state and federal privacy legislation.
   B. Discussed comments received from the American Council of Life Insurers (ACLI) and the Health Coalition on the Working Group’s 2022 work plan.

7. Discussed various Committee-level projects, including:
   A. The creation of a new Collaboration Forum that will serve as a platform for multiple NAIC committees to work together to identify and address foundational issues and develop a common framework that can inform the specific workstreams in each group. The first Collaboration Forum will be on algorithmic bias.
   B. The development of a portal or library of resources related to innovation, cybersecurity, data and consumer privacy, and technology, tentatively called the “ICT-Hub.”
   C. The creation of a forum to facilitate training and education of state insurance regulators on innovation and technology topics, supervisory technology (SupTech) issues, and potential ways that data and technology might affect the insurance sector in the future.

8. Received an update on implementation of the Insurance Data Security Model Law (#668) and the Unfair Trade Practices Act (#880) revised language specific to rebating.
NAIC/CONSUMER LIAISON COMMITTEE

April 8, 2022

1. Adopted its 2021 Fall National Meeting minutes.
2. Heard a presentation on the demise of the auto insurance appraisal clause by the Automotive Education & Policy Institute (AEPI). This presentation is important to consumers, insurers, and state insurance regulators, as the clause helps protect consumers and the auto repair insurance industry.
3. Heard a presentation on modernizing market regulation data collection by the Center for Economic Justice (CEJ).
4. Heard a presentation on the role of state insurance regulators in addressing discriminatory benefit design by the National Center for Transgender Equality (NCTE), the Disability Rights Education and Defense Fund (DREDF), and the HIV+ Hepatitis Policy Institute. This presentation is important to consumers, insurers, and state insurance regulators because discrimination harms everyone throughout the insurance industry.
5. Heard a presentation, “The Urgency of Now: Mental Health Parity and an Ongoing Pandemic,” by the National Women’s Law Center (NWLC) and the Georgetown University Center on Health Insurance Reforms (CHIR). This presentation is important to consumers, insurers, and state insurance regulators because it encourages compliance with federal mental health parity requirements.
6. Heard a presentation, “Standard Plan Design: Federal Developments and Lessons Learned in States,” by the Leukemia & Lymphoma Society (LLS) and the Colorado Children’s Campaign. This presentation is important to consumers, insurers, and state insurance regulators because it helps insurers and state insurance regulators provide standard plans that address developments at the federal level.

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

April 6, 2022

1. Adopted its 2021 Fall National Meeting minutes.
2. Heard a presentation on communication and outreach within the Indian culture by Montana Indian Ministries. This presentation is important to consumers and state insurance regulators to assist in understanding, educating, and protecting tribal consumers.
3. Heard a presentation on Montana’s experience with the federal Affordable Care Act (ACA) and its COVID-19/pandemic response by the Montana Department of Public Health and Human Services. This presentation is important to state insurance regulators as they share experiences to further enhance consumer protections.
4. Heard a presentation on consumer outreach and education about fraud by the Coalition Against Insurance Fraud (CAIF). This presentation is important to consumers, industry, and state insurance regulators as they work together to combat insurance fraud within tribal communities.
5. Heard an announcement that two presenters from the Blue Cross and Blue Shield of New Mexico will speak at a Liaison Committee meeting that will be scheduled before the Summer National Meeting.
6. Distributed the results of the state insurance regulator and consumer representative surveys about the goals of the Liaison Committee for 2022. The survey results will be discussed at a later date.
EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, April 8, 2022, Minutes ................................................................. 3-2
Adopted the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework)
(Attachment One) ........................................................................................................................................... 3-8
Report on States’ Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Two)....... 3-48
Executive (EX) Committee and Plenary  
Kansas City, Missouri  
April 8, 2022

The Executive (EX) Committee and Plenary met in Kansas City, MO, April 8, 2022. The following Committee and Plenary members participated: Dean L. Cameron, Chair (ID); Chlora Lindley-Myers, Vice Chair (MO); Andrew N. Mais, Vice President (CT); Jon Godfread, Secretary-Treasurer (ND); David Altmair, Most Recent Past President (FL); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Mark Fowler (AL); Alan McClain represented by Russ Galbraith (AR); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus represented by Shannon Whalen (IL); Amy L. Beard represented by Victoria Hastings (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Chris Nicolopoulos (NH); Marlene Caride represented by Justin Timmerman (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French (OH); Glen Mulready represented by Brian Downs (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Alexander S. Adams Vega represented by Brenda Perez (PR); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer represented by Daniel Morris (SC); Larry D. Deiter (SD); Carter Lawrence represented by Toby Compton (TN); Cassie Brown (TX); Jon Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler (WA); Nathan Houdek (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. **Adopted the LTCI MSA Framework**

Commissioner White reported that on Dec. 12, 2021, the Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). The LTCI MSA Framework has been a cornerstone goal of the Task Force and a key component in achieving the NAIC’s long-term care insurance (LTCI) initiatives. The LTCI MSA Framework was developed in an open process with input from both state insurance regulators and industry. The LTCI MSA Framework outlines a process for a timely, consistent state-based approach to reviewing LTCI rate increase filings. Through the LTCI MSA Framework, state insurance regulators seek to reduce or eliminate existing cross-state rate inequities and improve rate level parity across states. The LTCI MSA Framework outlines the operational and actuarial aspects of a rate review, the benefits of using the multistate actuarial (MSA) process for both states and insurers, and the detailed Rate Advisory Report that will contain an analysis and recommendation for states’ consideration. States retain the authority to perform their own review and make their own determinations on final rate approval. A critical component for the future success of the MSA process is through both state insurance department and insurer participation. The MSA process is expected to be implemented and operational by September 2022.

Commissioner McVey made a motion, seconded by Director Fox, to adopt the LTCI MSA Framework (Attachment One). The motion passed with New York abstaining.

2. **Ratified the Selection of State Insurance Regulator Representatives on the FSOC**

Commissioner Navarro made a motion, seconded by Director Dunning, to ratify the Executive (EX) Committee appointment of Superintendent Dwyer to the Financial Stability Oversight Council (FSOC) as the non-voting state insurance regulator representative. The motion passed unanimously.
3. **Received the Report of the Executive (EX) Committee**

Director Cameron reported that the Executive (EX) Committee met April 6 and adopted the April 4 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committed adopted the report of the Executive (EX) Committee, which met March 21, Feb. 3, and Jan. 14 and took the following action: 1) approved the System for Electronic Rates & Forms Filing (SERFF) Modernization – 2022 Transition Stages Fiscal Impact Statement after a 10-day public comment period; 2) discussed composition of the Government Relations (EX) Leadership Council; 3) approved the appointment of Director Daniels to serve on the National Insurance Producer Registry (NIPR) Board of Directors beginning in February 2022; 4) selected Los Angeles, CA, for the 2026 Spring National Meeting site location; and 5) approved the NAIC filing an amicus brief in the case of *In Re: Penn Treaty Network America Insurance Company (In Liquidation), In Re: American Network Insurance Company (In Liquidation).*

The Committee adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Long-Term Care Insurance (EX) Task Force; and 4) the Special (EX) Committee on Race and Insurance.

The Committee also: 1) adopted the proposal to establish a Catastrophe Modeling Center of Excellence (COE) within the NAIC’s Center for Insurance Policy and Research (CIPR); 2) adopted the proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use; 3) approved disbanding the SERFF Advisory Board; and 4) received the 2021 Annual Report of the NAIC Designation Program Advisory Board activities.

The Committee received a status report on the NAIC State Ahead strategic plan implementation.

The Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Mortgage Guaranty Insurance Model Act* (#630); 3) the *Nonadmitted Insurance Model Act* (#870); and 4) the Pet Insurance Model Act.

The Committee heard reports from NIPR and the Interstate Insurance Product Regulation Commission (Compact).

4. **Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the 2021 Fall National Meeting**

Director Lindley-Myers made a motion, seconded by Commissioner Mais, to adopt by consent the committee, subcommittee, and task force minutes of the 2021 Fall National Meeting. The motion passed unanimously.

5. **Received the Report of the Life Insurance and Annuities (A) Committee**

Director French reported that the Life Insurance and Annuities (A) Committee met April 7. During this meeting, the Committee: 1) adopted its 2021 Fall National Meeting minutes; 2) adopted the report of the Accelerated Underwriting (A) Working Group, including its interim meeting minutes and the *Accelerated Underwriting in Life Insurance Educational Report*; and 3) heard an update on the U.S. Department of Labor (DOL) Fiduciary Rule for retirement advice.

The Committee heard an update from the Annuity Suitability (A) Working Group that 21 states have adopted the best interest revisions to the *Suitability in Annuity Transactions Model Regulation* (#275), and seven states have state insurance regulations pending. Adoption by the remaining states remains a priority. The Working Group
plans to meet in May to continue work on a Frequently Asked Questions (FAQ) document to promote greater uniformity in the adoption of Model #275.

The Committee also: 1) adopted the report of the Life Actuarial (A) Task Force; 2) discussed having the Life Insurance Online Guide (A) Working Group focus on updating life insurance information on the NAIC website; and 3) heard an update from Workstream Four of the Special (EX) Committee on Race and Insurance that it hopes to focus on marketing in underserved communities.

6. Received the Report of the Health Insurance and Managed Care (B) Committee

Commissioner Downing reported that the Health Insurance and Managed Care (B) Committee met April 7. During this meeting, the Committee adopted its 2021 Fall National Meeting minutes.

The Committee heard from Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO), Deputy Director for Policy at the CCIIO, on the Biden administration’s activities of interest to the Committee. His update focused on the implementation and enforcement of the federal No Surprises Act (NSA) since it became effective Jan. 1. He discussed the federal Centers for Medicare & Medicaid Services’ (CMS’s) outreach efforts and tools created, such as a No Surprises Help Desk, new FAQ documents, and other web resources. He also discussed the CMS’s role in the enforcement of the NSA and its interactions with the states regarding NSA enforcement.

The Committee received an update from Workstream Five of the Special (EX) Committee on Race and Insurance that agreed that its focus should center on identifying demographic-based barriers to the acquisition and use of health insurance and creating strategies for mitigating or removing such barriers and understanding the role health insurance can play in addressing inequities in health outcomes and social determinates of health.

The Workstream also agreed on a framework for executing those objectives, including the specific topics it will cover during the year: benefit design and consumer empowerment and engagement. The Workstream plans to meet at least monthly to hear from various stakeholders, such as consumer groups, academics, and industry; and it would like to hold listening sessions, potentially in conjunction with Zone meetings, with community-based individuals and organizations who work with racially disadvantaged and historically underserved and underrepresented populations.

The Committee adopted its subgroup, working group, and task force reports and their interim meeting minutes.

The Committee adjourned into a regulator-to-regulator session with CCIIO representatives to candidly discuss any issues with the implementation of the NSA to date.

7. Received the Report of the Property and Casualty Insurance (C) Committee

Commissioner Chaney reported that the Property and Casualty Insurance (C) Committee met April 7. During this meeting, the Committee adopted its 2021 Fall National Meeting minutes.

The Committee adopted the reports of its task forces and working groups: 1) the Casualty Actuarial and Statistical (C) Task Force; 2) the Surplus Lines (C) Task Force; 3) the Title Insurance (C) Task Force; 4) the Workers’ Compensation (C) Task Force; 5) the Cannabis Insurance (C) Working Group; 6) the Catastrophe Insurance (C) Working Group; 7) the Terrorism Insurance Implementation (C) Working Group; and 8) the Transparency and Readability of Consumer Information (C) Working Group.

The Committee adopted revised charges reappointing the Pet Insurance (C) Working Group with the charge to “Complete the development of a model law to establish appropriate regulatory standards for the pet insurance
industry.” The Committee adopted an extension until the Summer National Meeting for revisions to the proposed Pet Insurance Model Act.

The Committee also: 1) heard a presentation from NAIC staff on private passenger auto (PPA) insurance results over the past 10 years; 2) heard a presentation from Susanna Gotsch (CCC Intelligent Solutions) and Robert Hartwig (University of South Carolina) regarding inflationary pressures in the property/casualty (P/C) insurance industry; 3) heard a federal update; and 4) heard an update from Peter Kochenburger (University of Connecticut School of Law) on a recent ordinance in San Jose, CA, requiring liability insurance for gun owners.

8. Received the Report of the Market Regulation and Consumer Affairs (D) Committee

Commissioner Pike reported that the Market Regulation and Consumer Affairs (D) Committee met April 7. During this meeting, the Committee adopted its 2021 Fall National Meeting minutes.

The Committee adopted its revised 2022 charges. The Privacy Protections (D) Working Group will now report to the Innovation, Cybersecurity, and Technology (H) Committee; the Speed to Market (H) Working Group will now report to the Market Regulation and Consumer Affairs (D) Committee; the Advisory Organization Examination Oversight (D) Working Group name was shortened to the Advisory Organization (D) Working Group; and the Antifraud Education Enhancement (D) Working Group was disbanded.

The Committee adopted the reports of its task forces and working groups: 1) the Antifraud (D) Task Force; 2) the Market Information Systems (D) Task Force; 3) the Producer Licensing (D) Task Force; 4) the Advisory Organization Examination Oversight (D) Working Group; 5) the Market Analysis Procedures (D) Working Group; 6) the Market Conduct Annual Statement Blanks (D) Working Group; 7) the Market Conduct Examination Guidelines (D) Working Group; 8) the Market Regulation Certification (D) Working Group; 9) the Privacy Protections (D) Working Group; and 10) the Speed to Market (D) Working Group.

The Improper Marketing of Health Insurance (D) Working Group under the Antifraud (D) Task Force is a priority this year as the group continues to coordinate state efforts to monitor the marketing of health plans and coordinate appropriate enforcement actions.

The Market Regulation Certification (D) Working Group was reappointed to focus on establishing and maintaining standards that promote sound practices relating to the market conduct examination, market analysis, and related continuum functions performed for insurance consumer protection. The Working Group will review suggested updates submitted by pilot states to the draft voluntary certification program.

9. Received the Report of the Financial Condition (E) Committee

Commissioner White reported that the Financial Condition (E) Committee met April 5. During this meeting, the Committee: 1) adopted its Jan. 12, 2022, and 2021 Fall National Meeting minutes, which included the following action: a) adopted the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation; b) adopted the RefAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers; and c) exposed a request for comment suggesting a revised approach to risk-based capital (RBC) requirements for structured securities and other asset-backed securities (ABS).

The Committee adopted the reports of its task forces and working groups: 1) the Accounting Practices and Procedures (E) Task Force; 2) the Capital Adequacy (E) Task Force; 3) the Financial Stability (E) Task Force; 4) the Reinsurance (E) Task Force; 5) the Valuation of Securities (E) Task Force; 6) the Group Capital Calculation (E) Working Group; 7) the Restructuring Mechanisms (E) Working Group; and 8) the National Treatment and Coordination (E) Working Group.
The Committee also: 1) received an extension request from the Mortgage Guaranty Insurance (E) Working Group on its work on Model #630; and 2) received an update on certain committee-supported initiatives related to low interest rates and asset risk.

Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee’s technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to the NAIC members shortly after completion of the Spring National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.

10. Received the Report of the Financial Regulation Standards and Accreditation (F) Committee

Director Wing-Heier reported that the Financial Regulation Standards and Accreditation (F) Committee met April 4 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, and: 1) discussed state-specific accreditation issues; and 2) voted to award continued accreditation to the insurance departments of Alabama, Mississippi, and North Carolina.

The Committee also met April 5 in open session and adopted its 2021 Summer National Meeting minutes.

The Committee also: 1) adopted, immediately by reference, 2021 revisions to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual (AP&P Manual)) and were deemed insignificant; and 2) exposed an update to the examination coordination guidelines recommended by the Financial Examiners Handbook (E) Technical Group for a 30-day public comment period ending May 6.

The Committee exposed the 2021 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to be acceptable for accreditation but not required, for a 30-day public comment period ending May 6. The revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership.

The Committee exposed the proposed updates to the Preamble of the Accreditation Program Manual to reference VM-21, Requirements for Principle-Based Reserves for Variable Annuities, for a 30-day public comment period ending May 6. The proposed revisions serve as a reference for how captives that reinsure variable annuity business are addressed in the accreditation standards.

11. Received the Report of the International Insurance Relations (G) Committee

Commissioner Anderson reported that the International Insurance Relations (G) Committee met April 7. During this meeting, the Committee adopted its Jan. 18, 2022, and 2021 Fall National Meeting minutes.

The Committee discussed international efforts on sustainability and climate, including a presentation by the Sustainable Insurance Forum (SIF) on its mission and workstreams and by Liberty Mutual on how it is addressing these issues.

The Committee heard an update on international activities, including: 1) recent and upcoming meetings, events, and speaking engagements with international regulators; 2) the Spring 2022 International Fellows Virtual
Program; and 3) upcoming meetings and participation in workstreams of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee.

Commissioner Anderson noted that registration is open for the 2022 International Insurance Forum to be held May 12–13 in Washington, DC.

12. Received the Report of the Innovation, Cybersecurity, and Technology (H) Committee

Commissioner Birrane reported that the Innovation, Cybersecurity, and Technology (H) Committee met April 5. During this meeting, the Committee adopted structural and charge revisions, which included the following action: a) moved the Speed to Market (H) Working Group to the Market Regulation and Consumer Affairs (D) Committee; b) moved the Privacy Protections (D) Working Group from the Market Regulation and Consumer Affairs (D) Committee to the Innovation, Cybersecurity, and Technology (H) Committee; c) modified the charge to the Privacy Protections (H) Working Group to add the words “data ownership and use rights”; and d) appointed a new working group, the Innovation in Technology and Regulation (H) Working Group, and adopted its proposed charges.

The Committee adopted the reports of its task forces and working groups: 1) the Big Data and Artificial Intelligence (H) Working Group; 2) the Cybersecurity (H) Working Group; and 3) the E-Commerce (H) Working Group.

The Committee received a report on the Casualty Actuarial and Statistical (C) Task Force predictive model review process, including rate filing issues and its predictive analytics webinars called the “Book Club.” The Task Force has reviewed 54 rate models and produced 127 reports to assist state insurance regulators with model reviews.

The Committee received a report from the Privacy Protections (D) Working Group, which met April 4 and took the following action: 1) heard updates on state and federal privacy legislation; and 2) discussed comments received from the American Council of Life Insurers (ACLI) and the Health Coalition on the Working Group’s 2022 work plan.

The Committee discussed various committee-level projects, including: 1) the creation of a new Collaboration Forum that will serve as a platform for multiple NAIC committees to work together to identify and address foundational issues and develop a common framework that can inform the specific workstreams in each group. The first Collaboration Forum will be on algorithmic bias; 2) the development of a portal or library of resources related to innovation, cybersecurity, data and consumer privacy, and technology tentatively called the “ICT-Hub”; and 3) the creation of a forum to facilitate training and education of state insurance regulators on innovation and technology topics, SupTech issues, and potential ways that data and technology might affect the insurance sector in the future.

The Committee received an update on the implementation of the Insurance Data Security Model Law (#668) and the Unfair Trade Practices Act (#880) revised language specific to rebating.

13. Received a Report on the States’ Implementation of NAIC-Adopted Model Laws and Regulations

Director Cameron referred attendees to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Two).

Having no further business, the Executive (EX) Committee and Plenary adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Spring National Meeting/4-Plenary

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Long-Term Care Insurance Multistate Rate Review Framework

Draft as of December 12, 2021

NAIC Long-Term Care Insurance (EX) Task Force
PREFACE

The Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) was drafted by the Ad Hoc Drafting Group of the NAIC Long-Term Care Insurance (EX) Task Force. The Ad Hoc Drafting Group consists of representatives from state insurance departments in Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington.

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on Dec. 12, 2021, and the NAIC Executive Committee and Plenary on [insert date].
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I. INTRODUCTION

A. Purpose

The NAIC charged the Long-Term Care Insurance (EX) Task Force with developing a consistent national approach for reviewing current long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the Task Force developed this framework for a multi-state actuarial (MSA) LTCI rate review process (MSA Review).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal1 and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team’s (MSA Team’s) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.2 Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This MSA framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the MSA Team’s MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may affect the insurer’s in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the Task Force and be revised as directed by the Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer’s rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

- “Impacted State” is defined as the domestic state, or any state for which the product associated with the insurer’s in force LTCI premium rate increase proposal is or has been issued.

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1 “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.

2 The term “rate increase filing” or “rate filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.
“Participating State” is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to increase in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report, which state insurance departments may consider when deciding on an insurer’s rate increase filing or to supplement the state’s own review process.

The MSA Review is conducted by a team of state’s regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff and Interstate Insurance Product Regulation Commission (Compact) staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD] States. The NAIC’s electronic infrastructure, SERFF, will be used to streamline the rate proposal and review process. Although the administrative services of Compact staff and SERFF’s Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review begins when an insurer expresses interest in an MSA Review being performed for an in force LTCI rate proposal to the MSA Team through SERFF or supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team with assistance, as needed, from supporting staff.

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than those resulting from loss ratio-based approaches and are outside the pure loss ratio requirements contained in many states’ laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review, the MSA Team will provide updates to the insurer. The MSA Team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review.

Additionally, the review will consider reduced benefit options (RBOs) that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States and insurers that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer’s proposal. Participating States can utilize the MSA Advisory Report or supplement their own state’s rate review with it as

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3 Certain processes for Impacted vs. Participating States are yet to be determined (TBD).
described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

The rate proposal, review process, actuarial methodologies, and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways. For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increase filings in their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states and actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize the MSA Team will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.
- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries, which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a qualified actuary include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state’s knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

Note that states’ use of and reliance on the MSA Advisory Report is expected to increase in the future as the MSA Review continues to be developed and refined, and the benefits of the MSA Review described above become more evident.

Long-Term Care (LTC) insurers will likewise see multiple benefits in participating in the MSA Review:

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase filings. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, it has functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.
- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier’s workload in developing often widely differing filings for states’ review.

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility, and/or decision making. Each state remains ultimately responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.
A Participating State’s use of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer’s obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their conclusions shall not be utilized by any insurer in a rate filing submitted to a non-Participating State, nor shall the MSA Advisory Reports be used outside of each state insurance regulator’s own review process or challenge the results of any individual state’s determination of whether to grant, partially grant, or deny a rate increase.

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of an MSA Team member or a Participating State need to be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (Master Agreement) between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States affirm and represent that they will provide any in force LTCI rate proposal, as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations.

Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide any MSA Advisory Report(s), as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The Long-Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.
II. MSA TEAM

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The Long-Term Care Insurance (EX) Task Force, or its appointed subgroup, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the chair of the Task Force or the chair of an appointed subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participates as a member of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (or an equivalent Subgroup appointed by the Long-Term Care Insurance (EX) Task Force) and the LTC Pricing (B) Subgroup.
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the Task Force or its appointed Subgroup

As both state insurance regulators and the MSA Review may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI.

Consideration will be given to joint membership where two actuaries within a state combine to meet the criteria stated above.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
D. Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the chair and vice chair of the Long-Term Care Insurance (EX) Task Force, or its appointed subgroup. Other interested state insurance regulators (e.g., domiciliary state insurance regulators) may be invited to participate on a call at the discretion of the MSA Team or the chair or vice chair of the Task Force or its appointed subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the Minnesota and Texas actuarial approaches.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

E. Conflicts, Confidentiality, and Authority of the MSA Team

Authority of the MSA Team

Members of the MSA Team serve on a purely voluntary basis, and any member’s participation shall not be viewed or construed to be any official act, determination, or finding on behalf of their respective jurisdictions.

Disclosures and Confidentiality Obligations, as Applicable

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will: a) provide any in force LTCI rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations; and, b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings.

Conflict of Interest Avoidance Procedures and Certifications

No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual state, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual
state. All conflicts of interest, whether real or perceived are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.

F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the Long-Term Care Insurance (EX) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. The material substance of such communication can be documented within SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA rate increase proposals at the direction of the MSA Team and as described in this framework.

III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal.

- Must be an in force LTCI product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCI product approved by states, not by the Compact.
- For Compact-approved products meeting certain criteria, the Compact office will provide the first-level advisory review subject to the input and quality review of the MSA.

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a proposal that does not meet eligibility criteria. An insurer will be notified if the proposal for an MSA Review is denied.

An insurer may ask questions for more information about a potential rate proposal through communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact web page. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues, and answer questions.

The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC’s SERFF application.
B. Process for Requesting an MSA Review

As noted in Section IC above, the MSA Review will utilize the Compact’s multistate review platform within the NAIC’s SERFF application and its format for in force LTCI rate increase proposals. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance regulators:

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless rate increase proposal.
- Instructions containing a checklist for information required to be included in the rate increase proposal, as reflected in Appendix B, will be available to insurers through the Compact’s web page or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase proposal is or has been issued. Participating States will have access to view the insurer’s rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [TBD].
- Rate increase proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the Impacted States upon receipt of the rate increase proposal with the SERFF Tracking Number.
- The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team’s review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state’s decision to approve, partially approve, or disapprove a rate increase filing except when: 1) the individual state is a (Participating/Impacted State [TBD]) that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer’s certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication Form, which will be available through the Compact web page. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria
for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate increase proposal in SERFF. The MSA Team will be notified, via SERFF, when the rate increase proposal is available for review.

The supporting NAIC and Compact staff will notify (Participating/Impacted States [TBD]) via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate increase proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet periodically to discuss the review and determine any needed correspondence with the insurer. Objections and communications with filers will be conducted through SERFF, like any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completing the MSA Team’s review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals through SERFF. The timeliness of any necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will affect the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and 2) the insurer will receive sufficient information regarding the MSA Team’s recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team’s reasoning.

C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF “reviewer notes” for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, the Society of Actuaries (SOA) and the Conference of Consulting Actuaries (CCA), should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States.
The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content, as reflected in Appendix A, with modifications, as necessary, for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the Long-Term Care Insurance (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the Task Force, or an appointed subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating states and the insurer, through this process.

D. Timeline for Review and Distribution of the MSA Advisory Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not affecting state insurance departments’ required timelines for review. However, use of the MSA Advisory Report by the state is expected to reduce the amount of time required for the state to complete its review.

Pre-Distribution - Share the draft MSA Advisory Report with the insurer. The insurer will be given the opportunity to interact with the MSA Team to ask questions and understand the MSA Team’s reasoning.

- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States.
- Day 5-7 – Regulator-to-regulator conference call of all Participating States during which the MSA Team will present the recommendations in the MSA Advisory Report and seek comments from states.
- Day 21 – Deadline for comments on the draft MSA Advisory Report.
- Day 35 – Distribution of the final MSA Advisory Report, with consideration of comments, to Participating States and the insurer.
- Date TBD by the Insurer – Individual rate increase filings submitted to each state insurance department.
- Date TBD by each state’s DOI – Approval or disapproval of the rate increase filing submitted in each state.

E. Feedback to the MSA Team

At the direction of the Long-Term Care Insurance (EX) Task Force, or an appointed subgroup, state insurance departments will be requested to periodically provide data and feedback on their state rate increase approval amounts and their state’s use of and reliance on the MSA Advisory Reports. The following items may be considered in a feedback survey:

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.
4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants’ needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff.
resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team’s Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections, and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more rate proposals are reviewed.

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review, and reviewing the actuarial formulas and results:

- Review insurer experience, insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time reasonably align those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
  - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team’s recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches: or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. As the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

The MSA Team will consider how to reflect the differences in the histories of states’ rate approvals. Current approach includes:

- The MSA Team’s recommendation results in the same rate per unit in each state following the current rate increase round, leading to higher percentage rate increases in states that approved lower rate increases in the past.
- Analysis of state cost differences affecting justifiable rate increases will continue. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states should receive lower percentage rate increases. Part of the reason is that there was a tendency for people
in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.

- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

**Consideration of Solvency Concerns**

If concerns exist regarding an insurer’s financial solvency and the impact of rate increases on future solvency, each state DOI, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review, including consultation with states as part of the MSA Advisory Report comment period.

**Follow-Up Proposals on the Same Block**

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve the development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before the implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase proposal on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state DOI.

**B. Loss Ratio Approach**

Key aspects of the loss ratio approach to the actuarial review of rate changes include:

1. At policy issuance, pricing based on a lifetime loss ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the *Long-Term Care Insurance Model Regulation* (#641), Section 19 for more details on compliance with loss ratio standards.

2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.

3. The loss ratio approach increases future premiums to a level, referred to as make-up premium, such that the original loss ratio target is once again attained.

4. The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.

   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead
to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.

b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.

5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58%/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach

Key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
   a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
   c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019⁴ are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.

2. Cost-sharing formula that increases the insurer’s burden as cumulative rate increases rise.
   a. This addition to the insurer’s burden moves rates away from a direction that could potentially be seen as misleading. The insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.

3. Assumption review.
   a. Verification that the insurer’s original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the insurer.
   b. Verification of appropriateness of current assumptions.
      i. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.
      ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the insurer-provided assumptions. This conservatism can be released as credible experience develops.

4. Interest rate / investment return component
   a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
      i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
      ii. In the Minnesota approach, all factors impacting the business are considered.
         1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
         2. If interest rates fall, this would tend to lead to higher rate increase approvals.

To prevent shifting of “good assets” and “bad assets” to supporting LTC rates and prevent an insurer from increasing rates based on risky investments turned into losses, an index of average corporate bond yields (e.g., Moody’s) is relied on to reflect experience and current expectations.

Original pricing typically includes an assumption on investment returns, for which premiums and other positive cash flows are assumed to accumulate. This forms the interest component of the original assumption.

The original pricing investment return in Section VC(4)iv is compared to the average corporate bond yields in Section VC(4)iii to determine the adversity associated with the interest rate factor.

5. Original Assumption Adjustment

a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium.”

i. This results in a lower rate increase.

ii. This adjustment wears off over 20 years from policy issue.

1. The rationale for the wearing off of this adjustment is the assumption that no insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.

iii. This adjustment is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarily justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

Key aspects of the Texas approach to the actuarial review of rate changes include:

1. Past losses are assumed by the insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits, the recoupment of past losses to some extent.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

3. Data Requirements for Calculation:

a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:

i. Present Value of Future Benefits (PVFB) under current assumptions.

ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

iii. Present Value of Future Premiums (PVFP) under current assumptions.

iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

1. Note that for all four projections above, the projection period is typically 40–50 years: although, some companies project for 60 or more years.

To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on waiver, on claim, or paid up) regardless of the reason. Projections under current actuarial assumptions must not include
policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
   a. Rate increases are commonly driven by a change to the persistency, morbidity, mortality assumption, or a combination of the three.
   b. Verification that assumption change(s) are supported by credible data.
   c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the insurer, not the policyholder.

The formula used in the Texas approach is provided in Appendix C.

E. RBOs

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

RBOs in the MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the insurer demonstrates the proposed RBOs’ reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state’s requirements. As the MSA Review develops and as the Subgroup continues its work, this area of review may evolve.

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group to collectively consider new RBOs as they arise. This process will provide for input and technical advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.

F. Non-Actuarial Considerations

The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations affecting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.
3. Waiting periods between rate change requests.
4. Considerations of prior rate change approvals and disapprovals.
5. Limits or disapproval on rate changes based solely or predominately on the number of policyholders in a particular state.
6. Limits or disapproval on rate changes based on attained age of the policyholder.
7. Fair and reasonableness considerations for policyholders.
8. The impact of the rate change on the financial solvency of the insurer.

Considerations in the MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer’s rate proposal, based on the information provided by the insurer, which may be affected by a state’s non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state’s non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be affected by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those affected aspects of the rate proposal when completing their individual state’s rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may affect the cost-sharing formula.
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may affect states that consider age caps.
- If it is determined that the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may affect the potential need for adjustments to the cost-sharing formula.
- Aspects of the coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in its review.

Future Non-Actuarial Considerations

The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the Task Force will encourage its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increase and the complexity of the rate proposal and the insurer’s financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary.
   a. Overall recommended rate increase, before consideration of different states’ history of approvals.

2. Disclaimers.
   a. Purpose and intent of how states should use the MSA Advisory Report.
   b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.
   c. Statement that the in force rate increase filing submitted to the respective states shall be subject to the approval of each state, and each state’s applicable state laws and regulations shall apply to the entire rate schedule increase filing.

3. Background on the MSA Review.
4. **Explanation of the insurer’s Proposal.**
   a. The explanation will be based on the aspects of the insurer’s rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.

5. **Summary of the MSA Team’s rate review analysis, including these aspects:**
   a. Actuarial review.
      i. The summary of the review and the MSA Team’s recommendation will be based on the aspects of the insurer’s rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins, or other aspects.
   b. Summary of consideration of differences in the history of state’s rate increase approvals.
   c. Non-actuarial considerations and findings.
   d. Financial solvency-related aspects and adjustments.
   e. Review for reasonableness and clarity of RBOs.
   f. Summary information about the mix of business.

6. **Appendices.**
   a. Summary of the drivers of the rate proposal.
   b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal.
   c. Summary of rate proposal correspondence.
   d. Examples of rate increases if an RBO is not selected.
   e. Potential cost-sharing formula for typical circumstances.

**B. Appendix B – Information Checklist**

At the request of the former Long-Term Care Insurance (B/E) Task Force, the Long-Term Care Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all states. In this context, “checklist” means the list or template of inquiries that states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*¹ (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

**Information Required for an MSA Review of a Rate Proposal**

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews”⁶ as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. **Identify all states for which the product associated with the rate proposal is or has been issued.**

2. **New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.**

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² https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx
a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
   a. Provide the month, year, and percentage amount of all previous rate revisions.
   b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial memorandum justifying the new rate schedule, which includes:
   a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.
      iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
      iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder’s own past premium deficiencies and/or subsidizes other policyholders’ past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

6. Statement that policy design, underwriting, and claims handling practices were considered.
   a. Show how benefit features (e.g., inflation and length of benefit period) and premium features (e.g., limited pay and lifetime pay) impact requested increases.
   b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
   c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

7. A demonstration that actual and projected costs exceed anticipated costs and the margin.

8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
   a. Provide applicable actual-to-expected ratios regarding key assumptions.
   b. Provide justification for any change in assumptions.

9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.

b. A comparison of the population or industry study to the in force related to the rate proposal should be performed, if applicable.

c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.

d. Provide the year of the most recent morbidity experience study.

   a. Comparison with asset adequacy testing reserve assumptions.
      i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
      ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) reserves.
   c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
   a. Present value of future benefits (PVFB) under current assumptions
   b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
   c. Present value of future premiums (PVFP) under current assumptions.
   d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

*To emphasize, these projections should include only active nationwide policyholders currently paying premium, and they should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.

   b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.

12. The Guidance Manual checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.

13. Assert that analysis complies with Actuarial Standards of Practice (ASOPs), including 18 and 41.

14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

16. Policyholder notification letter should be clear and accurate.
   a. Provide a description of options for policyholders in lieu of or to reduce the increase.
   b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
   c. Explain the comparison of value between the rate increase and policyholder options.
d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
e. How are partnership policies addressed?

17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

Supplemental Information

As part of the Long-Term Care Insurance (EX) Task Force’s pilot project in 2020–2021, the following supplemental information was identified by the MSA Team as beneficial; and, therefore, the Task Force may be requested to assist in the MSA Review.

1. Benefit utilization:
   a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
   b. Explain how benefit utilization assumptions vary by maximum daily benefit.
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
   a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
   b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
   c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. RBOs
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

4. Investment returns:
   a. Provide original and updated / average investment return assumptions underlying the pricing.
   b. Explain how the updated assumption reflects experience.

5. Expected loss ratio:
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
   b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.

6. Shock lapse history:
   a. Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling:
   a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
   b. Explain how counting is appropriate (as opposed to double counting or undercounting).

8. Actual-to-expected differences:
   a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. Assumption consistency with the most recent asset adequacy testing:
a. Explain the consistency or any significant differences between assumptions underlying the rate increase proposal and those included in Actuarial Guideline 51 testing.

C. Appendix C—Actuarial Approach Detail

Minnesota Approach

Details on the key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.

2. If-knew premium and makeup premium aspects – aggregate application.
   a. Makeup percentage:
      i. \( \left\{ \frac{\text{PV (claims)}}{\text{original LLR}} - \text{PV (past premium)} \right\} / \text{PV (future premium)} - 1 \).
      ii. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
   b. If-k new percentage:
      i. \( \frac{\text{PV (claims)}}{\text{PV (premiums)}} / \text{original LLR} - 1 \).
      ii. Premiums in the formula are at the original rate level.
      iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   c. Definitions and explanations:
      i. PV means present value.
      ii. LLR means lifetime loss ratio.
      iii. Interest rates underlying PVs and LLRs are based on:
         1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
         2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
      iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
      v. Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
      vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification.
   a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium.
         1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
         2. Apply first principles.
            a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
            b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
            c. Divide by the sum of the PV of an annuity of 1 per year.
d. Multiply \((b / c)\) times \((1 + \text{originally assumed profit percentage})\) to attain the original premium.

e. This premium provides the basis for comparison against the makeup and if-knew premium.

3. Replace the original premium with a benchmark premium.
   a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
   b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
   c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

ii. Calculate an estimate of the makeup premium.
   1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
   2. Calculate an updated dollar PV of profits for the sample policy using:
      a. Actual history of premiums and claims.
      b. Expectations of future claims.
      c. “Backed into” makeup premium.
   3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
      a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.
   1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
      b. Verifying the impact on expectation changes on rates
         i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
         ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
            1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
            2. Experience
            3. Impact on LLR of changes in expectations of morbidity.
            4. Industry information and trends (for reasonableness checks).
      c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
         i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer’s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
         ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
            1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
            2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).

4. Reconciliation of aggregate and sample policy applications.
   a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
   b. In other cases, some steps are taken to understand the difference, including additional requests for information.
   c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
   d. When reconciliation occurs after rounds of communication, decisions will be made based on the information provided.

5. Blending – same for aggregate and sample policy applications.
   a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
   b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
   c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
   d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. No haircut for the first 15%.
      ii. 10% for the portion of cumulative rate increase between 15% and 50%.
      iii. 25% for the portion of cumulative rate increase between 50% and 100%.
      iv. 35% for the portion of cumulative rate increase between 100% and 150%.
      v. 50% for the portion of cumulative rate increase in excess of 150%.

7. Reduction for past rate increase:
   a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. The original premium is $1,000
      ii. Makeup premium is $3,000.
      iii. If-knew premium is $1,500.
iv. 60% of policyholders remain.
v. Past rate increases are 50%:
vi. Blended amount is:
  1. $3,000 / $1,000 * 0.60 +
  2. $1,500 / $1,000 * 0.40
  3. – 1 =
  4. 180% + 60% – 1 = 240% – 1 = 140%
vii. Cost sharing is:
  1. 100% * 0.15 +
  2. 90% * 0.35 +
  3. 75% * 0.5 +
  4. 65% * 0.4 =
  5. 110%
viii. Deduction for past rate increases results in:
  1. (1 + 1.1) / (1 + 5) – 1 =
  2. 40%

Texas PPV Formula

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to active, premium-paying policyholders.

For rate stabilized policies:

\[
\text{rate increase} \% = \frac{\Delta PV \text{(future incurred claims)} - \left( \frac{0.58 + 0.85C}{1 + C} \right) \Delta PV \text{(future earned premiums)}}{0.85 PV_{\text{current}} \text{(future earned premiums)}}
\]

Where:

\( \Delta \) indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.

\( C \) is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then \( C = 0.5 \).

The \( \text{current} \) subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the \( \Delta PV \text{(future incurred claims)} \) term in the above formula could be multiplied by \( (1 + \text{margin}) \).

For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:

\[
\text{rate increase} \% = \frac{\Delta PV \text{(future incurred claims)} - \left( \frac{0.6 + 0.8C}{1 + C} \right) \Delta PV \text{(future earned premiums)}}{0.8 PV_{\text{current}} \text{(future earned premiums)}}
\]
Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

D. Appendix D—Principles of RBOs Associated with LTCI Rate Increases

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to “Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
   - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
   - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
   - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
   - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
   - Companies should present RBOs in clear and simple language, format, and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an insurer to offer certain RBOs:
   - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and insurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
   - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases (e.g., providing hand railings for fall prevention in high-risk homes) and identifying the pros and cons of such an approach.
Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture (CNF).
   i. Claim amount can be the sum of past premiums paid.
   ii. Only receive that benefit if the policyholder qualifies for a claim.

Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

E. Appendix E—Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: “What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?”

To complete the charge, the Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LTC insurer Penn Treaty Network America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas, and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for LTCI RBOs presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- **RECOMMENDS** that insurance companies recognize these fundamental principles.
- **CALLS ON** all insurance companies to consider the following principles in communicating RBOs available to consumers in the event of a rate increase.
- **UNDERLINES** that the following principles are complementary and should be considered as a whole.

**Filing Rate Action Letters**

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the Long-Term Care Insurance Model Regulation (#641) allows for the next anniversary date or next billing date.
• Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
• Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
• Disclosing all associated future planned rate increases approved by state insurance regulators in the initial and phased-in rate increase notification letters.
• Filing rate action letter templates in the NAIC SERFF rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
• Presenting innovative options to state insurance regulators prior to filing new RBOs.
  o This enables state insurance regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

Readability and Accessibility

Insurers should consider:

• Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
• Presenting the RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
• Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
• Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
• Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
• Including a Q&A section that is succinct but answers the commonly asked questions in plain language.
• Providing appropriate accommodations for policyholders with disabilities or policyholders for whom English is not a first language.

Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

• What is happening.
• Why it is happening to them.
  o Ensure the letter does not negatively reference the state insurance department.
• When it is happening.
• What they can do about it.
• How they take action.

Communication Touch and Tone

Insurers should consider:

• Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased an LTCI policy.
• Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
• Presenting RBOs fairly, refraining from the use of bolding, repeating, or emphasizing one option over another.
• Displaying the policyholder’s ability to maintain current benefits by paying the increased premium.
• Using word choices that appreciate how those words could influence a policyholder’s decision.
For instance, consider using “now” instead of “must”; or consider using “mitigation options,” “offset premium impact” or “manage an increase” instead of “avoid an increase.”

Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include phone number, email address, and website when available. For example:

- Customer service.
- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
  - For example, the header could say, “Your Long-Term Care Premiums Are Increasing.”
- Including the RBOs with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which RBO(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
  - If supplemental materials (e.g., insurer’s website) are provided, they would enhance the policyholder’s understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder’s premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history by:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:
  - Policy form(s) impacted.
  - Calendar year(s) the policy form(s) was available for purchase.
  - Percentage of increase approved to include the minimum and maximum if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.
Insurers should consider advising policyholders of their current benefits:

- For example, the communication could disclose the policyholder’s current benefits to include:
  - Daily maximum amount.
  - Inflation option.
  - Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

- Only listing RBOs that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact LTC costs, such as:
  - The average cost of care for in-home care, assisted living, and nursing home care in their area.
  - The inflation rate of the cost of care for in-home and nursing home care in their area.
  - The average age and duration of an LTC claim for in-home and nursing home care.
  - Factors that influence the age, duration, and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  - Buyout or cash-out disclosures.
    - The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

- Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - Daily/monthly benefit.
  - Benefit period.
  - Inflation option.
  - Maximum lifetime amount.
  - Premium increase percentage and/or new premium.
  - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  - Current premium.
- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
  - What will happen if they take no action?
  - What will happen if they make no payment before the policy anniversary date?
  - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
If they elect the cash buyout, there could be tax implications.
- If they elect a paid-up NFO, how long will the reduced benefit last if they had a claim?
- If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
- Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:

- Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by state insurance regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering CNF based on the full increase amount and offered with each phase of the rate action.
- Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
DATE: [Date]
RE: ABC Insurance Company – Block LTC1 – Draft of Initial MSA Advisory Report

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Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 35% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company’s block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified Texas and Minnesota approaches. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

Background

The MSA Team was formed to assist the Long-Term Care Insurance (EX) Task Force in developing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team’s actuarial analysis is provided below. The intention is that states can utilize

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Information contained in this sample report is an example only and is not derived from any actual rate filing.
this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

The MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

**Insurer’s Proposal**

ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests.

**Workstream-Related Review Aspects**

**Actuarial Review**

At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states’ laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

Minnesota also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to projected claim costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The Minnesota approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

The Texas approach results in an approvable rate increase of 29% in aggregate.

The MSA Team’s recommendation, in consideration of the Minnesota and Texas approaches, is to approve a rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

**Consideration of Differences in Histories of States’ Rate Increase Approvals**
According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC Company’s past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- Five states have granted cumulative approvals averaging 27%.
- Two states have granted cumulative approvals averaging 15%.

The insurer’s stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below $1,700 in some states (with the lowest past approvals) to over $2,200 in other states (with the highest past approvals).

The MSA Team’s recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases based on past cumulative approval history is provided in Appendix 2.

Non-actuarial & Valuation/Solvency Considerations

Non-actuarial considerations, including flexibility regarding the phase-in of rate increases, waiting periods between rate increases being coordinated with phase-in periods, and other issues are being discussed at the Task Force and the Subgroup.

Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC Company will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase proposal are consistent with assumptions underlying the reserve adequacy testing.

RBOs – Review for Reasonableness

Unless a rider was purchased, ABC Company policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

1) Extending the elimination period.
2) Decreasing the benefit period.
3) Reducing future inflation accumulation.

The insurer produced rate tables which demonstrate that the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.

Financial Impact for Insurer

The requested rate increase associated with recent adverse development would result in around $50 million of reduced losses for this block according to information contained in the actuarial memorandum.

Mix of Business

From the insurer’s actuarial memorandum:

Enrollees:
- Total enrollees as of date of proposal: 15,000
- Inflation protection: 9,000 (inflation protection) and 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits) and 6,500 (limited benefits)

Product type: Expense reimbursement:
- Average issue age: 58
- Average attained age: 75
- Annualized premium: $30 million; $2,000 average per policyholder

Appendix 1

Drivers of Rate Increase Proposal – Summary

The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding Minnesota Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:
- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
  - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup cumulative rate increase since issue: 123%
  - $0.62 \times 177\% + (1 - 0.62) \times 36\%, \text{ adjusted for rounding}
- Insurer cost share based on Minnesota formula (see Appendix 3): 12%
- Recommended cumulative rate increase since issue: 109%
  - $1 \times 0.12 \times 1.23, \text{ adjusted for rounding}
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
  - $(1 + 1.09) / (1 + 0.55) - 1, \text{ adjusted for rounding}$
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
  - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the Minnesota approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details Regarding Texas Approach

- Insurer Calculation (aggregate): 52%

PPV calculations
- Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%
LHAO Comments

- For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:

\[
\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left( \frac{58 + 85 \cdot C}{1 + C} \right) \Delta PV(\text{future earned premiums})}{85 \cdot PV_{\text{current}}(\text{future earned premiums})}
\]

Reconciliation of Minnesota and Texas Approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach’s recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team’s recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
  - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
  - Reasons for the rate increase, including which pricing assumptions were not realized and why.
  - Statement that policy design, underwriting, and claims handling practices were considered.
  - A demonstration that actual and projected costs exceed anticipated costs and the margin.
  - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
    - Comparison with asset adequacy testing reserve assumptions.
    - Provide actuarial assumptions from original pricing and most recent rate increase filing, and, have the original actuarial memorandum available upon request.
  - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
  - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
  - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
- Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
• Policyholder notification letter – should be clear and accurate.
  o Provide a description of options for policyholders in lieu of or to reduce the increase.
  o If inflation protection is removed or reduced, is accumulated inflation protection vested?
  o Explain the comparison of value between the rate increase and policyholder options.
  o Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
  o How are partnership policies addressed?

• Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program proposals:
  o Information on benefit utilization.
  o Attribution of rate increase by factor.
  o RBO history and reasonability analysis.
  o Investment returns.
  o Expected loss ratio.
  o Shock lapse history.
  o Waiver of premium handling.
  o Actual-to-expected differences.
  o Assumption consistency with Actuarial Guideline 51 asset adequacy testing.

• Following initial review of the proposal, additional information was requested by the MSA Team related to:
  o Original pricing assumptions.
  o Lapse assumption by duration.
  o Premiums and incurred claims by calendar year based on original assumptions.
  o Distribution of in force by inflation protection.
  o Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
  o Description of waiver of premium handling in premium and claim projections.
  o Commentary on COVID-19 short-term and long-term LTC impact.

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

<table>
<thead>
<tr>
<th>ABC Company</th>
<th>Past Cumulative Approved Increases</th>
<th>Increase to catch up</th>
<th>Recommended New</th>
<th>2021 Recommended Rate Incr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction Example*</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Example: state with average past approvals</td>
<td>55%</td>
<td>0%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Example: state with lower than average past approvals</td>
<td>27%</td>
<td>22%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*The recommendation for each state is based on the actual past cumulative approved increases in that state.

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance
Cumulative rate increase since issue date is haircut by:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%.
- 25% for the portion of cumulative rate increase between 50% and 100%.
- 35% for the portion of cumulative rate increase between 100% and 150%.
- 50% for the portion of cumulative rate increase in excess of 150%.

Example: if the pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

Justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.
The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit www.naic.org.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the *Unfair Trade Practices Act* (#880)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Two states have enacted the revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the *Annuity Disclosure Model Regulation* (#245)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Suitability in Annuity Transactions Model Regulation* (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. Seven states have enacted the revisions to the model.

- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 14 states have adopted the revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Health Maintenance Organization Model Act* (#430)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.

- Amendments to the *Insurance Holding Company System Regulatory Act* (#440)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Seven states have adopted the revisions to this model.

- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Two states have adopted the revisions to this model.
Property and Casualty Insurance (C) Committee

- Adoption of the Real Property Lender-Placed Insurance Model Act (#631)—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

Financial Condition (E) Committee

- Amendments to the Credit for Reinsurance Model Law (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019, conference call. 47 states have enacted this model.

- Amendments to the Credit for Reinsurance Model Regulation (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019, conference call. 31 states have enacted this model.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Spring National Meeting/Att 2 StatusAdoptedModels.pdf
EXECUTIVE (EX) COMMITTEE

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Executive (EX) Committee
Kansas City, Missouri
April 6, 2022

The Executive (EX) Committee met in Kansas City, MO, April 6, 2022. The following Committee members participated: Dean L. Cameron, Chair (ID); Chlora Lindley-Myers, Vice Chair (MO); Andrew N. Mais, Vice President (CT); Jon Godfread, Secretary-Treasurer (ND); David Altmaier, Most Recent Past President (FL); Lori K. Wing-Heier (AK); Michael Conway (CO); Trinidad Navarro (DE); Doug Ommen (IA); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Glen Mulready (OK); Andrew R. Stolfi (OR); Carter Lawrence (TN); and Scott A. White (VA). Also participating were: Barbara D. Richardson (NV); and Elizabeth Kelleher Dwyer (RI).

1. **Adopted the April 4 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee**

   Director Cameron reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met April 4 in joint session. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings.

   During this meeting, the Committee and Subcommittee: 1) adopted its 2021 Fall National Meeting minutes; and 2) adopted its March 21, 2022; Feb. 3, 2022; Jan. 14, 2022; and Oct. 12, 2021, minutes, which included the following action: a) approved the NAIC filing an amicus brief for *In Re: Penn Treaty Network America Insurance Company*; b) approved the System for Electronic Rates & Forms Filing (SERFF) Modernization – 2022 Transition Stages Fiscal Impact Statement after public exposure; c) approved the establishment of a foundation to promote diversity in the insurance regulatory community; d) approved the release of the SERFF Modernization – 2022 Transition Stages Fiscal for public exposure; e) appointed Director Evan G. Daniels (AZ) to the National Insurance Producer Registry (NIPR) Board of Directors; f) selected Los Angeles, CA, as the location of the 2026 Spring National Meeting; and g) reappointed Commissioner Mais to the International Association of Insurance Supervisors (IAIS) Executive Committee.

   The Executive (EX) Committee also adopted the report of the Audit Committee, which met March 30, including the 2021 Financial Audit Report.

   The Executive (EX) Committee also: 1) adopted the report of the Internal Administration (EX1) Subcommittee, which met March 8, including its amended 2022 charges; 2) appointed Director Cameron, NAIC President, to the IAIS Executive Committee; and 3) approved initial funding from the NAIC for the establishment of a foundation.

   Commissioner Donelon made a motion, seconded by Commissioner Mais, to adopt the April 4 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. **Adopted its March 21, Feb. 3, and Jan. 14 Interim Meeting Report**

   Commissioner Altmaier made a motion, seconded by Director Lindley-Myers, to adopt the Executive (EX) Committee’s March 21, Feb. 3, and Jan. 14 interim meeting report (Attachment One). The motion passed unanimously.
3. **Adopted the Reports of its Task Forces**

Commissioner Altmaier made a motion, seconded by Director Lindley-Myers, to adopt the reports of the: 1) Climate and Resiliency (EX) Task Force; 2) Government Relations (EX) Leadership Council; 3) Long-Term Care Insurance (EX) Task Force; and 4) Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed unanimously.

4. **Adopted the Proposal to Establish a Catastrophe Modeling Center of Excellence (COE) Within the NAIC’s Center for Insurance Policy and Research (CIPR)**

Commissioner Altmaier reported that the Climate and Resiliency (EX) Task Force was charged with evaluating the use of modeling by carriers and their reinsurers concerning climate risk. To facilitate that work, the Technology Workstream, led by Commissioner Donelon, exposed a proposal last September for the NAIC’s Center for Insurance Policy and Research (CIPR) to create a Catastrophe Model Center of Excellence (COE). The proposed COE has three goals: 1) to provide insurance departments with access to catastrophe modeling documentation and aid state insurance regulators in distilling technical information; 2) to work with catastrophe model vendors to develop education and training materials for state insurance regulators; and 3) to conduct applied research using models to explore options for improving resilience from natural hazards.

The Workstream received positive feedback on the proposal from state insurance regulators and the industry. NAIC staff created a frequently asked questions (FAQ) document to address questions about the purpose and scope of work to be developed by the COE. The proposal and the FAQ document were posted on the Climate and Resiliency Resource web page.

The Workstream adopted the proposal on Nov. 22, 2021, and submitted the recommendation to the Task Force on Dec. 14, 2021. Receiving no further comments, the Task Force adopted the proposal during its virtual meeting on March 21. Later this year, a fiscal will be presented to Executive (EX) Committee to address the resource and funding needs for this initiative.

Commissioner Altmaier made a motion, seconded by Commissioner Donelon, to adopt the proposal to establish a COE within the NAIC’s CIPR (Attachment Three). The motion passed unanimously.

5. **Adopted the Proposed Redesigned NAIC Climate Risk Disclosure Survey**

Commissioner Altmaier reported that the Executive (EX) Committee charged the Climate and Resiliency (EX) Task Force with considering appropriate climate risk disclosures within the insurance sector, including evaluation of the Climate Risk Disclosure Survey and alignment with other sectors and international standards.

The Climate Risk Disclosure Workstream, led by Commissioner Stolfi and Superintendent Dwyer, completed that work and adopted a revised Climate Risk Disclosure Survey on March 11. The revised survey is aligned with the Financial Stability Board’s (FSB’s) Task Force for Climate-Related Financial Disclosures (TCFD) framework, which the participating states have encouraged companies to use for the last two reporting years. The survey includes guiding questions specific to insurance to assist insurers required to submit the survey on an annual basis. The survey will remain a voluntary tool for states to use at their discretion, and it provides a considerable amount of leeway for state insurance regulators to offer insurers in terms of content reported and timelines for submission. The Workstream held multiple exposure periods and made changes to both the content of the survey and the timelines for reporting based on the feedback they received.

Commissioner Altmaier noted that many jurisdictions are placing an emphasis on climate disclosure, including the Federal Insurance Office (FIO), which has been instructed to look for gaps in the insurance regulatory framework.
regarding climate risk. By adopting the proposed changes to the Climate Risk Disclosure Survey to align it with Task Force on Climate-Related Financial Disclosures (TCFD) guidance, we are strengthening our argument that state insurance regulators are best suited to address any potential gaps. Implementing the revised survey provides state insurance regulators with a supervisory tool to assess how climate-related risks may affect the insurance industry, while allowing flexibility for states and aligning with international climate risk disclosure frameworks. Having a common framework for state insurance regulators reduces redundancy in reporting requirements for insurers. On March 21, the Climate and Resiliency (EX) Task Force voted to adopt the revised Climate Risk Disclosure Survey.

Commissioner Altmaier also noted that voting yes on the motion does not obligate states to use or in any way support the survey; it simply facilitates use of this uniform product to collect climate-related risk information from insurers writing business in the participating states.

Commissioner Altmaier made a motion, seconded by Director Fox, to adopt the proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use (Attachment Four).

Commissioner Mulready made a substitute motion, seconded by Commissioner Lawrence, to adopt the proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use and allowing insurance companies which meet the premium threshold in a calendar year a delayed survey response until the following calendar year.

Commissioner Stolfi commented that new companies coming on board and responding to the survey were discussed at the Workstream level. A company that has not responded previously to the survey would have until 2023 to respond, as provided for in the table on page 2 of the survey. This would also apply for companies when they first reach the $1 million point. They would have until the following year to respond. Commissioner Stolfi added that companies usually know when they are approaching different regulatory triggers, and they can plan for their participation in responding. If they request an extension, we would be prepared to respond to that, but even in that case the survey is very clear that any participating state has a lot of discretion to allow whatever flexibility they want as it’s a voluntary state survey.

Commissioner Lawrence qualified that his second to the substitute motion was not an opposition to the original motion but an addition, and he expressed his continued support for the state-based system of regulation as the forum to address this issue.

The substitute motion failed. The Committee then voted on the original motion to adopt the proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use. The motion passed unanimously.

6. **Approved Disbanding the SERFF Advisory Board**

Commissioner Richardson reported that the NAIC is undertaking a multi-year, multi-million-dollar project to modernize the SERFF platform. As part of this effort, the Executive (EX) Committee is looking at governance of the SERFF system and how to streamline state insurance regulator, industry, and consumer input.

The proposal before the Committee (Attachment Five) is to disband the current SERFF Advisory Board due to the overlap in its responsibilities with both the Committee and the group of state insurance regulators overseeing the SERFF Modernization project, as well as with the Speed to Market (H) Working Group and the SERFF Product Steering Committee (PSC).

Policy issues related to rate and form filing are within the purview of the Working Group, and SERFF system issues are reviewed by the PSC, the SERFF Oversight Group, and ultimately the Executive (EX) Committee. Industry and consumer input has and will continue to be considered on all issues related to SERFF.
The Advisory Board received comments from Birny Birnbaum (Center for Economic Justice—CEJ) that the proposal
to do away with the Advisory Board would do away with the role for consumer representative input into the SERFF
system and its modernization. The primary consumer interest in SERFF relates to the SERFF Filing Access public
access feature. The NAIC staff supporting the SERFF Modernization project are committed to seeking consumer
input when that portion of the project is reached. Consumer representatives are also welcomed to participate at
both the Working Group and the PSC.

Commissioner Godfread made a motion, seconded by Commissioner Mais, to disband the SERFF Advisory Board.
The motion passed unanimously.

7. Received the 2021 Annual Report of the NAIC Designation Program Advisory Board Activities

Commissioner Clark provided an update on the NAIC Designation Program Advisory Board’s activities and 2021
achievements for the NAIC Insurance Regulator Professional Designation Program (Attachment Six). At year-end,
enrollment totaled 3,021. State insurance regulators have earned 1,704 professional insurance regulation
designations. To date, all but one territory have at least one employee enrolled in the designation program.

Commissioner Clark noted that the Advisory Board met monthly in 2021 to discuss policy recommendations,
renewal credits, the future of the program, and how to best promote awareness and support.

Commissioner Clark also reported some notable accomplishments in 2021, including implementing the Certemy
program management system and selecting an online proctoring service, Integrity Advocate, with implementation
scheduled for 2022.

The Advisory Board is strategizing for the future of the program and how it can best serve members and state
insurance regulators. Commissioner Clark encouraged members to make additional recommendations that would
enhance the program for use by the states.

8. Received a Status Report on the NAIC State Ahead Strategic Plan Implementation

Director Cameron provided an update on NAIC State Ahead implementation efforts. State Ahead is a three-year
strategic plan for the organization intended to further advance the products, services, and support the NAIC
provides to state insurance regulators in order to better meet the changing regulatory landscape. Overall, NAIC
staff continue to make good progress on the many State Ahead projects (Attachment Seven). Planning has begun
at the member level for the next iteration of the strategic plan.

9. Received a Report of Model Law Development Efforts

Director Cameron presented a written report on the progress of ongoing model law development efforts
(Attachment Eight).

10. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the NIPR Board of Directors met April 4. During this meeting, the Board accepted
the 2021 independent financial audit conducted by RSM, a professional services firm. The audit report is part of
NIPR’s 2021 Annual Report released on April 4. The Annual Report highlights NIPR’s 2021 accomplishments,
including processing 42.5 million credentialing and report transactions on behalf of state departments of
insurance (DOIs), a year-over-year increase of 11.9%. NIPR had $61.6 million in revenue, representing a 29%
increase from 2020. It moved over $1 billion in state licensing fees from NIPR to DOIs, a 13.5% increase over last
year. Through February, NIPR revenues are 5.5% over budget and 9% over 2021.
NIPR is proud to announce several important initiatives that help fulfill its mission to provide cost-effective, streamlined, and uniform producer licensing services. NIPR continues to implement the Contact Change Request service for business entities, which allows industry to update email, telephone, and address changes required by states in one place. To date, NIPR has 31 state insurance departments using the service and has processed more than 18,000 transactions. This service provides an electronic solution for the states and industry, reducing time and cost for industry and state insurance regulators.

In 2022 the Massachusetts Division of Insurance authorized NIPR to process producer appointments and terminations on behalf of Massachusetts. NIPR is now processing producer appointments and terminations for all states. Massachusetts now offers the full array of NIPR’s online licensing services to all its producers and public adjusting.

Earlier this year, the Kansas Insurance Department began offering NIPR’s online licensing services to insurance producers and adjusters following the implementation of significant legislation designed to simplify and streamline the credentialing process.

11. Heard a Report from the Compact

Commissioner Birrane reported that the Interstate Insurance Product Regulation Commission (Compact) met April 5. During the meeting, the Compact adopted amendments to its bylaws. Many of these amendments came from recommendations made during the 2020 independent governance review conducted by Squire Patton Boggs.

One of the amendments made was to formalize the position of the past chair of the Compact in order to promote continuity and consistency of leadership. Superintendent Dwyer is the Compact’s past chair.

The members also voted to stay the effectiveness of the Uniform Standard for in-force rate increases for South Carolina for 120 days. It was also reported that South Carolina has a pending omnibus bill, which has a provision to repeal its participation in the Compact. The Compact received a favorable independent audit report. In 2021, the Compact ended the year with positive revenue of over $700,000. The Compact’s annual report was released April 5.

In March, the Compact made its third of 10 annual payments to the NAIC to service the outstanding debt incurred when the NAIC provided lines of credit to the Compact in its early years.

The Compact Governance Committee reported that it will release its recommendation with respect to the issue of implied congressional consent next week. This recommendation arises from the Colorado Supreme Court ruling and the outside legal counsel governance review, which found that the Compact has a compelling case that it received a form of congressional consent in 2006.

The Governance Committee has spent much of the past year working on this matter and is prepared to issue a position statement for further member review, as well as make it available publicly for notice and comment before considering it for adoption at the Compact’s next in-person meeting.

There are two new members of the Compact Consumer Advisory Committee. The Compact Management Committee appointed former Nebraska Insurance Director Bruce R. Ramge and former West Virginia Commissioner Jane Cline to serve as representatives on the Consumer Advisory Committee. Both are fully retired.

Having no further business, the Executive (EX) Committee adjourned.
EXECUTIVE (EX) COMMITTEE
March 21, 2022 / February 3, 2022 / January 14, 2022

Summary Report

The Executive (EX) Committee met March 21, Feb. 3, and Jan. 14, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Approved the System for Electronic Rates & Form Filings (SERFF) Modernization – 2022 Transition Stages Fiscal Impact Statement after a 10-day public comment period.

2. Discussed composition of the Government Relations Leadership Council (GRLC).

3. Appointed Director Evan G. Daniels (AZ) to serve on the National Insurance Producer Registry (NIPR) Board of Directors beginning in February 2022.

4. Selected Los Angeles, CA, for the 2026 Spring National Meeting site location.

5. Approved the NAIC filing an amicus brief in the case of In Re: Penn Treaty Network America Insurance Company (In Liquidation), In Re: American Network Insurance Company (In Liquidation).

NAIC Support Staff Hub/Member Meetings/Spring 2022/Cmte/Ex/Att 1 InterimMtgReport.docx
REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force met April 6 and took the following action: 1) adopted it March 21 minutes; 2) heard a presentation from Zurich North America and Resilient Cities Network on their partnership to improve community resilience; 3) heard a presentation from Munich Re America on solutions to improve community flood mitigation; and 4) heard a federal update. During its March 21 meeting, the Task Force adopted a proposal for the NAIC Center for Insurance Policy and Research (CIPR) to create a Catastrophe Model Center of Excellence, as well as the revised Climate Risk Disclosure Survey for states to use voluntarily at their discretion.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force met April 6 and took the following action: 1) adopted its 2021 Fall National Meeting minutes; 2) received a report on the implementation of the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework), which, upon adoption by the NAIC Executive (EX) Committee and Plenary, is anticipated to be implemented by September 2022; 3) heard a report on industry trends and factors affecting reserve levels; and 4) heard a report on the LTCI Multi-State Actuarial (MSA) Associate Program. Following the open meeting, the Task Force met in regulator-to-regulator session pursuant to policy paragraph #8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met April 6 and took the following action: 1) adopted its 2021 Fall National Meeting minutes; 2) received reports from its five workstreams; 3) discussed the Innovation, Cybersecurity, and (H) Committee Coordination Forum – Detecting and Addressing Unfair Bias; and 4) heard an update on the State Diversity Leaders Forum.

- Workstream One of the Special Committee is focused on researching and analyzing the level of diversity and inclusion within the insurance sector. The Workstream met in regulator-to-regulator session in October to receive an update from California and New York on their respective diversity, equity, and inclusion (DE&I) efforts and the diversity-related industry data that these states are collecting. The Workstream also met with stakeholders in November 2021 to better understand industry diversity-related programs, how companies are measuring progress, and what state insurance regulators can do to support these efforts. In terms of next steps, the Workstream co-chairs are working to outline proposed recommendations, as well as action steps for the Workstream to consider. The Workstream is also monitoring efforts by the U.S. House Committee on Financial Services’ Subcommittee on Diversity and Inclusion, which plans on having a hearing and producing a report on DE&I within the insurance sector. Much of what Chairwoman Maxine Waters (D-CA) and Chairwoman Joyce Beatty (D-OH) plan to evaluate falls within the charges of Workstream One: seeking additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and collecting input on any existing gaps in available industry diversity-related data. The Workstream will collaborate with the Special Committee in anticipation of the hearings and subsequent report.
• Workstream Two of the Special Committee has gathered responses to the zone level survey examining best practices and initiatives that state insurance departments may consider when promoting DE&I in their offices. The Workstream will soon develop a method and forum to share diversity and inclusion information among state insurance regulators. Much of Workstream Two’s recent work has been conducted by Evelyn Boswell, NAIC Director of Diversity, Equity, and Inclusion, through the State Diversity Leaders Forum. The Forum provides a space for diversity leaders in each state to come together and discuss best practices in promoting diversity in their respective insurance departments. Ms. Boswell provided an update on this work during the Special (EX) Committee on Race and Insurance’s meeting on April 6.

• Workstream Three of the Special Committee is focused on property/casualty (P/C) insurance issues. The Workstream co-chairs have met with leadership from the Innovation, Cybersecurity, and Technology (H) Committee, the Big Data and Artificial Intelligence (H) Working Group, the Accelerated Underwriting (A) Working Group and the Casualty Actuarial and Statistical (C) Task Force to discuss issues surrounding algorithmic auditing and how best to work together to understand such auditing. The Workstream plans to hear from various experts in the field to determine what education or tools state insurance regulators might need to evaluate algorithms and models to detect unfair bias. Workstream Three met March 22 in regulator-to-regulator session, pursuant to paragraph 3 (special companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss algorithmic auditing, as well as each of its charges.

• Workstream Four of the Special Committee is focused on life insurance. The co-chairs have met to discuss how best to focus the Workstream’s efforts in 2022 and have specifically explored having presenters that could talk more about the Workstream charge to “continue research and analysis related to insurance access and affordability issues, including the marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.” The Workstream hopes to meet following the Spring National Meeting to confirm the Workstream focus for 2022 and hear additional presentations to inform its work.

• Workstream Five of the Special Committee met Dec. 20, 2021. During this meeting, the Workstream discussed a revised draft Principles for Data Collection document based on its discussions during its Dec. 3, 2021, meeting and adopted the document. The Workstream recently met in a regulator-to-regulator session to discuss its focus for 2022. The Workstream plans to focus on identifying race-related barriers to the acquisition and use of health insurance, creating strategies for mitigating or removing such barriers, discussing the role health insurance can play in addressing racially based inequities in health outcomes, and addressing social determinants of health. The Workstream hopes to meet at least monthly to hear from various stakeholders, such as consumer groups, academics, and industry related to these issues with a focus on benefit design and consumer empowerment.
A Proposal to Establish a Catastrophe (CAT) Modeling “Center of Excellence” (COE) within the NAIC’s Center for Insurance Policy & Research (CIPR)

September 20, 2021

Introduction

The leadership and members of the NAIC have determined natural CAT risks and resiliency to be a top priority and organized several workstreams to pursue objectives intended to help ensure homes and businesses are protected from insured perils arising from natural CATs, while keeping markets stable through financially strong insurers and reinsurers. For example, the Catastrophe Risk (E) Subgroup has spent many years working to develop risk-based capital (RBC) factors for hurricane and earthquake exposures and, more recently, grappling with how best to address wildfire, flood, and convection storm perils. Separately, the Catastrophe Insurance (C) Working Group is charged with maintaining the NAIC State Disaster Response Plan, the Disaster Assistance Program, and the Catastrophe Computer Modeling Handbook. The Working Group has also commenced work to determine ways in which the private flood market can be facilitated and monitored by the state insurance regulators. The Climate and Resiliency (EX) Task Force has taken on significant work, which will require a deeper understanding of all aspects of climate and natural CAT risks. Further, many state insurance regulators are taking on new roles in working to create risk resilient communities within their jurisdictions.

Given these increased pressures and new roles, state insurance regulators need to improve their understanding of the CAT modeling technologies used by insurers and reinsurers. This means having access to the same knowledge, insights, and tools used by insurers. In doing so, state insurance regulators can more effectively engage with insurers and state and federal policymakers when discussing how best to maintain critical insurance coverages for their states’ economies and developing new regulatory policy. The NAIC can play an instrumental role fulfilling these needs.

In this regard, the Technology Workstream of the Climate and Resiliency (EX) Task Force was assigned the task of considering the potential application of technology, such as early warning systems and predictive modeling tools, to better understand and thereby evaluate insurers’ climate and natural CAT

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risk exposures. In particular, the Technology Workstream was tasked with determining whether technical support services were needed by state insurance departments regarding the industry’s use of CAT models.

To help facilitate the members’ consideration of such a need, NAIC/CIPR staff conducted two presentations on June 7 and Aug. 6, 2021, wherein staff laid out a range of support services for state insurance departments when encountering the use of commercial CAT models by insurers in rate making processes, solvency functions, and/or other insurance business decisions (e.g., strategic, reinsurance, claims management). NAIC/CIPR staff addressed potential support services in the areas of: 1) facilitating access to CAT modeling documentation; 2) providing technical education and training; and 3) conducting applied research to proactively address regulatory climate risk and resilience priorities. Finally, an additional related benefit highlighted is the ability to provide future support services for other modeled CAT risk beyond climate and natural CATs, including casualty/liability, cyber, terrorism, and infectious diseases such as pandemics. This additional support work could potentially influence other NAIC related committee activities, as appropriate.

Proposal

As outlined in the introduction above, the time has arrived for the NAIC to establish a permanent support group—i.e., the NAIC CAT Modeling COE—to provide the NAIC and state system of insurance regulation with the necessary technical expertise, tools, and information to effectively regulate the insurers and reinsurers exposed to catastrophic events for a secure and stable insurance marketplace. We believe this COE would be best positioned within the NAIC’s CIPR given CIPR’s: 1) existing knowledge, expertise, and recent NAIC applied research track record in this field; and 2) its ability to effectively work with modelers and state insurance regulators from a neutral perspective within the NAIC. Below is a complementary and integrated series of technical support services envisioned by the COE:

1) Facilitating insurance department access to CAT modeling documentation and assistance in the distilling of this information.

2) Providing general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures.

3) Conducting applied research analysis utilizing various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed for regulatory resilience priorities.

The first element from above provides for the CAT Modeling COE to facilitate insurance department access to CAT modeling documentation and other information, as well as centralizing accumulated knowledge and expertise to aid in the deciphering and distillation of CAT models. The COE would assist
with managing both CAT model vendor relationships and insurance department needs. As such, the COE would be briefed on the modeling technologies and inputs in a similar fashion as insurers and reinsurers are and have access to the same modeling documentation to develop internal expertise. This knowledge and expertise would then be actively shared with state insurance regulators for use in regulatory processes and other considerations. Critically, this information would be collected and stored on an NAIC regulator-only technological platform with proper CAT modeling vendor Data Use Agreements (DUAs) in place to allow for proprietary model information sharing, part of which has been a stumbling block to regulatory access to date.

The second element from above provides for technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures for state insurance regulators. Importantly, this technical training would be utilized to enhance regulatory operational activities, thereby bringing the science to operations. For example, it would allow for state insurance departments and the NAIC to reimagine the NAIC *Catastrophe Computer Modeling Handbook*, which could become the foundational authoritative literature on state insurance regulator use of CAT models. As state insurance regulators gain more practice with these models, the NAIC is also well-positioned to develop best practices on industry use, as well as state insurance regulator use. Consequently, the NAIC *Financial Condition Examiners Handbook* and the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* could be improved to account for the latest developments and best practices in CAT risk assessment. Further from a solvency perspective, both the development of related RBC CAT charges and climate stress testing would benefit greatly from such a technical foundation.

The third element from above provides for conducting applied research analysis to utilize various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed. CAT models are not limited to use by the insurance industry; they are tools for CAT risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities (e.g., how to increase the uptake and proliferation of home hardening activities related to hurricane and wildfire risk). Such mitigation activities are critical to reduce expected losses and improve the availability and affordability of coverage currently and in a future warming climate. Applied research utilizing CAT models can demonstrate the economic value of such mitigation activities, laying the proper foundation for policy discussions to address increasing property owner mitigation implementation.

Lastly, it is important to note that these identified support services will not be taking the place of individual state department of insurance (DOI) activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. Rather, the support services will allow the COE to engage with state insurance regulators as a trusted partner with a sufficient level
of CAT modeling expertise to enable the conduction of ongoing CAT modeling regulatory activities more effectively.

**Plan of Action**

In the past year, many of the above support services have already transpired and/or are currently underway. These include: 1) regulator-only technological platform infrastructure development and DUA executions; 2) NAIC Insurance Summit and CIPR events focused on CAT modeling education concerning wildfire and flood models, CAT model climate change incorporation and climate risk assessment, and casualty CAT modeling; 3) successful completion of a California, Colorado, and Oregon DOI wildfire mitigation report and wildfire CAT model technical documentation done in conjunction with the Insurance Institute for Business & Home Safety (IBHS) and Risk Management Solutions (RMS), which was further leveraged by the Catastrophe Risk (E) Subgroup for wildfire RBC factor development and the Catastrophe Insurance (C) Working Group *Catastrophe Computer Modeling Handbook* updates. Therefore, this proposal will not be to start such CAT modeling COE support service activities, but rather to build upon and leverage these activities for further enhancement and formalization at the NAIC.

Following the meeting of the Technology Workstream on Aug. 6, 2021, the proposal was released to the member states for further comments and questions. Comments were considered, and a revised proposal was approved for public exposure by the Technology, Solvency, and Pre-Disaster Mitigation Workstreams on Sept. 20, 2021.

Following the Sept. 20 regulator-only meeting, the proposal was released to interested parties for further comment and questions for 30 days. Comments will be considered by the Technology Workstream following this feedback and revisions may be made to the proposal, as agreed upon.

If the proposal advances through the above process steps, it will be prepared for recommendation to the Climate Risk and Resiliency (EX) Task Force at the NAIC 2021 Fall National Meeting in San Diego, CA.

We anticipate there would be no new charges associated with creation of the COE; i.e., the expenses associated with the COE resources would be effectively absorbed by the NAIC budget and have no special assessments, fee for services, etc. These resources may include: 1) recruiting a vendor/insurance department CAT modeling relationship manager and a CAT model research analyst; 2) funding for education/training development and implementation and the licensing and/or running of models for applied research to support and/or enhance regulatory operational activities; and 3) addressing regulatory resilience priorities.
Conclusion

In the face of extreme weather and the future climate significantly affecting property insurance markets, state insurance regulators need to have access to the same knowledge, insights, and CAT modeling tools used by insurers and reinsurers to assess and address climate risk and resiliency; i.e., knowledge and tools that are available for state insurance regulators to access, understand, and utilize. To accomplish this, we propose that the NAIC establish a permanent support group—i.e., the NAIC CAT Modeling COE—housed within the NAIC’s research unit; i.e., CIPR. We have laid out a proposal and plan of action that would build upon the work that the NAIC/CIPR has already been conducting around climate and CAT risks and allows the NAIC/CIPR to bring science to the operation of the DOIs in a way that is additive to the existing regulatory system, easy to access, and tailored to the needs of the state insurance regulators.

CATModelCOE Proposal
NAIC/Center for Insurance Policy and Research (CIPR) Catastrophe Model
Center of Excellence (COE)
Frequently Asked Questions (FAQ)
November 16, 2021

Governance & Oversight

Topic: Vendor and Insurer Continued Engagement with Departments of Insurance (DOIs)

Is the intent for the COE to become the primary point of contact between state insurance regulators and modelers?

No. As stated in the proposal, “identified support services will not be taking the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models.” However, we do envision the COE providing access to CAT modeling expertise to support state insurance regulator understanding, training, etc.

Will state insurance regulators continue to be open to discussions with modelers (and insurers) about models?

Yes. In fact, the COE will seek to improve communication between state insurance regulators and modelers/insurers, supplying state insurance regulators with expertise and information to help facilitate such discussions.

Topic: Transparency and Potential Bias of Modeled Results/Usage

How will the COE engage with interested stakeholders to remain transparent?

Most NAIC support resources interact with a committee for reporting and oversight. In this instance, at least for now, we propose that the catastrophe resource center will report to the Technology Workstream under the Climate and Resiliency (EX) Task Force, as well as coordinate with the Property and Casualty Insurance (C) Committee.

How will the COE work to ensure impartiality of vendor models?
The COE will make every effort to engage with all vendors willing to participate for all perils with available technical documentation. Furthermore, the COE will establish a governance structure to ensure that partiality is not provided to any model or vendor.

**Would the COE be engaging to connect learnings from the CAT model to specific insurer rate-making, solvency, and/or business—i.e., strategic, reinsurance, claims management—decisions?**

The COE support services will not take the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. The COE will work to understand models objectively from a general sense, not for individual rate filings or solvency assessments. We acknowledge that each insurer has their own risk profile that would need to be considered on an individual basis, which is outside the scope of the COE.

**Topic: Objective Science**

**Would the kind of information the COE conveys be facts-based or would it include opinions or analysis?**

The information provided to the state DOIs would be fact-based with relevant objective analysis, as requested. Providing this type of information to states highlights the importance of the placement of the COE within the NAIC’s independent research center, the CIPR.

**Topic: Addressing Regulatory “So What” Questions Through Applied Research**

**What are regulatory “so what” questions in support service #3 of the proposal conducting applied research analysis?**

State insurance regulators are responsible for maintaining well-functioning competitive insurance markets. Forward-looking models can be utilized to help analyze market performance, especially regarding the need for improved resilience. As stated in the proposal, CAT models are tools for catastrophe risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities. For example, models can be used to identify high-risk areas and where proliferation of home hardening activities can improve resilience to natural hazards, including hurricane, flood, severe convective storm, tornado, wildfire, and earthquake. Such mitigation activities are critical to reduce probable losses. Lower losses over time can improve the availability and affordability of coverage in the future. Applied research utilizing CAT models can demonstrate the economic value of mitigation activities. One
description provided via public comments that we considered useful is, “conducting applied research analysis that utilizes or analyzes the potential to utilize CAT models to further public and private risk mitigation and resiliency efforts; benefits and opportunities at the individual consumer or business; or public agency at the community, regional, state, or national level.”

**Regarding conducting applied research analyses utilizing CAT models, we would like to understand the research and support expectations from the COE on modelers.**

We envision working with modelers on applied research activities as applicable. We are requesting funding to allow for modeler engagement.

**Depending on the expected level of granularity for COE work, additional questions may be relevant, such as whether the COE (NAIC/CIPR) would need to be prepared to go to a hearing to testify or respond to discovery?**

It is not anticipated that the COE would maintain granular information about individual insurer use of CAT models. The level of detail would be around the actual CAT model to provide education and training to state DOIs.

**Will the COE be used to conduct research and analysis into the markets for CAT models. Will conflicts of interest or market failures distort the use of CAT models?**

No. It is not envisioned that the COE would set out to conduct this type of research and analysis.

**Implementation Considerations**

**Topic: COE Communication of Various Results, Information, and Observations to DOIs**

Given the complexity of models and breadth of expertise required to build and maintain them, there is a risk that any third party cannot adequately communicate the nuances and justification of models. Will the COE plan to coordinate model presentations from the modelers, rather than only relaying this information second-hand?

Yes. The COE would plan to coordinate model presentations from modelers.

**How will information, observations, and/or questions about models be conveyed to state insurance departments? What kind of output will be generated?**

We plan to hire a relationship manager responsible for communicating with the CAT model vendors and state insurance regulators. A regulator-only technology platform will help facilitate information sharing with state insurance regulators.
Research output could take multiple forms depending upon the nature of the analysis undertaken.

**What kinds of data fields will be included? Will others provide input into the design?**

The data fields selected would be contingent on the models being used and the research project under consideration. Data fields would follow from model inputs and outputs.

**Will the COE reviews and/or output be designed to be geography-specific?**

Yes. That is possible.

**Once a model has been reviewed, what renewal process is envisioned?**

Models will not be reviewed, nor would they be posted on the state insurance regulator-only website. However, model technical documentation and information will be updated as new versions of the models are released.

**Topic: Model Vendor Intellectual Property (IP) Protection**

**How will the COE safeguard intellectual property of the participating CAT model vendors?**

All modeling documentation, access, and usage will be centralized and monitored through the COE via legally binding data use agreements. The NAIC has an extensive track record of experience in collecting and protecting proprietary information. The actual models will not be posted on the state insurance regulator website, only the model documentation will be posted.

**Topic: Interaction with Modelers and Other External Experts**

**Will modelers engage in discussions with the COE about specific models? Do you expect insurers would be involved in model-related discussions?**

Yes. The COE would be engaged with modelers on the modeling technologies and inputs in a similar fashion as insurers and reinsurers and have access to the same modeling documentation to develop internal expertise. It is possible that insurers could be involved in model-related discussions with the COE, but the COE will not review individual insurer’s use of models.

**Is the CIPR planning to license and use modeler software or engage in paid consulting studies for their research and development of processes?**
Yes, depending on COE resources and the specific research use case. The CIPR would be willing to either license modeler software and/or engage in paid consulting studies for research and educational/training purposes, as directed by the appropriate NAIC authorities.

**How will results and underlying assumptions from licensed models be communicated to state insurance regulators?**

Any use of a licensed model, including distribution of modeled results, would be subject to the model license agreement and/or model vendor negotiated research consulting contract. Underlying assumptions from the various models utilized would be collected via the model technical documentation as part of the model vendor data use agreement. Note that it is possible that the model technical documentation, including underlying model assumptions, could be collected through a COE data use agreement without an associated model-based research project. If we were to license a model, the actual model would not be posted on the state insurance regulator-only website.

**Will modelers be involved in establishing workflows, best practices, agendas, and expectations of the COE, including timing?**

We anticipate that modelers will be actively engaged with the COE staff, advising on these items as appropriate.

**How many vendors is the COE considering supporting?**

The COE will not be “supporting” vendors, but rather the COE will collect model documentation and engage with model vendors. The COE will engage with any model vendor serving insurance markets where the information is relevant to state insurance regulators.

**Does the COE anticipate looking to external experts for some of the implementation or ongoing work?**

Yes. External collaboration would be welcome, whether that be with industry experts, public agencies, or the academic community.

**Topic: Resources - Staffing and Funding**

**How many states do you expect to be interfacing with the COE?**

The COE will be a resource of the NAIC potentially interfacing with all 56 jurisdictions.
Beyond recruiting for the identified new roles of CAT modeling relationship manager and CAT model research analyst, how many people at the NAIC/CIPR will be contributing to COE activities? Do you expect that to change over time?

The CIPR director, the NAIC solvency enterprise risk management (ERM) advisor, and potentially Property and Casualty Insurance (C) Committee staff support will have a role in supporting the work of the COE. We anticipate that additional technical and administrative support resources may be necessary as the workload and demand for services evolve with demonstrated success.

Will the staffing level proposed by the NAIC be able to provide meaningful analysis in the broad category of catastrophe modeling?

Prior to the creation of the COE, CIPR and NAIC staff have provided meaningful analysis on wildfire CAT modeling and applied wildfire resilience research. We aim to build off this success and need to start somewhere. Every little bit helps for the states, as stated by one industry commenter, “[t]he staffing issues mentioned above regarding experts at the NAIC are even larger for state insurance departments. Most states are not going to have enough or the right staff to review these models. They will have to rely on others to evaluate catastrophe model validity, and most likely will have to rely heavily on the decisions and evaluations made by others.”

Have long-term plans been prepared? Are there budget implications?

No long-term plan has been developed for the COE. The expenses associated with the COE would be subject to the NAIC budget process and have no special assessments or fees for service.
PROPOSED REDESIGNED NAIC CLIMATE RISK DISCLOSURE SURVEY

INTENT AND PURPOSE

The Climate Risk Disclosure Survey is a voluntary risk management tool for state insurance regulators to request from insurers on an annual basis a non-confidential disclosure of the insurers’ assessment and management of their climate-related risks.

The purpose of the Climate Risk Disclosure Survey is to:

- Enhance transparency about how insurers manage climate-related risks and opportunities.
- Identify good practices and vulnerabilities.
- Provide a baseline supervisory tool to assess how climate-related risks may affect the insurance industry.
- Promote insurer strategic management and encourage shared learning for continual improvement.
- Enable better-informed collaboration and engagement on climate-related issues among regulators and interested parties.
- Align with international climate risk disclosure frameworks to reduce redundancy in reporting requirements.

BACKGROUND

The NAIC adopted the original Climate Risk Disclosure Survey in 2010 and it has since been administered by the California Department of Insurance. In 2021, fifteen states participated in the climate risk disclosure survey initiative, up from six states in prior years. Because any insurer writing business in a participating state is required to submit their survey response annually, adding nine states in 2021, increased the market coverage from approximately 70% in 2020 to nearly 80% of the market in 2021 based on direct premium written.

In 2021, the Financial Stability Oversight Council (FSOC) produced a series of recommendations for financial regulators to enhance supervision, data analysis, staff resources, and regulatory cooperation related to climate risk. This included a recommendation to consider enhancing public reporting requirements for climate-related risks in a manner that builds on the four core elements of the Task Force on Climate-Related Financial Disclosure (TCFD), to the extent consistent with the U.S. regulatory framework and the needs of U.S. regulators and market participants.

This revised survey responds to FSOC’s recommendations and incorporates international best practices in adopting a TCFD aligned framework for US insurers to report on climate risks when requested by their state regulator.

The TCFD framework is structured around four thematic areas that are core elements.
for how insurers operate—governance, strategy, risk management, and metrics and targets. The four thematic areas are supported by key climate-related financial disclosures—referred to as recommended disclosures—that build out the framework with information that will help regulators and others understand how reporting organizations assess and approach climate-related issues.

INTRODUCTORY GUIDANCE

Timeline and expectation for reporting
We expect that every company who will be asked to complete the survey in 2022 will have already completed the existing NAIC survey or filed a TCFD report; nearly all companies having participated for several prior years. The table below outlines the timing and other expectations for reporting in 2022 and 2023 as the new survey is phased in. If a company has not previously responded to the NAIC survey, it should be given until 2023 to first respond.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Expectation Regarding Content</th>
<th>Deadline for Completion</th>
</tr>
</thead>
</table>
| 2022           | • If the insurer has already completed a TCFD for this reporting year, they can submit it as is.  
• If the insurer has not already completed a TCFD for this reporting year, they should make their best effort to complete the survey below or include such information in their TCFD filing, as is requested below.  
• Closed-ended questions are voluntary for 2022, and states may opt out of requesting responses to closed-ended questions. | To allow additional time for insurers to move to the new reporting structure, submission deadlines should be moved from Aug. 31 to Nov. 30. Extensions may be granted by the state that initiated the request to the company or the lead state for the group filing. |
| 2023           | Insurers are expected to address the content of the entire TCFD aligned survey below, to the best of their ability. | In accordance with prior years, submissions are due from insurers by Aug. 31st. Extensions may be granted by the state that initiated the request to the company. |

Threshold and voluntary state participation
The reporting threshold remains consistent with the threshold implemented each year since 2013. All insurers with countrywide premium written of at least $100 million, licensed to write in any of the participating states/territories, are required to complete and submit their survey on an annual basis. As of 2021, the following states/territories participate: California,

**Confidentiality and best effort basis**
While the existing NAIC survey and TCFD contain sufficient overlap in the analysis required to answer, we recognize that many insurers will be moving to a new reporting framework in the TCFD. Insurers should make their best effort to answer each question honestly and completely, keeping in mind that the information contained in the filing will be made public. During the transition to the TCFD aligned survey, state insurance regulators should work closely with insurers to provide as much flexibility as possible in terms of responding to the survey and deadlines. Confidential information should not be included in this public disclosure unless it is intended to be made public. If additional detail is requested by a state insurance regulator, that request will be handled directly between the regulator and insurer.

**Materiality**
There is no requirement to provide information that is immaterial to an assessment of financial soundness (insurers may choose to disclose such information voluntarily, with no implication that such information is in fact material). Insurers should justify their materiality assessment. For the definition of materiality, refer to the Financial Condition Examiners Handbook and/or the U.S. Securities and Exchange Commissioner Accounting Bulletin: No. 99, if applicable.

Consistent with TCFD guidance, the Strategy and Metrics and Targets Sections involve an assessment of materiality, except for the question on Scope 1 and Scope 2 greenhouse gas emissions within the Metrics and Targets Section. Disclosures related to Governance and Risk Management Sections do not involve an assessment of materiality.

**Assessing financial impact of climate-related risks and opportunities**
The financial impacts of climate-related issues on an insurer are driven by the specific climate-related risks and opportunities to which the insurer is exposed and its strategic and risk management decisions on seizing those opportunities and managing those risks (i.e., accept, avoid, pursue, reduce, or share/transfer). Once an insurer assesses its climate-related issues and determines its response to those issues, it can then consider actual and potential financial impacts on revenues, expenditures, assets and liabilities, and capital and financing.¹

Consistent with the TCFD Guidelines, determining whether an individual organization is or may be affected financially by climate-related issues usually depends on:

- the organization’s **exposure** to, and anticipated effects of, specific climate-related risks and opportunities;
- the organization’s planned **responses** to manage (i.e., accept, avoid, pursue, reduce, or share/transfer) its risks or seize opportunities; and

¹ [https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf](https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf), pg.9
• the implications of the organization’s planned responses on its income statement, cash flow statement, and balance sheet.²

Importantly, an organization should assess its climate-related risks and opportunities within the context of its businesses, operations, and physical locations in order to determine potential financial implications. In making such an assessment, an organization should consider (1) current and anticipated policy constraints and incentives in relevant jurisdictions, technology changes and availability, and market changes and (2) whether an organization’s physical locations or suppliers are particularly vulnerable to physical impacts from climate change.³

See pages 10-12 of the TCFD’s Implementation Recommendation Report for more guidance on assessing exposure, response and implications.

ADDITIONAL SPECIFIC GUIDANCE

One of the several benefits of aligning with the TCFD is that it allows insurers to benefit from years of guidance and supporting material developed and being regularly updated by the TCFD and other organizations.

For those insurers new to TCFD reporting, the Implementation Recommendation Report provides a useful guide. It contains guidance for all sectors on each of the four thematic areas of governance, strategy, risk management and metrics and targets. For example, in relation to the risk management disclosure to describe the insurers’ processes for identifying and assessing climate-related risks, it provides the following guidance:

<table>
<thead>
<tr>
<th>Organizations should describe their risk management processes for identifying and assessing climate-related risks. An important aspect of this description is how organizations determine the relative significance of climate-related risks in relation to other risks.</th>
</tr>
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<tbody>
<tr>
<td>Organizations should describe whether they consider existing and emerging regulatory requirements related to climate change (e.g., limits on emissions) as well as other relevant factors considered.</td>
</tr>
<tr>
<td>Organizations should also consider disclosing the following:</td>
</tr>
<tr>
<td>- processes for assessing the potential size and scope of identified climate-related risks and</td>
</tr>
<tr>
<td>- definitions of risk terminology used or references to existing risk classification frameworks used.⁴</td>
</tr>
</tbody>
</table>

The same document also provides supplemental insurance-sector specific guidance. For example, for the same disclosure question, it provides:

<table>
<thead>
<tr>
<th>Insurance companies should describe the processes for identifying and assessing climate-related risks on re-/insurance portfolios by geography, business division, or product segments, including the following risks:</th>
</tr>
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<tbody>
<tr>
<td>- physical risks from changing frequencies and intensities of weather-related perils;</td>
</tr>
<tr>
<td>- transition risks resulting from a reduction in insurable interest due to a decline in value, changing energy costs, or implementation of carbon regulation; and</td>
</tr>
<tr>
<td>- liability risks that could intensify due to a possible increase in litigation.</td>
</tr>
</tbody>
</table>

Notably, this general and supplemental guidance is not required to be included in a TCFD report. Rather, it is designed to support an insurer in developing climate-related financial disclosures consistent with the TCFD framework, including by providing context and suggestions for implementing the recommended disclosures.

The disclosures identified in bullet points in this survey are intended to be supplemental, insurance-sector specific guidance. They have been developed by the NAIC to respond to the TCFD and FSOC recommendations that regulators enhance public reporting requirements for climate-related risks in a manner that builds on the TCFD’s four core elements. They are designed to further support insurers’ in developing their disclosures by providing context and suggestions for the information a regulator may expect.

Additional guidance published by the TCFD includes:

*The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities* (2017) provides information on types of climate-related scenarios, the application of scenario analysis, and the key challenges in implementing scenario analysis to support an organization’s disclosure of the resilience of its strategy, taking into consideration different climate-related scenarios.

*Guidance on Risk Management Integration and Disclosure* (2020) describes considerations for organizations interested in integrating climate-related risks into their existing risk management processes and disclosing information on their risk management processes in alignment with the Task Force’s recommendations.

*Guidance on Metrics, Targets, and Transition Plans* (2021) describes recent developments around climate-related metrics and users’ increasing focus on information describing organizations’ plans for transitioning to a low-carbon economy. The guidance also describes a set of cross-industry, climate related metric categories (described in Appendix 2: Cross-Industry,

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Climate-Related Metric Categories) that the Task Force believes are applicable to all organizations.

The FSB frequently produces content to assist companies in creating TCFD reports, the knowledge hub with related content is accessible at https://www.tcfdhub.org/.

SURVEY QUESTIONS

To provide clear direction for achieving a robust, insurance-sector specific TCFD report, narrative and closed ended questions follow, grouped into the TCFD’s four topics: governance, strategy, risk management and metrics and targets.

The statements listed next to numbers and letters are directly taken from the TCFD Framework and should be fully addressed in the insurer’s response. As discussed in detail above, insurers should consider including the bulleted items in their response to the TCFD statement above it. For additional guidance on sector specific content to consider including, refer to the Implementation Recommendation Report.

Governance

1. Disclose the insurer’s governance around climate-related risks and opportunities. In disclosing the insurer’s governance around climate-related risks and opportunities insurers should consider including the following:
   - Identify and include any publicly stated goals on climate-related risks and opportunities.
   - Describe where climate-related disclosure is handled within the insurer’s structure, e.g., at a group level, entity level, or a combination. If handled at the group level, describe what activities are undertaken at the company level.
   A. Describe the board and/or committee responsible for the oversight of climate-related risks and opportunities.

   In describing the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks, insurers should consider including the following:
   - Describe the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks.
   B. Describe management’s role in assessing and managing climate-related risks and opportunities.

Strategy

2. Disclose the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy, and financial planning where such information is material.

   In disclosing the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy and financial planning, insurers should consider including the following:
   - Describe the steps the insurer has taken to engage key constituencies on the topic of climate risk and resiliency.
• Describe the insurer’s plan to assess, reduce, or mitigate its greenhouse gas emissions in its operations or organizations.*
  A. *Describe the climate-related risks and opportunities the insurer has identified over the short, medium, and long term.*

In describing the climate-related risks and opportunities the insurer has identified over the short, medium, and longer term, insurers should consider including the following:

- Define short, medium, and long-term, if different than 1-5 years as short term, 5-10 years as medium term, and 10-30 years as long term.

B. *Describe the impact of climate-related risks and opportunities on the insurer’s business, strategy, and financial planning.*

In describing the impact of climate-related risks and opportunities on the insurer’s business, strategy, and financial planning, insurers should consider including the following:

- Discuss if and how the insurer provides products or services to support the transition to a low carbon economy or helps customers adapt to climate-related risk.
- Discuss if and how the insurer makes investments to support the transition to a low carbon economy.

C. *Describe the resilience of the insurer’s strategy, taking into consideration different climate-related scenarios, including a 2 degree Celsius or lower scenario.*

**Risk Management**

3. *Disclose how the insurer identifies, assesses, and manages climate-related risks.*

In disclosing how the insurer identifies, assesses, and manages climate-related risks, insurers should consider including the following:

- Describe how the insurer considers the impact of climate-related risks on its underwriting portfolio, and how the company is managing its underwriting exposure with respect to physical, transition, and liability risk.*
- Describe any steps the insurer has taken to encourage policyholders to manage their potential physical and transition climate-related risks, if applicable.*
- Describe how the insurer has considered the impact of climate-related risks on its investment portfolio, including what investment classes have been considered.*

  A. *Describe the insurers’ processes for identifying and assessing climate-related risks.*

In describing the insurers’ processes for identifying and assessing climate-related risks, insurers should consider including the following:

- Discuss whether the process includes an assessment of financial implications and how frequently the process is completed.*

  B. *Describe the insurer’s processes for managing climate-related risks.*

  C. *Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management.*
In describing how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management, insurers should consider including the following:

- Discuss whether climate-related risks are addressed through the insurer’s general enterprise-risk management process or a separate process and how frequently the process is completed.
- Discuss the climate scenarios utilized by the insurer to analyze its underwriting risks, including which risk factors the scenarios consider, what types of scenarios are used, and what timeframes are considered.
- Discuss the climate scenarios utilized by the insurer to analyze risks on its investments, including which risk factors are utilized, what types of scenarios are used, and what timeframes are considered.

**Metrics and Targets**

4. Disclose the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material.

In disclosing the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material, insurers should consider including the following:

- Discuss how the insurer uses catastrophe modeling to manage the climate-related risks to your business. Please specify for which climate-related risks the insurer uses catastrophe models to assess, if any.
  
  A. Disclose the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process.

In disclosing the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process, insurers should consider including the following:

- In describing the metrics used by the insurer to assess and monitor climate risks, consider the amount of exposure to business lines, sectors, and geographies vulnerable to climate-related physical risks [answer in absolute amounts and percentages if possible], alignment with climate scenarios, [1 in 100 years probable maximum loss, Climate VaR, carbon intensity], and the amount of financed or underwritten carbon emissions

  B. Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.

  C. Describe the targets used by the insurer to manage climate-related risks and opportunities and performance against targets.
Closed-ended questions directly correspond to the narrative above, allowing for explanation and qualification of the yes/no answers. Closed-ended questions are voluntary for reporting year 2022 and individual states may elect not to request them.

**Governance**
- Does the insurer have publicly stated goals on climate-related risks and opportunities? (Y/N)
- Does your board have a member, members, a committee, or committees responsible for the oversight of managing the climate-related financial risk? (Y/N)
- Does management have a role in assessing climate-related risks and opportunities? (Y/N)
- Does management have a role in managing climate-related risks and opportunities? (Y/N)

**Strategy**
- Has the insurer taken steps to engage key constituencies on the topic of climate risk and resiliency? (Y/N) *
- Does the insurer provide products or services to support the transition to a low carbon economy or help customers adapt to climate risk? (Y/N)
- Does the insurer make investments to support the transition to a low carbon economy? (Y/N)
- Does the insurer have a plan to assess, reduce or mitigate its greenhouse gas emissions in its operations or organizations? (Y/N)*

**Risk Management**
- Does the insurer have a process for identifying climate-related risks? (Y/N)
  - If yes, are climate-related risks addressed through the insurer’s general enterprise-risk management process? (Y/N)
- Does the insurer have a process for assessing climate-related risks? (Y/N)
  - If yes, does the process include an assessment of financial implications? (Y/N)
- Does the insurer have a process for managing climate-related risks? (Y/N)
- Has the insurer considered the impact of climate-related risks on its underwriting portfolio? (Y/N/Not Applicable)*
- Has the insurer taken steps to encourage policyholders to manage their potential climate-related risks? (Y/N)*
- Has the insurer considered the impact of climate-related risks on its investment portfolio? (Y/N)*
- Has the insurer utilized climate scenarios to analyze their underwriting risk? (Y/N)
- Has the insurer utilized climate scenarios to analyze their investment risk? (Y/N)

**Metrics and Targets**
- Does the insurer use catastrophe modeling to manage your climate-related risks? (Y/N)
- Does the insurer use metrics to assess and monitor climate-related risks? (Y/N)
- Does the insurer have targets to manage climate-related risks and opportunities? (Y/N)
- Does the insurer have targets to manage climate-related performance? (Y/N)
* Asterisks represent questions derived from the original Climate Risk Disclosure Survey.

NAIC Support Staff Hub/Member Meetings/Spring 2022/Cmte/Ex/Att 4 ClimateRiskDisclosureSurvey.pdf
MEMORANDUM

TO: NAIC Executive (EX) Committee

FROM: Kay Noonan

DATE: March 23, 2022

RE: SERFF Advisory Board

The NAIC’s System for Electronic Rates and Forms Filing (SERFF) was launched collaboratively by regulators and industry more than 22 years ago to provide an efficient process for product filing and review. Today, 53 jurisdictions accept SERFF filings made by more than 6500 industry users. The NAIC is currently engaged in a multi-year SERFF modernization effort. The overall modernization is a $20 million-dollar, three year project and all expenditures are subject to Executive (EX) Committee approval, with input from an Oversight group of state regulators.

As the SERFF modernization efforts move forward, the Executive (EX) Committee has also been considering modernizing the governance of SERFF and the avenues for regulator, industry, and consumers into the SERFF system. Given the overlap between the roles of the Executive (EX) Committee, the SERFF Oversight Group, the Product Steering Committee, the Speed to Market (D) Working Group and the SERFF Advisory Board, the proposal before the Committee is to disband the SERFF Advisory Board and streamline industry and consumer input into SERFF operations through the other available forums.

The Speed to Market (D) Working Group will continue to be the primary forum for public policy discussions related to rate and form filing and review. Meetings of the Working Group are open. The Product Steering Committee which currently reports to the SERFF Advisory Board will now report to the Speed to Market (D) Working Group and will be the primary source of industry and consumer input into the SERFF modernization efforts. Meeting of the PSC are open to all SERFF users and membership of the PSC includes both regulator and industry representatives, as well as two representatives from the IIPRC.

The current SERFF Advisory Board held a meeting on Feb. 24, 2022, to discuss the proposal. The NAIC Members participating supported the proposal. An industry representative participating commented that the SERFF oversight group and the PSC have been very effective in gathering feedback and prioritizing work on behalf of the industry and would support the change if that transparency continues. The minutes of the Feb. 24, 2022 meeting are attached to this memorandum.

Birny Birnbaum raised a concern that if the SERFF Advisory is disbanded there will not be a formal role for consumers to provide input into the development and operation of SERFF. The primary consumer interest in SERFF relates to the operation of the SERFF Filing Access (SFA) Function. Consumer representatives can participate in any meeting of the Product Steering Committee where that functionality is discussed. Based on consumer input to date, there are changes to SFA contemplated. NAIC SERFF staff will specifically seek consumer feedback when the modernization efforts reach that point.
The SERFF Advisory Board met Feb. 24, 2022. The following Advisory Board members participated: Barbara D. Richardson, Chair (NV); Doug Ommen (IA); Russell Toal (NM); Carter Lawrence represented by Brian Hoffmeister (TN); Birny Birnbaum (Center for Economic Justice—CEJ); Andrea Davey (Athene Annuity and Life Company); Susan Gould (The Hanover Insurance Group); Phyllis Hollerbach (Zurich North America); and Karen Schutter (Interstate Insurance Product Regulation Commission—Compact). There was no representation from Kansas or Rhode Island.

1. **Discussed Continued State Insurance Regulator, Industry, and Consumer Representative Input Related to the Operation of SERFF**

Commissioner Richardson called the meeting to order. She discussed the purpose of this meeting, the history of the System for Electronic Rates & Forms Filing (SERFF) Advisory Board (SAB), the current forums for discussing SERFF operations and development efforts, and the current support for disbanding the SAB.

As the SERFF modernization effort moves forward and the NAIC reviews its overall governance structure, the Executive (EX) Committee is considering disbanding the SAB and focusing on the other venues for industry and consumer input into the continued development and management of SERFF. SERFF is a product of the NAIC that is operated for the benefit of state insurance regulators, industry, and consumers. The NAIC has undertaken a substantial SERFF modernization effort overseen by the Executive (EX) Committee. The SERFF modernization effort has been informed by industry and consumer input through: 1) numerous interviews during the SERFF Assessment phase to gather industry and consumer feedback (2019-2020); 2) regular and ongoing reporting to the SERFF Product Steering Committee (PSC); 3) regular and ongoing workshops with the SERFF PSC; and 4) capability-specific focus groups with the SERFF PSC. As the modernization efforts continue, NAIC and SERFF staff hope to continue to utilize the PSC as the primary source of industry and consumer input. Those meetings are open to all SERFF users. That group will report up through the Speed to Market (EX) Working Group, and the NAIC is in the process of revising the charges for that group to accurately reflect its role. The Executive (EX) Committee oversight of SERFF has been informed by an ad hoc committee of state insurance regulators—i.e., the SERFF Oversight Group—and the NAIC expects that to continue. As of today, the SERFF Oversight Group is made up of nine state insurance regulators: 1) Commissioner Andrew N. Mais (CT); 2) Superintendent Eric A. Cioppa, who will be replaced given his retirement, (ME); 3) Commissioner Richardson (NV); 4) Superintendent Toal (NM); 5) Commissioner Jon Godfread (ND); 6) Tynesia Dorsey (OH); 7) Superintendent Elizabeth Kelleher Dwyer (RI), representing the Compact; 8) Nancy Clark (TX); and 9) Molly Nollette (WA). Given the overlap between the roles of the Executive (EX) Committee, the SERFF Oversight Group, the PSC, and the SAB, this proposal will streamline industry and consumer input into SERFF operations.

The current plan is for the Executive (EX) Committee to consider disbanding the SERFF Advisory Board at the Executive Committee’s April meeting.

Commissioner Ommen said he supports the change. His experience and engagement with the Speed to Market (EX) Working Group showcases that there are other avenues to keep updated with SERFF modernization efforts and current redundancies in reporting.

Ms. Gould stated that she attends the PSC meetings, and the SERFF Oversight Group is doing a great job with gathering feedback and prioritizing work on behalf of the industry. She reiterated the importance of the industry
continuing to have input opportunities going forward, and she would support the change so long as there is continued transparency.

Mr. Birnbaum mentioned his concern with the SAB disbanding, as he believes this is the only forum where the consumer group can share consumer concerns related to SERFF. He mentioned that there are no consumer seats on the PSC, and it is unclear where else there is opportunity and enablement for consumer participation regarding requests or answers to questions regarding the application. He requested that the proposed change be formalized into documentation so he and his colleagues could review and provide feedback at the upcoming Executive (EX) Committee meeting in April. Kay Noonan (NAIC) will add this item to the agenda and provide the action item ahead of said meeting.

Having no further business, the SERFF Advisory Board adjourned.
To: Members of the NAIC Executive Committee  
From: Commissioner Sharon Clark, Kentucky Department of Insurance  
Chair, NAIC Insurance Regulator Professional Designation Program Advisory Board  
Date: April 6, 2022  
Subject: 2021 Annual Report of NAIC Designation Program Advisory Board Activities

In October of 2006, the NAIC launched the Insurance Regulator Professional Designation Program (“Designation Program”), a formal credentialing program designed for regulators, by regulators to establish structured training and development paths for insurance department employees. In that same year, the Internal Administration (EX1) Subcommittee directed the program’s Advisory Board to present a brief annual report of program benchmarks and board activities. This memorandum, with its supplemental charts, sets forth an account of the program’s year in review.

Program Enrollments
We continued our outreach to states and have seen increased interest and enrollments across the board. In 2021, the Designation Program surpassed 3,000 enrollments, bringing the total number of enrollments since 2006 to 3,021.

By year-end, earned designation totals were as follows: 1,227 APIR designees, 452 PIR designees, 22 SPIR designees, and 3 IPIR designees.

The Designation Program Mentoring Network
States have been encouraged to appoint a “mentor” that can serve as a liaison between the Department and the NAIC’s Education & Training Department as a means of disseminating information about the program to interested regulators, and to assist candidates as they have questions. Most mentors have earned an NAIC Designation or are currently working toward one.

Designation Program Advisory Board Meetings
The Designation Program Advisory Board met monthly throughout 2020 via WebEx to discuss policy matters and other issues. Discussion items included policy recommendations and promotion of the program to increase awareness and participation.

2021 Accomplishments
Significant accomplishments of 2021 include:

- Fully rolled out the new program management system (Certemy) to streamline and automate many of the processes done manually. Work was completed with a soft rollout of the new system in February 2021, with a full rollout in late March 2021.
- Began work to select an online proctoring service vendor, which will roll out in 2022.
About the Insurance Regulator Professional Designation Program Advisory Board
The 2020 Advisory Board was composed of Laura Arp (NE Department of Insurance), Rachel Chester (RI Insurance Division), Eric Fletcher (ID Department of Insurance) and Scott Sanders (GA Department of Insurance).

Kentucky Commissioner Sharon Clark chaired the 2021 Advisory Board.

In addition to overseeing Designation Program policy and advising NAIC Education Department staff on designation program policy administration, the board members work on outreach to regulators during NAIC Zone Meetings and other regulatory meetings. Additional information about the Designation Program can be found by visiting the NAIC website: http://naic.org/education_designation.htm
## TOTAL ENROLLMENTS - 3021
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#### As of December 31, 2021

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| Total              | **649**     |                   | **963**     |
Enrollments by Zone

- 41.53% Western
- 34.91% Southeastern
- 29.39% Midwestern
- 16.47% Northeastern

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Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting, and it plans to continue meeting until it completes its work. During its meetings, the Subgroup has discussed several issues, including its approach for revising the model’s disability income insurance coverage provisions, and it decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact’s) approach. After pausing its work due to the ACA’s potential repeal, replacement, or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again in May 2018. Revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) were adopted by the full NAIC membership at the 2019 Spring National Meeting. The Subgroup has been meeting to consider revisions to Model #171 for consistency with the revised Model #170 since the 2019 Summer National Meeting discussion on comments received on Sections 1–5 of Model #171. In December 2019, the Subgroup set a public comment period ending Feb. 7, 2020, to receive comments on Sections 6–7 of Model #171. Due to the COVID-19 health emergency, the Subgroup has not scheduled any meetings. Any future meetings will depend on when a new co-chair is appointed and the duration of the COVID-19 health emergency. As requested, the Subgroup received comments from stakeholders on Sections 6–7 of Model #171. A new Subgroup co-chair has been appointed. The Subgroup met June 7, 2021, to discuss the status of the proposed revisions to Model #171 and its next steps. The Subgroup decided to establish a new public comment period ending July 2, 2021, to receive comments on Sections 1–7 of Model #171. The Subgroup did not meet at the 2021 Fall National Meeting. Since the 2021 Summer National Meeting, the Subgroup has been meeting to discuss possible revisions to Model #171 based on the comments received by the July 2, 2021, public comment deadline. During some of these meetings, the Subgroup heard from industry presenters about the products currently covered under Model #171 and the products to be covered under Model #171 after it is revised. The Subgroup is continuing its discussions of revisions to Model #171. Currently, it is focused on revisions related to fixed indemnity products.

Amendments to the Mortgage Guaranty Insurance Model Act (#630)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #630 at the 2013 Summer National Meeting. The Mortgage Guaranty Insurance (E) Working Group has developed proposed changes to the model, which have been exposed for comment, and subsequent changes have been made to address the comments. However, the Working Group has been focused on the development of a capital model, which is currently incorporated as a requirement in the model, but further changes are expected to be made to that model before adoption can occur. The Working Group has requested an extension from the Financial Condition (E) Committee, which is expected to be considered at the Spring National Meeting, which would continue work on the capital model until the 2023 Spring National Meeting.

Amendments to the Nonadmitted Insurance Model Act (#870)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #870 at the 2021 Spring National Meeting. The amendments will modernize the model and bring it into alignment with the federal Nonadmitted and Reinsurance Reform Act (NRRA). The Surplus Lines (C) Task Force met Aug. 5, 2021, and appointed a drafting group to work on the revisions to Model #870.
New Model: Pet Insurance Model Act—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group held numerous meetings to draft the model law to define a regulatory structure for pet insurance and address issues such as producer licensing, policy terms, coverages, claims handling, premium taxes, disclosures, arbitration, and preexisting conditions. The Working Group adopted the Pet Insurance Model Act on Aug. 4, 2021, and the Property and Casualty Insurance (C) Committee adopted it on Nov. 10, 2021. The Model was removed from the Executive (EX) Committee and Plenary agenda at the 2021 Fall National Meeting. The Pet Insurance (C) Working Group will consider additional revisions prior to considering the model for adoption. Because the work on the Pet Insurance Model Act is not yet completed, an additional request for extension is expected by the Property and Casualty Insurance (C) Committee at the 2022 Spring National Meeting.
CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force April 6, 2022, Minutes................................................................. 4-44
Climate and Resiliency (EX) Task Force March 21, 2022, Minutes (Attachment One) ............................ 4-48
Center for Insurance Policy and Research (CIPR) Catastrophe Modeling Center of Excellence
   (COE) Proposal (Attachment One-A)........................................................................................................... 4-53
Climate Risk Disclosure Survey (Attachment One-B) .............................................................................. 4-64

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1. **Adopted its March 21 Minutes**

Commissioner Altmaier said the Task Force met March 21. During this meeting, the Task Force took the following action: 1) heard reports from its workstreams; 2) adopted a proposal for the NAIC’s Center for Insurance Policy and Research (CIPR) to create a catastrophe model center of excellence (COE); and 3) adopted a revised Climate Risk Disclosure Survey for state insurance departments to voluntarily use at their discretion.

Commissioner Richardson made a motion, seconded by Ms. Biehn, to adopt the Task Force’s March 21 minutes (Attachment One). The motion passed unanimously.

2. **Heard a Presentation from Zurich North America and Resilient Cities Network Regarding Their Partnership to Improve Community Resilience**

Ricardo Lara said Zurich North America and Resilient Cities Network formed a partnership last year to mitigate the effect of flooding on urban communities in Houston, TX, and Boston, MA. Earlier this month, they established a resilient community impact fund to facilitate investment for the projects.

Brandon Fick (Zurich North America) said Zurich North America and the Z Zurich Foundation partnered with Resilient Cities Network for a three-year commitment to help customers and communities adapt and become more resilient to the increasing frequency and severity of extreme weather events. Natural disasters are expensive and disruptive for societies, and the impact is exacerbated for vulnerable populations. Based on Zurich North America’s commitment to helping communities and improving sustainability, it created the Z Zurich Foundation, which is a Swiss-based charitable foundation. Two of the pillars of the Z Zurich Foundation are climate adaptation and social equity.
Mr. Fick said insurers have an opportunity to work closely with key stakeholders, including governments and non-governmental organizations to align on key performance indicators and strategic vision, as well as identify the tools and resources available from each stakeholder. He said Zurich North America developed a flood resilience tool many years ago, which is continuously updated and expanded to include additional perils. He said Houston and Boston were selected as initial areas of focus, but they plan to develop future projects in other cities. He said the partnership identified Houston and Boston as the initial areas of focus due to several factors, including local poverty level, state and local leadership’s prioritization of the vulnerable population, Zurich North America’s customer base in the area, and the prevalence of natural hazards, particularly around flood and extreme temperatures in the region. Zurich North America will leverage its customer base in these areas to help educate and inform local populations and support public policy.

Stewart Sarkozy-Banoczy (Resilient Cities Network) said Resilient Cities Network is interested in building equitable resilience and focusing on the pre-event mindset rather than reactive recovery. He said Zurich North America and Resilient Cities Network started with a common language, common definitions, and a common goal, which helped the participants quickly gain trust in each other and form a collective vision. Resilient Cities Network is a leading global network focused on urban resilience, led by cities and connected to chief resilience officers. The organizations’ goals are to empower, mobilize, and implement resilience strategies. The team has conducted site visits, reviewed and trained on the flood resilience tool, launched joint organization committees, hosted training and events, and announced the call for co-funding for the Resilient Community Impact Fund (RCIFund).

Mr. Sarkozy-Banoczy said to involve and empower local communities, the team works with local leaders to create a multi-hazard, multi-shock, and stress testing tool to identify the resilience of the city and the local communities. Zurich North America created the tool for flood risk, and as a partnership with Resilient Cities Network, they are working to expand it to include other perils, including extreme heat. The tool can be used to pinpoint vulnerabilities, as well as support their goal to identify return on resilience value. In addition to the tool, a key driver is identifying communities that are already receiving public assistance. Mr. Sarkozy-Banoczy said they are looking into resilience in terms of affordable housing, community facilities, and nature-based solutions. They are considering the role of community development financial institutions (CDFIs), investors, and other stakeholders in delivering better outcomes and co-benefits resulting in resilience dividends and return on investment.

Mr. Sarkozy-Banoczy said Resilient Cities Network has operations in cities across the country and plans to take the key learnings discovered through its work in Boston and Houston to benefit projects in other regions. Future work has already been slated for Charleston, SC; New Orleans, LA; and Chicago, IL.

Director Farmer expressed gratitude to the Z Zurich Foundation for its Post-Event Review Capability (PERC) following South Carolina’s historic flooding in 2015. He asked Mr. Fick and Mr. Sarkozy-Banoczy to elaborate on the collateral benefits of the partnership. Mr. Fick and Mr. Sarkozy-Banoczy said through the partnership, they continually learn and grow to expand the benefits into additional communities.

Commissioner Anderson asked what it would look like for other companies to participate in the program. Mr. Fick said other companies could invest in the fund and bring knowledge and expertise to the table to maximize the benefits for vulnerable communities.

Mr. Bradner expressed interest in connecting Resilient Cities Network with the local network in Connecticut for a future resilience project. Mr. Sarkozy-Banoczy said a good way to start is building out the resilience tool to identify return on resilience value, working with CDFIs and Green Banks, and identifying the greatest needs, including the effect on broader sectors in the area.
Commissioner Lara asked how Resilient Cities Network is approaching extreme heat. Mr. Sarkozy-Banoczy said two years ago, it began working with chief resilience officers, through their communities of practice, to discuss issues and develop best practices regarding extreme heat.

Commissioner Donelon asked if any other insurers expressed interest in joining the partnership. Mr. Fick said Zurich North America looks forward to partnering with others in the industry to circumvent issues with insurability. Mr. Sarkozy-Banoczy said Resilient Cities Network is having conversations with potential partners to add expertise, knowledge, and funding to the identified projects.

Commissioner Woods expressed interest in engaging with Resilient Cities Network for a future project in the District of Columbia.

3. **Hear a Presentation from Munich Re Regarding Solutions to Improve Community Flood Mitigation**

Raghuveer Vinukollu (Munich Re) said Munich Re has taken a top-down approach to risk mitigation to develop an understanding of the impact on coverage. He said Munich Re views climate risk as systemic, and it includes multiple components; i.e., the hazard, the vulnerability, and the exposure. Over time, and as extreme weather events occur at greater frequency and severity, local communities will need to adapt to their identified risk. Mr. Vinukollu said Munich Re collaborated with The Nature Conservancy and the University of California, Santa Cruz to develop a technical paper, “Financing coastal resilience by combining nature-based risk reduction with insurance” to identify the trade-off between risk reduction and risk transfer. By linking mitigation action to risk reduction, they were able to monetize the risk reduction and calculate the savings to be passed through to the customer in premium reduction. Mr. Vinukollu said insurance is a feedback loop with two variables that influence the premium based on the value at risk, the average annual loss, and the standard deviation. In periods of increasingly frequent and severe storms, the value at risk and the standard deviation increase, creating market disruptions. The market disruption plays out in issues with affordability and rate adequacy.

Mr. Vinukollu said drawing upon its learnings in the technical paper, Munich Re again worked with The Nature Conservancy, this time on a study of inland flooding along the Missouri River in the southern part of Nebraska and the northwest region of Missouri. Through this effort, they identified a community-based solution to increase take-up rates and drive down the cost of coverage.

Mr. Vinukollu said in Missouri and Nebraska combined, there were only 15,967 National Flood Insurance Program (NFIP) policies in 2018, and the average premium was $942. In the area affected by the failed levee system, there were only 142 NFIP policies, and the average premium was $1,166. Because damages from inland flooding and extreme precipitation are rarely a total loss, the average claim was only $15,000, so the cost of coverage was high relative to the loss experience. Multiple flooding events occurred in 2019, including the Missouri River. Total flood losses in 2019 were estimated to be $20 billion, but only $200 million was insured.

Munich Re worked with the U.S. Army Corps of Engineers and The Nature Conservancy to develop a pricing model, accounting for the levee setback. The levees needed to be rebuilt; by acquiring land adjacent to the river, they were able to set back the levees, reduce the risk for nearby properties, and provide a nature-based solution. The Nature Conservancy worked to acquire the land, and the U.S. Army Corps of Engineers was able to set back the levees, allowing the river to expand. Munich Re calculated the risk reduction from the levee setback and used the modeling to develop pricing for a community-based solution. The risk reduction from the levee setback provides savings on the flood insurance coverage for residents. Spreading the risk and increasing the penetration through a community-based product drives down the price even further. The original cost of an NFIP policy in the identified area near the levee was $1,166. The cost of coverage with the levee setback in place decreased to $581. If purchased on a community, mandated basis with the levee setback in place, the cost of coverage decreased to
$313. Reducing the policy limits to match the average claim amount, the cost of coverage can become even more affordable.

4. **Heard a Federal Update**

Brooke Stringer (NAIC) said on March 21, the U.S. Securities and Exchange Commission (SEC) voted 3-1 to issue a proposal for comment, which would require publicly traded companies to disclose their direct and indirect climate change contributions. In its proposed ruling, the SEC cited the work of the Financial Stability Board’s (FSB’s) Task Force on Climate-Related Financial Disclosures (TCFD) and the Greenhouse Gas (GHG) Protocol.

Ms. Stringer said the Federal Insurance Office (FIO) is expected to complete its report assessing climate-related issues or gaps in insurance supervision and regulation by the end of 2022. The NAIC submitted a comment letter in November 2021, in response to the FIO’s request for information.

Ms. Stringer said the NAIC supports the Disaster Mitigation and Tax Parity Act (S.2432/H.R.4675) introduced by U.S. Sen. Dianne Feinstein (D-CA) and U.S. Rep. Glenn Thompson (R-PA). The Act would ensure that state-based disaster mitigation grants receive the same federal tax exemptions as federal mitigation grants. Ms. Stringer said in the week leading up to the meeting, the U.S. Senate (Senate) Committee on Homeland Security and Governmental Affairs approved the Community Disaster Resilience Zones Act of 2022 (S. 3875), advancing it to the full Senate. Chairman Gary Peters (D-MI) and Ranking Member Rob Portman (R-OH) sponsored the bill, and the Reinsurance Association of America (RAA) has been a strong proponent. The bill would amend the Stafford Disaster Relief and Emergency Assistance Act to make permanent the National Risk Index, or a similar tool, and utilize its data to identify and designate community disaster resilience zone communities that are the most at risk to natural hazards. This would allow the Federal Emergency Management Agency (FEMA) to identify communities in need of assistance for mitigation projects.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/2022 Spring National Meeting/Executive (EX) Committee/Climate and Resiliency (EX) Task Force
The Climate and Resiliency (EX) Task Force met March 21, 2022. The following Task Force members participated: Ricardo Lara, Co-Chair, Mike Peterson, Deborah Halberstadt, Kara Voss, Rabab Charafeddine, and Camilo Pizzaro (CA); David Altmair, Co-Chair, Christina Huff, Susanne Murphy, and Alexis Bakofsky (FL); Colin M. Hayashida, Co-Vice Chair (HI); James J. Donelon, Co-Vice Chair, Tom Travis, and Stewart Guerin (LA); Kathleen A. Birrane, Co-Vice Chair, and Alexander Borkowski (MD); Barbara D. Richardson, Co-Vice Chair (NV); Andrew R. Stolfi, Co-Vice Chair, represented by Aeron Teverbaugh, Ying Liu, and David Dahl (OR); Elizabeth Kelleher Dwyer, Co-Vice Chair, Matt Gendron, and Jack Broccoli (RI); Raymond G. Farmer, Co-Vice Chair (SC); Lori K. Wing-Heier and Alex Reno (AK); Alan McClain (AR); Jim L. Ridling and Erick Wright (AL); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by William Arfanis, George Bradner, and Wanchin Chou (CT); Karima M. Woods and Sharon Shipp (DC); Trinidad Navarro represented by Frank Pyle and Christina Miller (DE); Doug Ommen, Travis Grassel, and Kim Cross (IA); Dana Popish Severinghaus, C.J. Metcalf, Shannon Whalen, Patrice Dziire, and Susan Berry (IL); Sharon P. Clark (KY); Gary D. Anderson, Rachel M. Davison, and Caleb Huntington (MA); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Parker Fisher and Renee Campbell (MI); Grace Arnold represented by Peter Teved Arkansas (MN); Chlorinda Lindley-Myers, John Rehagen, Jo LeDuc, and Shannon Schroeder (MO); Mike Chane (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Michelle Osborne and Jackie Obusek (NC); Jon Godfread represented by Matt Fischer, Chris Aufenthie, Holly Brockman, and John Arnold (ND); Eric Dunning represented by Connie Van Slyke, Justin Schrader, Martin Swanson and Lindsay Crawford (NE); Marlene Caride and Jesse Kolodin (NJ); Adrienne A. Harris represented by Bob Kasinow, Avani Shaw, and Sahana Zutshi (NY); Judith L. French, Lori Barron, Tynesia Dorsey, and Meredith Craig (OH); Michael Humphreys, Melissa Greiner, David Buono, and Katie Merritt (PA); Alexander S. Adams Vega and Natalia Maldonado (PR); Carter Lawrence represented by Bill Huddleston and Stephanie Cope (TN); Scott A. White represented by Greg Chew (VA); Tregenza A. Roach represented by Suzette Richards, Glendina Matthews, and Cheryl Charleswell (VI); Michael S. Picciak represented by Mary Block, Marcia Violette, Karla Nuesl, Isabelle Turpin Keiser, Nick Marineau, and Rosemary Rasza (VT); Mike Kreidler, Jay Bruns, and Byron Welch (WA); Nathan Houdek, Sarah Smith, Rebecca Rebholz, and Darcy Paskey; (WI); and Jeff Rude (WY). Also participating were: Tate Flott and Shannon Lloyd (KS); Kate Kixmiller (IN); Marianne Baker (TX); and Tracy Klausmeier (UT).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner Caride made a motion, seconded by Superintendent Dwyer, to adopt the Task Force’s Dec. 14, 2021, minutes ([see NAIC Proceedings – Fall 2021, Climate and Resiliency (EX) Task Force](#)). The motion passed unanimously.

2. **Heard Reports from its Workstreams**

   a. **Innovation Workstream**

Commissioner Hayashida said that in 2022, the Innovation Workstream will continue to explore innovative products that address coverage gaps created by natural catastrophes. He said the Workstream will hear a presentation from the Demex Group on April 13. The Demex Group provides solutions to assess risks from natural hazards and designs coverage options for commercial enterprises.
All meetings of the Innovation Workstream are posted on the Climate and Resiliency Resource catalog innovative product offerings.

b. **Pre-Disaster Mitigation Workstream**

Commissioner Richardson said that in 2022, the Pre-Disaster Mitigation Workstream will continue participating in multi-agency stakeholder educational efforts on coverage gaps and pre-disaster mitigation related to climate risks. The Workstream will consider the risks associated with all perils, identify mitigation actions at the community and individual property level, and prioritize consumer education and awareness of coverage gaps that exist due to natural catastrophes. The Workstream will continue to explore state and industry-driven mitigation actions, including mitigation grant programs, building code advocacy, and risk assessment tools.

Commissioner Richardson said the Workstream is planning to host a virtual meeting in May to hear presentations on the benefits of and funding options for prescribed burns to reduce the risk of wildfire. She said Workstream members are mindful not just of the risk for property damage, but also the risk of new or worsening health conditions and loss of life. The Workstream plans to explore how mitigation can help reduce human-related risks in addition to the property impacts.

c. **Solvency Workstream**

Commissioner Birrane said the Solvency Workstream held a series of public meetings in 2021 and then issued a set of questions to solicit input on potential enhancements to existing regulatory financial solvency tools. Many commenters suggested that enhancements would be most appropriate to the *Financial Condition Examiners Handbook* and the *NAIC Own Risk and Solvency Assessment Guidance Manual* (ORSA Guidance Manual). On March 21, the Workstream released for comment draft referral letters to the Financial Examiners Handbook (E) Technical Group and the Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup. Comments will be accepted through April 20. The Solvency Workstream will hold a public meeting following the comment deadline to consider the comments received and finalize the referral letters.

Commissioner Birrane said after finalizing the referrals regarding the *Financial Condition Examiners Handbook* and the *NAIC Own Risk and Solvency Assessment Guidance Manual*, the Workstream will begin considering the need for updates to the *Financial Analysis Handbook*. Later in 2022, the Workstream will host presentations to gather information on scenario analysis and stress testing.

3. **Adopted the Proposal for the CIPR to Create a Catastrophe Model Center of Excellence**

Commissioner Donelon said the Technology Workstream adopted the proposal for the NAIC’s Center for Insurance Policy and Research (CIPR) to create a Catastrophe Model Center of Excellence (COE) on Nov. 22 following multiple discussions and an open comment period. The recommendation was reported to the Climate and Resiliency (EX) Task Force on Dec. 14 during the 2021 Fall National Meeting. The purpose of the COE is three-fold. First, it will provide state insurance departments with access to catastrophe modeling documentation and provide assistance distilling the technical information received. The information shared by catastrophe modelers will be protected through data use agreements and provided to state insurance regulators through a permissioned resource. This resource is already built and has gone through NAIC legal review. Two catastrophe modelers have already signed data use agreements to share information. Second, the COE will provide general technical education and training materials on the mechanics of commercial models, as well as the treatment of perils and risk exposures. It will provide fact-based, unbiased information to state insurance regulators and will work with all vendors who choose to provide information. It is recommended that a governance structure be put in place to ensure transparency and impartiality. Third, the COE will conduct applied research using model platforms to address regulatory
questions concerning resilience priorities. It will report to the Technology Workstream quarterly and to the Catastrophe Insurance (C) Working Group as appropriate.

Commissioner Richardson made a motion, seconded by Commissioner Chaney, to adopt the proposal for the NAIC’s CIPR to create a COE (Attachment One-A). The motion passed unanimously.

4.  **Adopted the Revised Proposed Climate Risk Disclosure Survey**

Superintendent Dwyer said that in early 2021, the Climate Risk Disclosure Workstream began holding public meetings to hear from interested stakeholders, including academic organizations, climate risk reporting agencies, investment management firms, insurers, industry representatives, state insurance regulators, and consumer groups. The Workstream solicited feedback from stakeholders in the spring of 2021 to guide its work before drafting a revised Climate Risk Disclosure Survey (survey) to companies. Four states participated in the initial drafting: California, New York, Oregon and Washington. The first draft was exposed for comment on Nov. 15, 2021. Commissioner Stolfi presented on that draft during the Task Force’s Dec. 14, 2021, meeting. The Workstream then held an open meeting on Jan. 26, 2022, to hear from the commenters. The draft was updated pursuant to comments received. Notable revisions include content added to the introduction regarding confidentiality, materiality, and guidance consistent with the Financial Stability Board’s (FSB’s) Taskforce on Climate-Related Financial Disclosures (TCFD). All multiple-choice questions were removed, questions considered to be duplicative were eliminated, and compound “yes or no” questions were separated. The “yes or no” questions were made voluntary, and the bulleted questions under the TCFD statements were made into guidance for how insurers would address the TCFD statements, not separate questions an insurer must answer.

The Workstream met again on Feb. 28, 2022, to expose the latest draft and take additional comments. Based on comments following that meeting, the Workstream decided that any insurer who had already completed their TCFD in 2022 may submit it as is, without modification. The reporting deadline was extended for 2022, from Aug. 31 to Nov. 30. The introduction was updated to include clarification regarding reporting deadlines and expectations for content to include in the insurers’ response and provide flexibility for state departments to offer extensions at their discretion. Additionally, states may elect not to even request that companies voluntarily answer the “yes or no” questions. Superintendent Dwyer said according to the latest TCFD update, more than 120 state insurance regulators and government organizations support the TCFD. The Financial Stability Oversight Council (FSOC) report issued in October 2021 encouraged all members to consider enhancing climate-related disclosure requirements and offered TCFD as an example.

Under the proposed Climate Risk Disclosure Workstream recommendation, the survey would remain elective for state use. The reporting threshold for insurers would remain the same at $100 million in direct premium written and licensed in any one of the 15 participating states. The Workstream is not aware of any new states joining this year, so it is anticipated that all insurers required to report this year will have reported an NAIC Climate Risk Disclosure Survey in the past. If there are any new insurers who recently crossed the reporting threshold, their deadline is Aug. 30, 2023, instead of Nov. 30, 2022. Additionally, states can use their discretion to offer extensions to companies. Participating states send letters to companies to request the information so insurers should make requests for accommodation to the state that sent the letter. The Climate Risk Disclosure Workstream adopted the revised survey during its March 11 meeting.

Director French asked if language could be added to the survey specifying that any new companies be given an extra year for reporting in 2023 and beyond. Superintendent Dwyer said states have discretion to offer leeway for all companies, not limited to new companies. She and Commissioner Altmaier said the survey is voluntary for states to use and, therefore, are provided with a lot of flexibility in terms of implementation. Superintendent
Dwyer said comments received very early on were supportive of moving to the TCFD, which is what the Workstream has proposed.

Dennis Burke (Reinsurance Association of America—RAA) said the U.S. Securities and Exchange Commission (SEC) exposed its proposed climate disclosure within the last few hours and requested that the Task Force pause the vote until the SEC proposal can be fully reviewed to determine how it compares to the revised NAIC survey.

David Snyder (American Property Casualty Insurance Association—APCIA) said APCIA is requesting that insurers who had been previously submitting the eight-question NAIC survey be given until 2023 to submit the revised survey. Mr. Snyder expressed concern regarding the public nature of the disclosure. He also requested alignment between the revised survey and regulator-only content that may be recommended by the Solvency Workstream via referrals to relevant Financial Condition (E) Committee groups.

Patrick Reeder (American Council of Life Insurers—ACLI) said companies have concerns about moving from the eight-question survey to the proposed survey in the proposed time frame. Mr. Reeder also expressed concerns regarding the public nature of reporting and confidentiality concerns of insurers. He said there has not been enough time to review the proposed SEC requirements, but the time frame for reporting would be staged over a three- to four-year period depending on the size of the company and the content of reporting.

Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) said NAMIC would like assurance for companies new to reporting. He requested that new companies not be required to report in the initial year. This would apply to companies just crossing the reporting threshold, as well as companies added due to increased state participation.

Commissioner Altmaier said that the Task Force will review the SEC proposal, but given that it is only a proposal at this time and there will be additional time to compare the disclosure frameworks, he would prefer not to delay the Task Force vote to wait for the SEC determination, which will likely not be finalized until December 2022. He said the Workstream has included guidance to insurers regarding confidentiality within the introduction of the survey. Commissioner Altmaier said the Workstream has included in the draft a significant amount of flexibility in the content and timeline for reporting, as well as discretion to the participating states.

Superintendent Dwyer said the request to delay any climate risk disclosure until 2023 is a step back since companies have already been reporting the eight-question NAIC Climate Risk Disclosure Survey in prior years. She said she is unaware of any new companies being asked to report, and industry representatives have been unable to name any upon request. She said companies that have never participated in the NAIC Climate Risk Disclosure Survey, should there be any, have already been exempted from reporting in 2022. Ms. Teverbaugh said the Workstream included bulleted items to assist companies in determining the type of information to include in a TCFD, easing them into the process.

Amy Bach (United Policyholders) encouraged members to continue making progress on this important initiative. Commissioner Lara said the Workstream will review the SEC guidance but intends to keep moving forward, including through additional guidance to companies, striving for consistency, and aligning the survey to the TCFD framework. Ms. Teverbaugh said there is so much flexibility already built into the voluntary survey for states to use, it seems unnecessary to undermine the state discretion by adding language to limit their timeline for implementation. Acting Commissioner Humphreys (PA) said Pennsylvania began participating in 2021, and few companies had concerns with completing the survey in the same calendar year. Commissioner Humphreys said the state had flexibility to work with companies with concerns and offered extensions upon request. Commissioner Anderson said Massachusetts had a similar experience to Pennsylvania, having joined as a participating state in 2021.
Director French made a motion, seconded by Commissioner Donelon, to amend the survey based on NAMIC’s suggestion to extend the reporting deadline for new companies in 2023 and future years.


The motion to amend the survey did not pass.

Director Lindley-Myers made a motion, seconded by Commissioner Kreidler to adopt the revised survey (Attachment One-B).


The motion passed.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.
A Proposal to Establish a Catastrophe (CAT) Modeling “Center of Excellence” (COE) within the NAIC’s Center for Insurance Policy & Research (CIPR)

September 20, 2021

Introduction

The leadership and members of the NAIC have determined natural CAT risks and resiliency to be a top priority and organized several workstreams to pursue objectives intended to help ensure homes and businesses are protected from insured perils arising from natural CATs, while keeping markets stable through financially strong insurers and reinsurers. For example, the Catastrophe Risk (E) Subgroup has spent many years working to develop risk-based capital (RBC) factors for hurricane and earthquake exposures and, more recently, grappling with how best to address wildfire, flood, and convection storm perils. Separately, the Catastrophe Insurance (C) Working Group is charged with maintaining the NAIC State Disaster Response Plan, the Disaster Assistance Program, and the Catastrophe Computer Modeling Handbook. The Working Group has also commenced work to determine ways in which the private flood market can be facilitated and monitored by the state insurance regulators. The Climate and Resiliency (EX) Task Force has taken on significant work, which will require a deeper understanding of all aspects of climate and natural CAT risks. Further, many state insurance regulators are taking on new roles in working to create risk resilient communities within their jurisdictions.

Given these increased pressures and new roles, state insurance regulators need to improve their understanding of the CAT modeling technologies used by insurers and reinsurers. This means having access to the same knowledge, insights, and tools used by insurers. In doing so, state insurance regulators can more effectively engage with insurers and state and federal policymakers when discussing how best to maintain critical insurance coverages for their states’ economies and developing new regulatory policy. The NAIC can play an instrumental role fulfilling these needs.

In this regard, the Technology Workstream of the Climate and Resiliency (EX) Task Force was assigned the task of considering the potential application of technology, such as early warning systems and predictive modeling tools, to better understand and thereby evaluate insurers’ climate and natural CAT
risk exposures. In particular, the Technology Workstream was tasked with determining whether technical support services were needed by state insurance departments regarding the industry’s use of CAT models.

To help facilitate the members’ consideration of such a need, NAIC/CIPR staff conducted two presentations on June 7 and Aug. 6, 2021, wherein staff laid out a range of support services for state insurance departments when encountering the use of commercial CAT models by insurers in rate making processes, solvency functions, and/or other insurance business decisions (e.g., strategic, reinsurance, claims management). NAIC/CIPR staff addressed potential support services in the areas of: 1) facilitating access to CAT modeling documentation; 2) providing technical education and training; and 3) conducting applied research to proactively address regulatory climate risk and resilience priorities. Finally, an additional related benefit highlighted is the ability to provide future support services for other modeled CAT risk beyond climate and natural CATs, including casualty/liability, cyber, terrorism, and infectious diseases such as pandemics. This additional support work could potentially influence other NAIC related committee activities, as appropriate.

Proposal

As outlined in the introduction above, the time has arrived for the NAIC to establish a permanent support group—i.e., the NAIC CAT Modeling COE—to provide the NAIC and state system of insurance regulation with the necessary technical expertise, tools, and information to effectively regulate the insurers and reinsurers exposed to catastrophic events for a secure and stable insurance marketplace. We believe this COE would be best positioned within the NAIC’s CIPR given CIPR’s: 1) existing knowledge, expertise, and recent NAIC applied research track record in this field; and 2) its ability to effectively work with modelers and state insurance regulators from a neutral perspective within the NAIC. Below is a complementary and integrated series of technical support services envisioned by the COE:

1) Facilitating insurance department access to CAT modeling documentation and assistance in the distilling of this information.
2) Providing general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures.
3) Conducting applied research analysis utilizing various model platforms to proactively answer the regulatory "so what" questions that may need to be addressed for regulatory resilience priorities.

The first element from above provides for the CAT Modeling COE to facilitate insurance department access to CAT modeling documentation and other information, as well as centralizing accumulated knowledge and expertise to aid in the deciphering and distillation of CAT models. The COE would assist
with managing both CAT model vendor relationships and insurance department needs. As such, the COE would be briefed on the modeling technologies and inputs in a similar fashion as insurers and reinsurers are and have access to the same modeling documentation to develop internal expertise. This knowledge and expertise would then be actively shared with state insurance regulators for use in regulatory processes and other considerations. Critically, this information would be collected and stored on an NAIC regulator-only technological platform with proper CAT modeling vendor Data Use Agreements (DUAs) in place to allow for proprietary model information sharing, part of which has been a stumbling block to regulatory access to date.

The second element from above provides for technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures for state insurance regulators. Importantly, this technical training would be utilized to enhance regulatory operational activities, thereby bringing the science to operations. For example, it would allow for state insurance departments and the NAIC to reimagine the NAIC Catastrophe Computer Modeling Handbook, which could become the foundational authoritative literature on state insurance regulator use of CAT models. As state insurance regulators gain more practice with these models, the NAIC is also well-positioned to develop best practices on industry use, as well as state insurance regulator use. Consequently, the NAIC Financial Condition Examiners Handbook and the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual could be improved to account for the latest developments and best practices in CAT risk assessment. Further from a solvency perspective, both the development of related RBC CAT charges and climate stress testing would benefit greatly from such a technical foundation.

The third element from above provides for conducting applied research analysis to utilize various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed. CAT models are not limited to use by the insurance industry; they are tools for CAT risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities (e.g., how to increase the uptake and proliferation of home hardening activities related to hurricane and wildfire risk). Such mitigation activities are critical to reduce expected losses and improve the availability and affordability of coverage currently and in a future warming climate. Applied research utilizing CAT models can demonstrate the economic value of such mitigation activities, laying the proper foundation for policy discussions to address increasing property owner mitigation implementation.

Lastly, it is important to note that these identified support services will not be taking the place of individual state department of insurance (DOI) activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. Rather, the support services will allow the COE to engage with state insurance regulators as a trusted partner with a sufficient level
of CAT modeling expertise to enable the conduction of ongoing CAT modeling regulatory activities more effectively.

**Plan of Action**

In the past year, many of the above support services have already transpired and/or are currently underway. These include: 1) regulator-only technological platform infrastructure development and DUA executions; 2) NAIC Insurance Summit and CIPR events focused on CAT modeling education concerning wildfire and flood models, CAT model climate change incorporation and climate risk assessment, and casualty CAT modeling; 3) successful completion of a California, Colorado, and Oregon DOI wildfire mitigation report and wildfire CAT model technical documentation done in conjunction with the Insurance Institute for Business & Home Safety (IBHS) and Risk Management Solutions (RMS), which was further leveraged by the Catastrophe Risk (E) Subgroup for wildfire RBC factor development and the Catastrophe Insurance (C) Working Group Catastrophe Computer Modeling Handbook updates. Therefore, this proposal will not be to start such CAT modeling COE support service activities, but rather to build upon and leverage these activities for further enhancement and formalization at the NAIC.

Following the meeting of the Technology Workstream on Aug. 6, 2021, the proposal was released to the member states for further comments and questions. Comments were considered, and a revised proposal was approved for public exposure by the Technology, Solvency, and Pre-Disaster Mitigation Workstreams on Sept. 20, 2021.

Following the Sept. 20 regulator-only meeting, the proposal was released to interested parties for further comment and questions for 30 days. Comments will be considered by the Technology Workstream following this feedback and revisions may be made to the proposal, as agreed upon.

If the proposal advances through the above process steps, it will be prepared for recommendation to the Climate Risk and Resiliency (EX) Task Force at the NAIC 2021 Fall National Meeting in San Diego, CA.

We anticipate there would be no new charges associated with creation of the COE; i.e., the expenses associated with the COE resources would be effectively absorbed by the NAIC budget and have no special assessments, fee for services, etc. These resources may include: 1) recruiting a vendor/insurance department CAT modeling relationship manager and a CAT model research analyst; 2) funding for education/training development and implementation and the licensing and/or running of models for applied research to support and/or enhance regulatory operational activities; and 3) addressing regulatory resilience priorities.
Conclusion

In the face of extreme weather and the future climate significantly affecting property insurance markets, state insurance regulators need to have access to the same knowledge, insights, and CAT modeling tools used by insurers and reinsurers to assess and address climate risk and resiliency; i.e., knowledge and tools that are available for state insurance regulators to access, understand, and utilize. To accomplish this, we propose that the NAIC establish a permanent support group—i.e., the NAIC CAT Modeling COE—housed within the NAIC’s research unit; i.e., CIPR. We have laid out a proposal and plan of action that would build upon the work that the NAIC/CIPR has already been conducting around climate and CAT risks and allows the NAIC/CIPR to bring science to the operation of the DOIs in a way that is additive to the existing regulatory system, easy to access, and tailored to the needs of the state insurance regulators.

CATModelCOE Proposal
NAIC/Center for Insurance Policy and Research (CIPR) Catastrophe Model
Center of Excellence (COE)
Frequently Asked Questions (FAQ)
November 16, 2021

Governance & Oversight

Topic: Vendor and Insurer Continued Engagement with Departments of Insurance (DOIs)

Is the intent for the COE to become the primary point of contact between state insurance regulators and modelers?

No. As stated in the proposal, “identified support services will not be taking the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models.” However, we do envision the COE providing access to CAT modeling expertise to support state insurance regulator understanding, training, etc.

Will state insurance regulators continue to be open to discussions with modelers (and insurers) about models?

Yes. In fact, the COE will seek to improve communication between state insurance regulators and modelers/insurers, supplying state insurance regulators with expertise and information to help facilitate such discussions.

Topic: Transparency and Potential Bias of Modeled Results/Usage

How will the COE engage with interested stakeholders to remain transparent?

Most NAIC support resources interact with a committee for reporting and oversight. In this instance, at least for now, we propose that the catastrophe resource center will report to the Technology Workstream under the Climate and Resiliency (EX) Task Force, as well as coordinate with the Property and Casualty Insurance (C) Committee.

How will the COE work to ensure impartiality of vendor models?
The COE will make every effort to engage with all vendors willing to participate for all perils with available technical documentation. Furthermore, the COE will establish a governance structure to ensure that partiality is not provided to any model or vendor.

**Would the COE be engaging to connect learnings from the CAT model to specific insurer rate-making, solvency, and/or business—i.e., strategic, reinsurance, claims management—decisions?**

The COE support services will not take the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. The COE will work to understand models objectively from a general sense, not for individual rate filings or solvency assessments. We acknowledge that each insurer has their own risk profile that would need to be considered on an individual basis, which is outside the scope of the COE.

**Topic: Objective Science**

**Would the kind of information the COE conveys be facts-based or would it include opinions or analysis?**

The information provided to the state DOIs would be fact-based with relevant objective analysis, as requested. Providing this type of information to states highlights the importance of the placement of the COE within the NAIC’s independent research center, the CIPR.

**Topic: Addressing Regulatory “So What” Questions Through Applied Research**

**What are regulatory “so what” questions in support service #3 of the proposal conducting applied research analysis?**

State insurance regulators are responsible for maintaining well-functioning competitive insurance markets. Forward-looking models can be utilized to help analyze market performance, especially regarding the need for improved resilience. As stated in the proposal, CAT models are tools for catastrophe risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities. For example, models can be used to identify high-risk areas and where proliferation of home hardening activities can improve resilience to natural hazards, including hurricane, flood, severe convective storm, tornado, wildfire, and earthquake. Such mitigation activities are critical to reduce probable losses. Lower losses over time can improve the availability and affordability of coverage in the future. Applied research utilizing CAT models can demonstrate the economic value of mitigation activities. One
Regarding conducting applied research analyses utilizing CAT models, we would like to understand the research and support expectations from the COE on modelers.

We envision working with modelers on applied research activities as applicable. We are requesting funding to allow for modeler engagement.

Depending on the expected level of granularity for COE work, additional questions may be relevant, such as whether the COE (NAIC/CIPR) would need to be prepared to go to a hearing to testify or respond to discovery?

It is not anticipated that the COE would maintain granular information about individual insurer use of CAT models. The level of detail would be around the actual CAT model to provide education and training to state DOIs.

Will the COE be used to conduct research and analysis into the markets for CAT models. Will conflicts of interest or market failures distort the use of CAT models?

No. It is not envisioned that the COE would set out to conduct this type of research and analysis.

Implementation Considerations

Topic: COE Communication of Various Results, Information, and Observations to DOIs

Given the complexity of models and breadth of expertise required to build and maintain them, there is a risk that any third party cannot adequately communicate the nuances and justification of models. Will the COE plan to coordinate model presentations from the modelers, rather than only relaying this information second-hand?

Yes. The COE would plan to coordinate model presentations from modelers.

How will information, observations, and/or questions about models be conveyed to state insurance departments? What kind of output will be generated?

We plan to hire a relationship manager responsible for communicating with the CAT model vendors and state insurance regulators. A regulator-only technology platform will help facilitate information sharing with state insurance regulators.
Research output could take multiple forms depending upon the nature of the analysis undertaken.

**What kinds of data fields will be included? Will others provide input into the design?**

The data fields selected would be contingent on the models being used and the research project under consideration. Data fields would follow from model inputs and outputs.

**Will the COE reviews and/or output be designed to be geography-specific?**

Yes. That is possible.

**Once a model has been reviewed, what renewal process is envisioned?**

Models will not be reviewed, nor would they be posted on the state insurance regulator-only website. However, model technical documentation and information will be updated as new versions of the models are released.

**Topic: Model Vendor Intellectual Property (IP) Protection**

How will the COE safeguard intellectual property of the participating CAT model vendors?

All modeling documentation, access, and usage will be centralized and monitored through the COE via legally binding data use agreements. The NAIC has an extensive track record of experience in collecting and protecting proprietary information. The actual models will not be posted on the state insurance regulator website, only the model documentation will be posted.

**Topic: Interaction with Modelers and Other External Experts**

Will modelers engage in discussions with the COE about specific models? Do you expect insurers to be involved in model-related discussions?

Yes. The COE would be engaged with modelers on the modeling technologies and inputs in a similar fashion as insurers and reinsurers and have access to the same modeling documentation to develop internal expertise. It is possible that insurers could be involved in model-related discussions with the COE, but the COE will not review individual insurer’s use of models.

Is the CIPR planning to license and use modeler software or engage in paid consulting studies for their research and development of processes?
Yes, depending on COE resources and the specific research use case. The CIPR would be willing to either license modeler software and/or engage in paid consulting studies for research and educational/training purposes, as directed by the appropriate NAIC authorities.

How will results and underlying assumptions from licensed models be communicated to state insurance regulators?

Any use of a licensed model, including distribution of modeled results, would be subject to the model license agreement and/or model vendor negotiated research consulting contract. Underlying assumptions from the various models utilized would be collected via the model technical documentation as part of the model vendor data use agreement. Note that it is possible that the model technical documentation, including underlying model assumptions, could be collected through a COE data use agreement without an associated model-based research project. If we were to license a model, the actual model would not be posted on the state insurance regulator-only website.

Will modelers be involved in establishing workflows, best practices, agendas, and expectations of the COE, including timing?

We anticipate that modelers will be actively engaged with the COE staff, advising on these items as appropriate.

How many vendors is the COE considering supporting?

The COE will not be “supporting” vendors, but rather the COE will collect model documentation and engage with model vendors. The COE will engage with any model vendor serving insurance markets where the information is relevant to state insurance regulators.

Does the COE anticipate looking to external experts for some of the implementation or ongoing work?

Yes. External collaboration would be welcome, whether that be with industry experts, public agencies, or the academic community.

Topic: Resources – Staffing and Funding

How many states do you expect to be interfacing with the COE?

The COE will be a resource of the NAIC potentially interfacing with all 56 jurisdictions.
Beyond recruiting for the identified new roles of CAT modeling relationship manager and CAT model research analyst, how many people at the NAIC/CIPR will be contributing to COE activities? Do you expect that to change over time?

The CIPR director, the NAIC solvency enterprise risk management (ERM) advisor, and potentially Property and Casualty Insurance (C) Committee staff support will have a role in supporting the work of the COE. We anticipate that additional technical and administrative support resources may be necessary as the workload and demand for services evolve with demonstrated success.

Will the staffing level proposed by the NAIC be able to provide meaningful analysis in the broad category of catastrophe modeling?

Prior to the creation of the COE, CIPR and NAIC staff have provided meaningful analysis on wildfire CAT modeling and applied wildfire resilience research. We aim to build off this success and need to start somewhere. Every little bit helps for the states, as stated by one industry commenter, “[t]he staffing issues mentioned above regarding experts at the NAIC are even larger for state insurance departments. Most states are not going to have enough or the right staff to review these models. They will have to rely on others to evaluate catastrophe model validity, and most likely will have to rely heavily on the decisions and evaluations made by others.”

Have long-term plans been prepared? Are there budget implications?

No long-term plan has been developed for the COE. The expenses associated with the COE would be subject to the NAIC budget process and have no special assessments or fees for service.
PROPOSED REDESIGNED NAIC CLIMATE RISK DISCLOSURE SURVEY

INTENT AND PURPOSE
The Climate Risk Disclosure Survey is a voluntary risk management tool for state insurance regulators to request from insurers on an annual basis a non-confidential disclosure of the insurers’ assessment and management of their climate-related risks.

The purpose of the Climate Risk Disclosure Survey is to:
- Enhance transparency about how insurers manage climate-related risks and opportunities.
- Identify good practices and vulnerabilities.
- Provide a baseline supervisory tool to assess how climate-related risks may affect the insurance industry.
- Promote insurer strategic management and encourage shared learning for continual improvement.
- Enable better-informed collaboration and engagement on climate-related issues among regulators and interested parties.
- Align with international climate risk disclosure frameworks to reduce redundancy in reporting requirements.

BACKGROUND
The NAIC adopted the original Climate Risk Disclosure Survey in 2010 and it has since been administered by the California Department of Insurance. In 2021, fifteen states participated in the climate risk disclosure survey initiative, up from six states in prior years. Because any insurer writing business in a participating state is required to submit their survey response annually, adding nine states in 2021, increased the market coverage from approximately 70% in 2020 to nearly 80% of the market in 2021 based on direct premium written.

In 2021, the Financial Stability Oversight Council (FSOC) produced a series of recommendations for financial regulators to enhance supervision, data analysis, staff resources, and regulatory cooperation related to climate risk. This included a recommendation to consider enhancing public reporting requirements for climate-related risks in a manner that builds on the four core elements of the Task Force on Climate-Related Financial Disclosure (TCFD), to the extent consistent with the U.S. regulatory framework and the needs of U.S. regulators and market participants.

This revised survey responds to FSOC’s recommendations and incorporates international best practices in adopting a TCFD aligned framework for US insurers to report on climate risks when requested by their state regulator.

The TCFD framework is structured around four thematic areas that are core elements
for how insurers operate—governance, strategy, risk management, and metrics and targets. The four thematic areas are supported by key climate-related financial disclosures—referred to as recommended disclosures—that build out the framework with information that will help regulators and others understand how reporting organizations assess and approach climate-related issues.

INTRODUCTORY GUIDANCE

Timeline and expectation for reporting
We expect that every company who will be asked to complete the survey in 2022 will have already completed the existing NAIC survey or filed a TCFD report; nearly all companies having participated for several prior years. The table below outlines the timing and other expectations for reporting in 2022 and 2023 as the new survey is phased in. If a company has not previously responded to the NAIC survey, it should be given until 2023 to first respond.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Expectation Regarding Content</th>
<th>Deadline for Completion</th>
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| 2022           | • If the insurer has already completed a TCFD for this reporting year, they can submit it as is.  
• If the insurer has not already completed a TCFD for this reporting year, they should make their best effort to complete the survey below or include such information in their TCFD filing, as is requested below.  
• Closed-ended questions are voluntary for 2022, and states may opt out of requesting responses to closed-ended questions. | To allow additional time for insurers to move to the new reporting structure, submission deadlines should be moved from Aug. 31 to Nov. 30. Extensions may be granted by the state that initiated the request to the company or the lead state for the group filing. |
| 2023           | Insurers are expected to address the content of the entire TCFD aligned survey below, to the best of their ability. | In accordance with prior years, submissions are due from insurers by Aug. 31st. Extensions may be granted by the state that initiated the request to the company. |

Threshold and voluntary state participation
The reporting threshold remains consistent with the threshold implemented each year since 2013. All insurers with countrywide premium written of at least $100 million, licensed to write in any of the participating states/territories, are required to complete and submit their survey on an annual basis. As of 2021, the following states/territories participate: California,
Confidentiality and best effort basis
While the existing NAIC survey and TCFD contain sufficient overlap in the analysis required to answer, we recognize that many insurers will be moving to a new reporting framework in the TCFD. Insurers should make their best effort to answer each question honestly and completely, keeping in mind that the information contained in the filing will be made public. During the transition to the TCFD aligned survey, state insurance regulators should work closely with insurers to provide as much flexibility as possible in terms of responding to the survey and deadlines. Confidential information should not be included in this public disclosure unless it is intended to be made public. If additional detail is requested by a state insurance regulator, that request will be handled directly between the regulator and insurer.

Materiality
There is no requirement to provide information that is immaterial to an assessment of financial soundness (insurers may choose to disclose such information voluntarily, with no implication that such information is in fact material). Insurers should justify their materiality assessment. For the definition of materiality, refer to the Financial Condition Examiners Handbook and/or the U.S. Securities and Exchange Commissioner Accounting Bulletin: No. 99, if applicable.

Consistent with TCFD guidance, the Strategy and Metrics and Targets Sections involve an assessment of materiality, except for the question on Scope 1 and Scope 2 greenhouse gas emissions within the Metrics and Targets Section. Disclosures related to Governance and Risk Management Sections do not involve an assessment of materiality.

Assessing financial impact of climate-related risks and opportunities
The financial impacts of climate-related issues on an insurer are driven by the specific climate-related risks and opportunities to which the insurer is exposed and its strategic and risk management decisions on seizing those opportunities and managing those risks (i.e., accept, avoid, pursue, reduce, or share/transfer). Once an insurer assesses its climate-related issues and determines its response to those issues, it can then consider actual and potential financial impacts on revenues, expenditures, assets and liabilities, and capital and financing.1

Consistent with the TCFD Guidelines, determining whether an individual organization is or may be affected financially by climate-related issues usually depends on:

- the organization’s exposure to, and anticipated effects of, specific climate-related risks and opportunities;
- the organization’s planned responses to manage (i.e., accept, avoid, pursue, reduce, or share/transfer) its risks or seize opportunities; and

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the implications of the organization’s planned responses on its income statement, cash flow statement, and balance sheet.²

Importantly, an organization should assess its climate-related risks and opportunities within the context of its businesses, operations, and physical locations in order to determine potential financial implications. In making such an assessment, an organization should consider (1) current and anticipated policy constraints and incentives in relevant jurisdictions, technology changes and availability, and market changes and (2) whether an organization’s physical locations or suppliers are particularly vulnerable to physical impacts from climate change.³

See pages 10-12 of the TCFD’s Implementation Recommendation Report for more guidance on assessing exposure, response and implications.

**ADDITIONAL SPECIFIC GUIDANCE**

One of the several benefits of aligning with the TCFD is that it allows insurers to benefit from years of guidance and supporting material developed and being regularly updated by the TCFD and other organizations.

For those insurers new to TCFD reporting, the Implementation Recommendation Report provides a useful guide. It contains guidance for all sectors on each of the four thematic areas of governance, strategy, risk management and metrics and targets. For example, in relation to the risk management disclosure to describe the insurers’ processes for identifying and assessing climate-related risks, it provides the following guidance:

- Organizations should describe their risk management processes for identifying and assessing climate-related risks. An important aspect of this description is how organizations determine the relative significance of climate-related risks in relation to other risks.

- Organizations should describe whether they consider existing and emerging regulatory requirements related to climate change (e.g., limits on emissions) as well as other relevant factors considered.

- Organizations should also consider disclosing the following:
  - processes for assessing the potential size and scope of identified climate-related risks and
  - definitions of risk terminology used or references to existing risk classification frameworks used.⁴

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² [https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf](https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf), pg.10
The same document also provides supplemental insurance-sector specific guidance. For example, for the same disclosure question, it provides:

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Insurance companies should describe the processes for identifying and assessing climate-related risks on re-/insurance portfolios by geography, business division, or product segments, including the following risks:
- physical risks from changing frequencies and intensities of weather-related perils;
- transition risks resulting from a reduction in insurable interest due to a decline in value, changing energy costs, or implementation of carbon regulation; and
- liability risks that could intensify due to a possible increase in litigation.5
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Notably, this general and supplemental guidance is not required to be included in a TCFD report. Rather, it is designed to support an insurer in developing climate-related financial disclosures consistent with the TCFD framework, including by providing context and suggestions for implementing the recommended disclosures.

The disclosures identified in bullet points in this survey are intended to be supplemental, insurance-sector specific guidance. They have been developed by the NAIC to respond to the TCFD and FSOC recommendations that regulators enhance public reporting requirements for climate-related risks in a manner that builds on the TCFD’s four core elements. They are designed to further support insurers’ in developing their disclosures by providing context and suggestions for the information a regulator may expect.

Additional guidance published by the TCFD includes:

- **The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities (2017)** provides information on types of climate-related scenarios, the application of scenario analysis, and the key challenges in implementing scenario analysis to support an organization’s disclosure of the resilience of its strategy, taking into consideration different climate-related scenarios.

- **Guidance on Risk Management Integration and Disclosure (2020)** describes considerations for organizations interested in integrating climate-related risks into their existing risk management processes and disclosing information on their risk management processes in alignment with the Task Force’s recommendations.

- **Guidance on Metrics, Targets, and Transition Plans (2021)** describes recent developments around climate-related metrics and users’ increasing focus on information describing organizations’ plans for transitioning to a low-carbon economy. The guidance also describes a set of cross-industry, climate related metric categories (described in Appendix 2: Cross-Industry,

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Climate-Related Metric Categories) that the Task Force believes are applicable to all organizations.

The FSB frequently produces content to assist companies in creating TCFD reports, the knowledge hub with related content is accessible at https://www.tcfdhub.org/.

SURVEY QUESTIONS
To provide clear direction for achieving a robust, insurance-sector specific TCFD report, narrative and closed ended questions follow, grouped into the TCFD’s four topics: governance, strategy, risk management and metrics and targets.

The statements listed next to numbers and letters are directly taken from the TCFD Framework and should be fully addressed in the insurer’s response. As discussed in detail above, insurers should consider including the bulleted items in their response to the TCFD statement above it. For additional guidance on sector specific content to consider including, refer to the Implementation Recommendation Report.

Governance
1. Disclose the insurer’s governance around climate-related risks and opportunities. In disclosing the insurer’s governance around climate-related risks and opportunities insurers should consider including the following:
   - Identify and include any publicly stated goals on climate-related risks and opportunities.
   - Describe where climate-related disclosure is handled within the insurer’s structure, e.g., at a group level, entity level, or a combination. If handled at the group level, describe what activities are undertaken at the company level.
   A. Describe the board and/or committee responsible for the oversight of climate-related risks and opportunities.
   In describing the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks, insurers should consider including the following:
      - Describe the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks.
   B. Describe management’s role in assessing and managing climate-related risks and opportunities.

Strategy
2. Disclose the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy, and financial planning where such information is material. In disclosing the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy and financial planning, insurers should consider including the following:
   - Describe the steps the insurer has taken to engage key constituencies on the topic of climate risk and resiliency.*i
Describe the insurer’s plan to assess, reduce, or mitigate its greenhouse gas emissions in its operations or organizations.*

A. Describe the climate-related risks and opportunities the insurer has identified over the short, medium, and long term.

In describing the climate-related risks and opportunities the insurer has identified over the short, medium, and long term, insurers should consider including the following:

- Define short, medium, and long-term, if different than 1-5 years as short term, 5-10 years as medium term, and 10-30 years as long term.

B. Describe the impact of climate-related risks and opportunities on the insurer’s business, strategy, and financial planning.

In describing the impact of climate-related risks and opportunities on the insurer’s business, strategy, and financial planning, insurers should consider including the following:

- Discuss if and how the insurer provides products or services to support the transition to a low carbon economy or helps customers adapt to climate-related risk.
- Discuss if and how the insurer makes investments to support the transition to a low carbon economy.

C. Describe the resilience of the insurer’s strategy, taking into consideration different climate-related scenarios, including a 2 degree Celsius or lower scenario.

Risk Management

3. Disclose how the insurer identifies, assesses, and manages climate-related risks.

In disclosing how the insurer identifies, assesses, and manages climate-related risks, insurers should consider including the following:

- Describe how the insurer considers the impact of climate-related risks on its underwriting portfolio, and how the company is managing its underwriting exposure with respect to physical, transition, and liability risk.*
- Describe any steps the insurer has taken to encourage policyholders to manage their potential physical and transition climate-related risks, if applicable.*
- Describe how the insurer has considered the impact of climate-related risks on its investment portfolio, including what investment classes have been considered.*

A. Describe the insurers’ processes for identifying and assessing climate-related risks.

In describing the insurers’ processes for identifying and assessing climate-related risks, insurers should consider including the following:

- Discuss whether the process includes an assessment of financial implications and how frequently the process is completed.*

B. Describe the insurer’s processes for managing climate-related risks.

C. Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management.
In describing how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management, insurers should consider including the following:

- Discuss whether climate-related risks are addressed through the insurer’s general enterprise-risk management process or a separate process and how frequently the process is completed.
- Discuss the climate scenarios utilized by the insurer to analyze its underwriting risks, including which risk factors the scenarios consider, what types of scenarios are used, and what timeframes are considered.
- Discuss the climate scenarios utilized by the insurer to analyze risks on its investments, including which risk factors are utilized, what types of scenarios are used, and what timeframes are considered.

**Metrics and Targets**

4. Disclose the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material.

In disclosing the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material, insurers should consider including the following:

- Discuss how the insurer uses catastrophe modeling to manage the climate-related risks to your business. Please specify for which climate-related risks the insurer uses catastrophe models to assess, if any.
  
  A. Disclose the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process.

  In disclosing the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process, insurers should consider including the following:

  - In describing the metrics used by the insurer to assess and monitor climate risks, consider the amount of exposure to business lines, sectors, and geographies vulnerable to climate-related physical risks [answer in absolute amounts and percentages if possible], alignment with climate scenarios, [1 in 100 years probable maximum loss, Climate VaR, carbon intensity], and the amount of financed or underwritten carbon emissions.

  B. Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.

  C. Describe the targets used by the insurer to manage climate-related risks and opportunities and performance against targets.
Closed-ended questions directly correspond to the narrative above, allowing for explanation and qualification of the yes/no answers. Closed-ended questions are voluntary for reporting year 2022 and individual states may elect not to request them.

**Governance**
- Does the insurer have publicly stated goals on climate-related risks and opportunities? (Y/N)
- Does your board have a member, members, a committee, or committees responsible for the oversight of managing the climate-related financial risk? (Y/N)
- Does management have a role in assessing climate-related risks and opportunities? (Y/N)
- Does management have a role in managing climate-related risks and opportunities? (Y/N)

**Strategy**
- Has the insurer taken steps to engage key constituencies on the topic of climate risk and resiliency? (Y/N) *
- Does the insurer provide products or services to support the transition to a low carbon economy or help customers adapt to climate risk? (Y/N)
- Does the insurer make investments to support the transition to a low carbon economy? (Y/N)
- Does the insurer have a plan to assess, reduce or mitigate its greenhouse gas emissions in its operations or organizations? (Y/N)*

**Risk Management**
- Does the insurer have a process for identifying climate-related risks? (Y/N)
  - If yes, are climate-related risks addressed through the insurer’s general enterprise-risk management process? (Y/N)
- Does the insurer have a process for assessing climate-related risks? (Y/N)
  - If yes, does the process include an assessment of financial implications? (Y/N)
- Does the insurer have a process for managing climate-related risks? (Y/N)
- Has the insurer considered the impact of climate-related risks on its underwriting portfolio? (Y/N/Not Applicable)*
- Has the insurer taken steps to encourage policyholders to manage their potential climate-related risks? (Y/N)*
- Has the insurer considered the impact of climate-related risks on its investment portfolio? (Y/N)*
- Has the insurer utilized climate scenarios to analyze their underwriting risk? (Y/N)
- Has the insurer utilized climate scenarios to analyze their investment risk? (Y/N)

**Metrics and Targets**
- Does the insurer use catastrophe modeling to manage your climate-related risks? (Y/N)
- Does the insurer use metrics to assess and monitor climate-related risks? (Y/N)
- Does the insurer have targets to manage climate-related risks and opportunities? (Y/N)
- Does the insurer have targets to manage climate-related performance? (Y/N)
* Asterisks represent questions derived from the original Climate Risk Disclosure Survey.
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Spring National Meeting.
Draft: 4/12/22

Long-Term Care Insurance (EX) Task Force
Kansas City, Missouri
April 6, 2022

The Long-Term Care Insurance (EX) Task Force met in Kansas City, MO, April 6, 2022. The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Jimmy Gunn (AL); Evan G. Daniels (AZ); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Tanisha Merced (DE); David Almtaier represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron (ID); Dana Popish Seeveringhaus (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Sharon P. Clark represented by Rob Roberts (KY); James J. Donelon (LA); Gary D. Anderson (MA); Timothy N. Schott (ME); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold represented and Fred Andersen (MN); Chlora Lindley-Myers represented by Jo LeDuc (MO); Mike Chaney (MS); Troy Downing represented by Kati McGrath Ellis (MT); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Barbara D. Richardson represented by David Cassetty (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Eli Snowbarger (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Stephanie Cope (TN); Cassie Brown represented by Chris Herrick (TX); Jon Pike (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. ** Adopted its 2021 Fall National Meeting Minutes **

Commissioner McVey made a motion, seconded by Commissioner Kreidler, to adopt the Task Force’s Dec. 12, 2021, minutes (see NAIC Proceedings – Fall 2021, Long-Term Care Insurance (EX) Task Force). The motion passed unanimously.

2. ** Received the Report on the Implementation Plans for the LTCI MSA Framework **

Commissioner White said the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) is expected to be adopted during the Executive (EX) Committee and Plenary meeting on April 8. Upon adoption, the Task Force have given itself until September to work through implementation issues and have the Multistate Actuarial (MSA) Process operational.

Commissioner Conway said there are three categories of tasks planned for the implementation of the LTCI MSA Framework.

Commissioner Conway said NAIC staff-level tasks include: 1) identifying if any technical updates need to be made to the NAIC’s System for Electronic Rates & Forms Filings (SERFF) application; 2) adding the MSA; and 3) differentiating MSA filings. He said NAIC staff have begun to work on drafting filing instructions for insurers and any legal forms and disclaimers, as noted in the LTCI MSA Framework. Closer to implementation, a web page will be set up to house the instructions, checklists, and any other forms for insurers.

As part of the implementation process, instructions for the MSA Team will be developed to document such things as communication channels, review controls, and process instructions to aid MSA Team members. This documentation may take longer to complete as the MSA Team gains more experience with MSA reviews. Mr. Andersen and members of the MSA Team are developing the new MSA Associate Program.
Commissioner Conway said the second category of implementation topics is focused on items that may require consideration by the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup or the Task Force. The Subgroup may be asked to review and approve any forms or instructions, as deemed necessary. The Subgroup and the Task Force will develop a plan to promote the MSA Process to both insurers and state insurance regulators to encourage use of the program, which will be critical to the future success of this program and achieving the goals of the Task Force. He said while the LTCI MSA Framework outlines on a high-level basis the development of a process for feedback to the Subgroup and Task Force for future evaluation of the program, this feedback process will need to be further developed. This will include identifying data points and how that data will be collected. For example, feedback requested from participating insurers versus feedback from state insurance regulators. Based on the feedback and the experience of the MSA Team in conducting reviews, the Subgroup will address any future updates that may be necessary to the LTCI MSA Framework.

Commissioner Conway said two topics would be Executive (EX) Committee level consideration. The first item to address would be if additional NAIC full-time employees are needed to facilitate the MSA Process. The second item would be if filing fees should be charged to the insurer for use of the MSA. This is noted as a “to be determined” topic in the LTCI MSA Framework; however, this is expected to be a long-term consideration and not an immediate consideration.

3. Heard From the ACLI on Participation in the MSA Process

Jan M. Graeber (American Council of Life Insurers—ACLI) said the ACLI has a strong desire for the MSA Process to work, but there needs to be balance from both insurers and state insurance regulators. She said general reactions from member companies that participated in the MSA Pilot Program are mixed and vary by insurer. Feedback differs between insurers that participated early in the pilot compared to those that participated later. Ms. Graeber said the process changed the conversation, and states seem to be more informed on the issues and challenges of long-term care insurance (LTCI). The process of developing the LTCI MSA Framework seemed to spread knowledge and awareness. However, it has not moved the needle on consistency of the approved amount of rate increase across states. Even states that were supportive of the process did not forego their own methodology, making companies feel as though the MSA Process was just another step added to the review. Ms. Graeber said she feels this could be overcome if states and insurers are willing to participate and rely on the results of the recommendation.

Ms. Graeber said knowing where states stand will be essential for insurers to be willing to use the process. There is not a mechanism that is meant to encourage states to participate and be accountable. As a starting point, the ACLI would encourage state insurance commissioners to affirmatively express whether they support the MSA Process and the results of the rate review recommendation. If commissioners are supportive, they should ensure they communicate that message to their staff that perform the necessary review. Member companies that participated in the MSA Pilot Program have indicated that this may not have been the case.

Ms. Graeber said the ACLI is supportive of the MSA Associate Program and encourages the Task Force to leverage expertise of the ACLI actuaries to help educate junior-level staff on LTCI.

Ms. Graeber said there is recognition of the issues that occurred with LTCI when it was originally priced; i.e., insurers have filed for rate increases for these products, and now policyholders must grapple with rates that are very different from what they expected. Policyholders may not have recognized at the beginning how much the benefit pools would grow or the value of those benefit pools. Ms. Graeber said policyholders may have benefit pools more than $500,000 to $750,000, where the premium paid is small. This is not sustainable and in conflict with the fundamental insurance principle that premiums need to be reasonable in relationship to the underlying benefit. The ACLI thinks it is time to ensure that actuarially justified rates are approved so policyholders can make informed decisions and meaningful coverage. Ms. Graeber said insurers need predictably and sufficiently of the
MSA recommendation. A question would be what method will be applied to the filing and what criteria is being used to evaluate which methodology is applied. Ms. Graeber said the ACLI recommends engaging in a dialogue on the issues and questions that need to be addressed. This may help further refine the current process so insurers will have greater insight into how the process will work, and state insurance regulators will have a better sense of the level of industry engagement. Ms. Graeber said she believes most insurers are willing to submit to a consistent process but are reluctant to waive their understanding of how the process works in exchange for a potentially more efficient process. She said the problem of LTCI needs collective, long-term solutions.

Commissioner Conway asked if ACLI members believe the MSA Process has more certainty than the current state-by-state review. Ms. Graeber said the answer is no. When insurers were going to an individual state, they knew what to expect from that state. Even though the LTCI MSA Framework outlines the two methodologies, there is a blend of methodologies applied or one methodology over another. Insurers will file what they believe is an actuarially justified rate increase. To the extent that there are adjustments or blending, the insurer needs to understand and be able to take those adjustments and blending into account when developing longer-term objectives. She said member insurers said there were status updates given during the review process. However, there needs to be more dialogue between the reviewer and the insurer that submitted the filing to ensure both understand how the information and data in the filing is being interpreted.

Commissioner White said the Task Force is in the MSA Pilot Project stage and will continue to take insurer and stakeholder feedback to improve the MSA Process, so everyone has more comfort with the MSA Process moving forward.

4. **Heard an Update on LTCI Industry Trends**

Mr. Andersen said there are two teams of state insurance regulators. One group looks at rates. A second group is a subset of the Valuation Analysis (E) Working Group that reviews insurers’ Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) filings to focus on reserves and solvency. This group communicates findings to NAIC leadership, domestic state insurance departments, and other NAIC groups. Two trends have been reviewed this year: 1) cost-of-care inflation trends, which have been observed over the past five years and are now a credible trend. This affects policies with 5% inflation protected benefits. Some insurers have strengthened benefit utilization assumptions, which is the amount of actual daily benefit spent on care; and 2) the impact of COVID-19, which was thought to be short-term. Mr. Andersen said this will continue to be studied, specifically if there is a shift from facility care to home care.

5. **Received a Report on the MSA Associate Program**

Commissioner White said the MSA Associate Program is intended to develop and sustain the LTCI MSA Framework by filling the MSA Team with a diverse pool of qualified actuaries. It is understood that as actuaries retire or leave state regulatory roles, there is a need to be prepared to fill the positions on the MSA Team when that occurs and to get fresh perspectives from other actuaries.

Mr. Andersen said the strength of state regulatory knowledge on LTCI is important to both state insurance departments and industry. The MSA Associate Program has many opportunities, including having more state insurance department actuaries become part of the MSA Process and adding to the general educational level on LTCI actuarial issues. It also allows the current MSA Team to learn from actuaries in other states. Mr. Andersen said 16 state actuaries from various states have signed up for the program. He said an initial introductory call was held to discuss backgrounds and how the group can get engaged in the MSA Process and educational opportunities. He said state actuaries or other staff involved in LTCI wishing to join can reach out to him or NAIC staff.
6. **Disbanded the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup**

Commissioner White said at the 2021 Fall National Meeting, the Task Force adopted two work products from the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The Subgroup was given 2022 charges if the 2021 work of the Subgroup was not completed before the end of the year. However, the charges of the Subgroup were completed in 2021, and there are currently no tasks that require the Subgroup’s attention. If new related topics arise in the future in this area, the Task Force can consider re-establishing a Subgroup.

Commissioner Conway made a motion, seconded by Commissioner McVey, to disband the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The motion passed unanimously.

Bonnie Burns (California Health Advocates) said there needs to be simplification of the consumer notices of rate increases. The notices may be confusing, and consumers may not know which notices to give their attention to. Ms. Burns said consumers believe the only options available to them are the options provided by the insurer. She believes there needs to be regulatory scrutiny of the notices and consumers’ reactions to the notices. She said there needs to be attention given to consumers that receive the notices and how they make decisions in their best interest.

Brenda J. Cude (University of Georgia) said she agrees with Ms. Burns. She said she is working on an NAIC Center for Insurance Policy and Research (CIPR) project to gain an understanding of consumer reactions on reduced benefit options (RBOs) and consumers’ questions. She said they have talked to financial planners who should have a higher level of understanding than the consumer of RBOs. The financial planners have a better understanding of what the consumers’ reactions are, and they have their own questions. That research could contribute to this discussion.

Commissioner White said the Task Force can put this issue on the agenda for the next Task Force meeting to consider where to address the concern.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

Special (EX) Committee on Race and Insurance April 6, 2022, Minutes .............................................................. 4-81
Draft: 4/22/22

Special (EX) Committee on Race and Insurance
Kansas City, Missouri
April 6, 2022

The Special (EX) Committee on Race and Insurance met in Kansas City, MO, April 6, 2022. The following Special Committee members participated: Dean L. Cameron, Co-Chair (ID); Chlora Lindley-Myers, Co-Chair (MO); Raymond G. Farmer, Chair Emeritus (SC); Andrew N. Mais, Co-Vice Chair (CT); Jon Godfrey, Co-Vice Chair (ND); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Timothy N. Schott (ME); Anita G. Fox (MI); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Troy Downing (MT); Mike Causey (NC); Eric Dunning (NE); Marlene Caride (NJ); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jon Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak (VT); Mike Kreidler (WA); Nathan Houdek (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. Adopted its 2021 Fall National Meeting Minutes

Commissioner McVey made a motion, seconded by Commissioner Mais, to adopt the Special (EX) Committee on Race and Insurance’s Dec. 14, 2021, minutes (see NAIC Proceedings – Fall 2021, Special (EX) Committee on Race and Insurance). The motion passed unanimously.

2. Received a Status Report on Workstream One

Director Lindley-Myers said, “I hope that as you hear these reports you appreciate the continued work being done to identify barriers to access to insurance careers and insurance products and the challenging efforts towards identifying and removing any unfair discrimination.”

Director Lindley-Myers noted that the NAIC is monitoring efforts by the U.S. House of Representatives (House) Financial Services Subcommittee on Diversity and Inclusion, which plans on having a hearing and producing a report on diversity, equity, and inclusion (DE&I) within the insurance sector. NAIC staff met with Chairwoman Maxine Waters’ (D-CA) office about its efforts, and they are aware that letters and surveys went out to many in the industry. The NAIC plans to continue following the work of the Subcommittee in anticipation of the hearings and the subsequent report.

Executive Deputy Superintendent To reported that Workstream One is charged with continuing research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including: 1) seeking additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts; and 2) collecting input on any existing gaps in available industry diversity-related data.

Since the adoption of its 2021/2022 charges, the Workstream has met in regulator-only session three times and held two open calls with stakeholders.

In October 2021, the Workstream heard a presentation from California and New York regarding their respective DE&I efforts and the diversity-related industry data that these states are collecting.
In November 2020, the Workstream held a public call with stakeholders to discuss actions companies can take to foster a more inclusive environment to gain more diverse executives and board members, as well as how state insurance regulators can support these efforts.

In November 2021, the Workstream held another public call with stakeholders to better understand industry diversity-related programs, how companies are measuring progress, and what state insurance regulators can do to support these efforts.

State insurance regulators were pleased by the industry’s willingness to step up, and they asked three of the presenters from the second stakeholder call to present to the full Special (EX) Committee on Race and Insurance during the 2021 Fall National Meeting: 1) the American Property Casualty Insurance Association (APCIA) and Dr. Leroy Nunery II; 2) the Blue Cross and Blue Shield of Illinois; and 3) Zurich.

In terms of next steps, the Workstream co-chairs are working to outline proposed recommendations and action steps for the Workstream to consider.

State insurance regulators want to support the insurance industry in increasing diversity and inclusion at all levels of their organizations and be of assistance in bringing more and diverse talent into the applicant pool.

3. **Received a Status Report on Workstream Two**

Commissioner Clark reported that Workstream Two has gathered responses to the zone-based survey examining best practices and initiatives state insurance departments may consider when promoting DE&I in their departments. The Workstream will soon meet to discuss a method and forum to share diversity and inclusion best practices among state insurance regulators.

Commissioner Mulready stated that the NAIC continues its work implementing diversity initiatives. Much of the Workstream’s recent work has been conducted by Evelyn Boswell (NAIC), Director of Diversity, Equity, and Inclusion, through the State Diversity Leaders Forum. This Forum provides a space for diversity leaders in each state to come together and discuss best practices in promoting diversity in their respective insurance departments. Commissioner Mulready encouraged commissioners to send Ms. Boswell their department’s diversity contact information.

4. **Received a Status Report on Workstream Three**

Director Wing-Heier reported on interactions the leadership and members of Workstream Three have had in recent months to address the Workstream’s charges. Much of the focus of the Workstream has been on how to address Charge F, which addresses continuing research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact, as well as making recommendations for statutory or regulatory changes and additional steps, including developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination.

Leadership from the Workstream, the Innovation, Cybersecurity, and Technology (H) Committee, the Accelerated Underwriting (A) Working Group, the Big Data and Artificial Intelligence (H) Working Group, and the Casualty Actuarial and Statistical (C) Task Force met with Cathy O’Neil (O’Neil Risk Consulting & Algorithmic Auditing—ORCAA) earlier this year as a follow-up to a presentation she gave to the Workstream late last year. The primary focus of this discussion was on algorithmic auditing and what tools or education state insurance regulators might need to better identify and address any unfair bias that can occur in algorithms or other models.
From this discussion, this same group of commissioners had further conversations about how to meet with similar experts—i.e., academics, consultants, start-ups, or others—who have expertise in artificial intelligence (AI), machine learning (ML), and algorithms. The idea discussed on the March 22 Workstream call is that the Committee can create a forum where all groups can hear from subject matter experts (SMEs) in one forum; then, individual groups, such as the Workstream, can take that knowledge and apply it to their specific charges.

On the March 22 call, the Workstream also discussed recent papers from the Casualty Actuarial Society (CAS) released examining approaches to defining and measuring fairness in predictive models and examining issues of racial bias in the financial industry, and the Workstream explored at what stage the Workstream might want to understand the different ways these terms are defined. Finally, the Workstream reviewed the status of each of its charges and how best to address them.

5. **Received a Status Report on Workstream Four**

Director French reported that while Workstream Four has yet to meet in 2022, the co-chairs have been meeting to discuss how best to focus its efforts in 2022. This year, the Workstream will focus on the charge to “continue research and analysis related to insurance access and affordability issues, including the marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays,” exploring options for presentations to help the Workstream identify how state insurance regulators and the NAIC might be able to advance equity in the marketing and distribution of life insurance in underserved communities.

Director French has met with representatives from Nationwide, a charter member of the Financial Alliance for Racial Equity (FARE). FARE is a partnership of financial services organizations, associations, and historically black colleges and universities (HBCUs). The FARE mission statement is “to increase racial diversity, drive greater equity, and foster inclusion within the financial services industry and the communities served.”

Founding members of FARE include Morgan Stanley, M Financial Group, NFP, Miami Life, Huntington, the Employee Benefit Research Institute (EBRI), the American College of Financial Services, and Nationwide Financial in partnership with HBCUs, including Hampton University, Lincoln University, Virginia State University, Virginia Union University, Winston-Salem State University, and Howard University.

The Workstream will schedule a panel presentation with FARE members and invite other workstreams to participate. The goal is to present state insurance regulators and the NAIC with practical strategies and opportunities for better meeting the needs of underserved communities.

The Workstream will begin holding open meetings and have significant progress to report to the Special (EX) Committee on Race and Insurance at the Summer National Meeting.

6. **Received a Status Report on Workstream Five**

Commissioner Birrane provided the Workstream Five report and highlighted the Workstream’s work to date and plans for the next few months.

Since the Workstream’s last update to the Special (EX) Committee on Race and Insurance at the 2021 Fall National Meeting, the Workstream met in open session in December 2021 and adopted its draft Principles for Data Collection document.

Commissioner Arnold and Commissioner Birrane stepped into the co-chair positions in January. Commissioner Birrane thanked previous co-chairs, Commissioner Lara and Commissioner Altman, for the foundational work they
led from the inception of the Special Committee. Commissioner Birrane said she and Commissioner Arnold discussed with the previous co-chairs the work they envisioned for the Workstream in 2022.

The Workstream then met in regulator-only session to discuss its focus and full work plan for 2022. The Workstream agreed that its focus should center on: 1) identifying demographic-based barriers to the acquisition and use of health insurance and creating strategies for mitigating or removing such barriers; and 2) understanding the role health insurance can play in addressing inequities in health outcomes and social determinates of health.

The Workstream also agreed on a framework for executing those objectives, including the specific topics the Workstream will focus on this year: 1) benefit design, including examining provider network design and benefit structures; and 2) consumer empowerment and engagement.

The first topic is foundational, as it is critically important that products are inclusive in design and carriers consider the actual health needs of certain communities (e.g., whether formularies are designed to ensure that medications that treat conditions more prevalent among certain demographic groups are offered with no or minimal co-pays, what preventative services look like, and how wellness programs are designed and promoted). Scales and Fitbits may be great incentives for some people to focus on their health, but nutritional support and transportation may be far more important for people whose health is affected by their environment. Likewise, what the network looks like, not only in the traditional sense of the availability of appointments, but the impact of the kind of provider and the cultural competency of providers on the willingness and ability of people to utilize services, must be considered. The model of picking up the phone or going online to navigate physician appointment systems in not familiar or comfortable for everyone, so how carriers are ensuring that their networks take into consideration how care is sought must also be considered.

With respect to the second topic, consumer engagement and empowerment, the Workstream will look at successful strategies for enrollments and facilitating consumer understanding of how to access care through insurance and how to navigate claims issues.

The Workstream also discussed what its end work product should be with respect to these topics and is looking at the development of a guide for state insurance regulators that compiles information about barriers and presents potential tools and strategies for state insurance regulators to use to address these barriers.

The Workstream is mapping out a schedule for completing its work on these topics before the end of the year, and it hopes to meet at least monthly to hear from various stakeholders, such as consumer groups, academics, and industry on the topics it has identified as its focus for this year; i.e., benefit design and consumer empowerment.

With respect to the second objective, the Workstream discussed holding listening sessions, potentially in conjunction with Zone meetings, with community-based individuals and organizations who work with various disadvantaged and historically underserved and underrepresented populations to facilitate a ground zero understanding of how insurance can impact the health outcomes and social determinants of health.

Acting Commissioner Humphreys noted that Pennsylvania looks forward to supporting the Workstream and the document on data principles in the collection of race and ethnicity data. Pennsylvania is moving forward with a statement of policy, which is a statement that Pennsylvania will not enforce existing guidance that prohibits insurers on an application from asking for race and ethnicity information on a voluntary basis and subject to privacy and other protections.
7. **Discussed the Innovation, Cybersecurity, and Technology (H) Committee Collaboration Forum – Detecting and Addressing Unfair Bias**

Commissioner Birrane provided an update on the Collaboration Forum that has been established within the Innovation, Cybersecurity, and Technology (H) Committee and the work on algorithmic bias that will be the first project of the Forum.

For context, an important and foundational charge of the Committee is facilitating coordination and collaboration among NAIC work groups, also called related groups, that are addressing issues that concern innovative technologies, cybersecurity, and privacy. The Committee leadership met with the leadership of all other letter committees and other relevant groups, such as the Special (EX) Committee on Race and Insurance Workstreams Three, Four, and Five, to establish a framework for interface between the Committee and those related groups. The Collaboration Forum has been established within the Committee for coordination and collaboration among related groups on innovation, cybersecurity, and technology topics that are of broad impact to ensure foundational matters are addressed and decided with the full complement of SMEs and disciplines involved. There are very few things within the industry that are not affected by innovation, cybersecurity, and technology issues, and when those issues are being addressed by multiple working groups, it is important that to consider where a common framework is necessary and ensure that that common framework is established through consensus so each group can move forward with confidence from that firm foundation as they address the application of the pertinent issues within the scope of their charges.

When an innovation, cybersecurity, and technology related topic being addressed by multiple NAIC working groups is identified and it is agreed that collaboration and coordination is important, a project will be established within the Collaboration Forum. The members of the project will be the leadership of each NAIC working group that is working on the topic and any other state that wishes to join. There will be a chair and vice chairs, as necessary, for each project, and the project members will identify the scope of their collaborative work, like what common elements are to be determined, what the deliverable is, and what the work plan and time frame are. Projects will operate like any other NAIC working group, meetings will generally be open, and the work will be inclusive and transparent with opportunity for stakeholder input.

The first project of the Collaboration Forum is the Algorithmic Bias Project. Algorithmic bias describes systematic errors in AI/ML driven computing systems that result in discriminatory outcomes. Insurers make important decisions about marketing, underwriting, pricing, claim processing, and fraud detection using predictive models that are developed through the application of ML supported computing to data. All are aware that unfair bias can and does creep into AI/ML driven decisional systems and complex predictive models, resulting in unfair discrimination. Therefore, it is important that state insurance regulators are well educated and informed about algorithmic bias, how to address it both with respect to governance frameworks and best practices designed to eliminate or mitigate the risk of such bias and methods for detecting such bias.

There are many NAIC workstreams that are focused on algorithmic bias, including the Casualty Actuarial and Statistical (C) Task Force, the Big Data and Artificial Intelligence (H) Working Group, the Antifraud Technology (D) Working Group, the Accelerated Underwriting (A) Working Group, and the Special (EX) Committee on Race and Insurance’s Workstream Two. Director Wing-Heier and Commissioner Richardson, co-chairs of the Workstream, recognized the need for coordination for the purposes of both consistency and efficiency, and they called a joint meeting, which then blossomed into the Algorithmic Bias Project.

This project will be focused on methods that can be used or relied upon by state insurance regulators in evaluating models used by insurers for unfair bias. A series of educational sessions will be hosted with the objective of developing a practical guide for state insurance regulators that identifies the concerns and provides viable options and tools for state insurance regulators to use.
The next step is to bring together the full complement of related groups and solidify the scope of the Special Committee’s work, which includes looking at: 1) where along the continuum of activity from data creation to model application the Project should focus; 2) with respect to any such activity, what the foundational concepts, definitions, and elements are that underlie each group’s work in this area; and 3) what the necessary common framework is that each group should respect and work from in carrying out their specific charges. All expected deliverables, work plans, and time frames will be made public.

This project will enable NAIC members to come together to address this important topic in a coordinated, efficient, and collaborative manner; it will also be a test case for the Collaboration Forum and what will necessarily be the iterative process of standing up this function.

8. **Heard an Update on the State Diversity Leaders Forum**

Ms. Boswell provided an update on behalf of Workstream Two on the State Diversity Leaders Forum. Looking at the charges of the Workstream, the State Diversity Leaders Forum determined that its mission is to create a communication forum for best practices in DE&I in which each jurisdiction’s insurance department has access to education, guidance, and collaboration with stakeholders; can share and learn ideas to incorporate in their organizations; offers feedback for regulatory training coursework that will be provided by the NAIC; and enables the NAIC and its regulated entities to fully fulfill their mission. A regulator-only website is being created where NAIC members can access the best practices and resources identified by the forum. The forum started with about a dozen state insurance regulators and now has over 20 members. States are encouraged to send their contacts to Ms. Boswell to be included in the forum.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
Draft: 4/12/22

Life Insurance and Annuities (A) Committee
Kansas City, Missouri
April 7, 2022

The Life Insurance and Annuities (A) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Judith L. French, Chair, and Peter Weber (OH); Carter Lawrence, Vice Chair (TN); Jim L. Ridling (AL); Karima M. Woods represented by Philip Barlow (DC); Colin M. Hayashida represented by Melissa Hamada (HI); Doug Ommen (IA); Vicki Schmidt (KS); Marlene Caride (NJ); Barbara D. Richardson (NV); Adrienne A. Harris represented My Chi To (NY); Cassie Brown and Mike Boerner (TX); Scott A. White and Craig Chupp (VA); and Nathan Houdek (WI). Also participating was: Fred Andersen (MN).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner White made a motion, seconded by Commissioner Caride, to adopt the Committee’s Dec. 15, 2021, minutes (see NAIC Proceedings – Fall 2021, Life Insurance and Annuities (A) Committee). The motion passed unanimously.


Commissioner Arnold gave the report of the Accelerated Underwriting (A) Working Group. She said the Working Group met Feb. 23 and March 24 in lieu of meeting at the Spring National Meeting. She explained that during each meeting, the Working Group reviewed the most recent draft of the *Accelerated Underwriting in Life Insurance Educational Report*, and stakeholders were given an opportunity to highlight their comments. She said the Working Group unanimously adopted the March 4 draft of the Educational Report during its March 24 meeting.

Commissioner Arnold explained that the Educational Report started with an outline exposed for public comment in late 2020. She said an ad hoc group made up of six or so state insurance regulators convened to draft the Educational Report and synthesize comments that were incorporated into subsequent drafts. She explained that starting with the outline, sections of the report were completed and released for comment, with each set of comments incorporated into the next exposure draft. She said stakeholders had many opportunities to comment as the paper was developed, which included the ability to comment on previous sections in light of later sections. She explained that the first section of the report was exposed for comment in May 2021, additional sections were exposed in July 2021, the entire paper was exposed for comment in November 2021, and a revised draft was exposed for comment in January. The March 4 draft was exposed for a final two-week comment period to identify any novel issues or errors of fact, and it was adopted by the Working Group on March 24.

Commissioner Arnold said the Working Group made every effort to keep this document narrowly focused on accelerated underwriting in life insurance, recognizing that there are a lot of other groups at the NAIC working on related issues, including the Innovation, Cybersecurity, and Technology (H) Committee and several of its working groups. She explained that the Educational Report is intended to impart information gathered by the Working Group through presentations. It identifies issues and makes broad recommendations, largely following the lead of the NAIC Principles on Artificial Intelligence. Commissioner Arnold emphasized that the Working Group does not envision this Educational Report being the final word on accelerated underwriting in life insurance, rather it provides a solid start.
Ms. To asked for more information about what the Working Group plans to do next, specifically whether it plans to address the questions forwarded by Birny Birnbaum (Center for Economic Justice—CEJ) during the Feb. 23 meeting. Commissioner Arnold said she envisions the Working Group working on regulatory guidance, which it can accomplish under its current charge. She said there will be a need to coordinate and be consistent with the efforts of the other groups working on similar issues, particularly the Innovation, Cybersecurity, and Technology (H) Committee and its work on algorithmic auditing. She said there is a specific need for guidance for state insurance regulators with respect to accelerated underwriting in life insurance, and she envisions the development of specific questions states could ask and approaches to take.

Mr. Birnbaum said he participated, along with Brendan Bridgeland (Center for Insurance Research—CIR) and Peter Kochenburger (University of Connecticut School of Law), and he did not think the Educational Paper was particularly good. He said it did not say anything other than watch out for unfair discrimination, which is so obvious and vague it is almost not worth mentioning. He encouraged the Working Group to work on specific guidance for the use of accelerated underwriting. He gave a couple of examples of specific guidance he would like to see. He mentioned that consumer protections in place for the use of credit information in home and auto insurance should be extended to life insurance. He also said the use of facial analytics is known to be biased against people of color in law enforcement and should be targeted for regulatory review if it is used in accelerated underwriting. Mr. Kochenburger said he agrees with Mr. Birnbaum and would like to see specific recommendations around transparency, which the Educational Report rightly highlights as a recommendation. He said specific guidance for state insurance regulators, consumer, and industry about what transparency means and how it is to be accomplished in the context of increasingly sophisticated models and without special expertise is the kind of specific recommendation that he would welcome from the Working Group.

Commissioner Houdek made a motion, seconded by Commissioner Lawrence, to adopt the report of the Accelerated Underwriting (A) Working Group, including its March 24 (Attachment One) and Feb. 23 (Attachment One-A) minutes, as well as the March 4 draft Accelerated Underwriting in Life Insurance Educational Report (Attachment Two). The motion passed with New York abstaining.

3. Heard a Federal Update on the Implications of the DOL Fiduciary Rule

Brooke Stringer (NAIC) explained that the U.S. Department of Labor (DOL) indicated that it is planning to work on a revised Fiduciary Rule for retirement advice, and the Government Relations (EX) Leadership Committee is interested in feedback from the Life Insurance and Annuities (A) Committee and its stakeholders.

Ms. Stringer said state insurance regulators, the DOL, the U.S. Securities and Exchange Commission (SEC), and the Financial Industry Regulatory Authority (FINRA) all have a role in the administration and enforcement of standards for retirement plans and products within their jurisdiction. She said depending on the financial products offered and the financial services provided, an insurance agent could be subject to overlapping regulations at the state and federal level, particularly if they work with products or provide services related to 401(k) plans covered by the federal Employee Retirement Income Security Act of 1974 (ERISA). She said it is anticipated that the DOL will soon unveil a new Fiduciary Rule for retirement advice this spring.

Ms. Stringer explained that the DOL started its work on a Fiduciary Rule in 2010, which was withdrawn. Then, the Obama administration proposed and finalized a Fiduciary Rule for retirement plans. In that rule, the definition of fiduciary required that retirement advisors act in the best interests of their clients and put their clients’ interests above their own. The NAIC has not taken a position on that Fiduciary Rule, but it submitted two comment letters over the years that were included in the meeting materials.

Ms. Stringer explained that in 2018, the U.S. Court of Appeals for the Fifth Circuit vacated the Obama administration’s Fiduciary Rule for retirement advice. She said in 2020, the Trump administration released its own
proposed rule. That new rule included exemptions to fiduciary conduct if providers adhered to “impartial conduct standards” modeled after the SEC’s Regulation Best Interest. The Trump administration rule was supposed to go into effect in 2021, but the Biden administration delayed enforcement through early 2022.

Ms. Stringer said since last year, the DOL has indicated that further guidance would be forthcoming, and the potential for further rulemaking was included on its regulatory agenda. She said the NAIC does not know specifics, but it believes the DOL guidance is likely to revisit the definition of fiduciary, along with potential additional changes to the existing prohibited transaction exemptions.

Patrick C. Reeder (American Council of Life Insurers—ACLI) said a fiduciary standard is not a bad standard, and it is an appropriate legal standard for situations where there is an ongoing relationship providing financial advice. He said the problem with the DOL proposal is that it is a fiduciary-only approach, which would eliminate commission-based sales; i.e., the way that lower and mid-range clients buy products. He said the DOL should recognize the changes that have taken place since 2017. He said both the SEC’s Regulation Best Interest standard and the NAIC best interest revisions to the Suitability in Annuity Transactions Model Regulation (#275) provide a strong standard of care that is vigorously enforced. He said state insurance regulators have a strong story to tell, and the DOL needs to hear from the NAIC.

Jason Berkowitz (Insured Retirement Institute—IRI) said the states have done a great job adopting the best interest revisions to Model #275. He said a fiduciary relationship is appropriate when there is a special relationship of trust and confidence. He said the best interest standards emulate the fiduciary standard but ensure that the small and mid-sized savers are not disadvantaged. He said he does not agree with assertions that annuity suitability is not robust, and he said the regulatory environment has changed. He encouraged the NAIC to reach out to the DOL and to report how things are working.

Micah Hauptman (Consumer Federation of America—CFA) said there are gaps in the current regulatory framework. He said he does not believe consumers’ reasonable expectations are being met. He said the DOL should require a fiduciary duty, regardless of what products are being sold or how they are being sold. He said consumers all expect and deserve high quality advice without the taint of conflicts of interest.

4. **Adopted the Report of the Life Actuarial (A) Task Force**

Mr. Boerner said the report of the Life Actuarial (A) Task Force was included in the materials, but he is going to highlight three of the efforts going on at the Task Force. He said the first topic was the economic scenario generator (ESG). In 2017, the American Academy of Actuaries (Academy) informed the Task Force that it did not have the resources to continue to maintain the prescribed ESG. He said the need for a replacement ESG was further heightened in 2019 when the Financial Stability (E) Task Force noted a potential deficiency in the prescribed ESGs related to a limited reflection of extended periods of low and even negative interest rates. At that time, the Financial Stability (E) Task Force requested that the Valuation Analysis (E) Working Group assess the macroprudential risk to insurance organizations in the U.S. with a focus on variable annuity writers.

In July 2019, the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group requested that NAIC staff consider issuing a Request for Proposal (RFP) for a vendor to build and maintain a new ESG to be used in the determination of statutory reserves and capital. Mr. Boerner said development of this RFP included extensive work with state insurance regulators and ESG subject matter experts (SMEs) from the life insurance industry. He said the NAIC issued the RFP in March 2020. Six companies submitted proposals, and Conning was selected as the ESG vendor and approved by the Executive (EX) Committee in September 2020.

After the contract with Conning was in place, state insurance regulators worked in ESG Drafting Group calls with Conning, NAIC staff, and industry SMEs. He said there were weekly calls over most of the past year to develop
recommendations to the Task Force and the Working Group for a June field test. He said these recommendations relate to scenarios from a Treasury model, scenarios from an Equity model, and scenarios from a Corporate Bond model.

Mr. Boerner explained that some of the significant collaborative work over this past year includes: 1) development of acceptance criteria for the Treasury model, which included statistics and input from SMEs; 2) development of scenarios by Conning for an alternative Treasury calibration requested by SMEs. These scenarios are included as one of the proposed Treasury models to field test; and 3) work performed by Conning to alter the international equity indices, as requested by SMEs, to align the fund’s expected returns on a risk/reward basis relative to the U.S. large cap fund for the Equity model.

Mr. Boerner also said another example of the collaborative work is the plans for Conning to work on the development of a Simplified Corporate Bond model, which is requested by SMEs to have full transparency for this model. While Conning’s Corporate Bond model reproduces key dynamics of bond returns, some of the information in their model is proprietary. Given the amount of work needed to develop this Simplified Corporate Bond model, it will not be available for the June field test, and the Conning Corporate Bond model will be used instead. However, the intent is for the Simplified Corporate Bond model to have similar scenarios to the Conning Corporate Bond model so the use of the Conning model will be relevant for this June field test.

Mr. Boerner said weekly ESG Field Test calls have now replaced the weekly ESG Drafting Group calls to expedite preparation for the June field test. These calls continue to have industry SME representation. He said achieving the June field test is very important to help determine the impact on industry reserves and capital and help state insurance regulators understand the materiality of technical issues brought up by the industry SMEs. He said there are other weekly ESG planning calls, which include ACLI and Academy representation to support planning for future efforts and calls of the ESG initiative. He said joint Task Force and Working Group calls will also continue. He said the upcoming April 14 joint call will include discussion of comments requested on an exposure regarding models proposed for the June field test.

Mr. Boerner said some key next steps prior to the ESG June Field Test include: 1) any refinement of the recommended ESG models for field testing; 2) building out field test specifications, instructions for participants, and a results template; 3) determining the final set of field test participants and field test product coverage; and 4) preparing the necessary scenario sets for delivery to field test participants.

Mr. Boerner said next steps after the June field test include: 1) analysis of the field test results; 2) adjustments of ESG models, as appropriate; 3) development of the Simplified Corporate Bond model, as mentioned previously; and 4) planning for a field test early next year of expected adjustments to models.

Mr. Andersen gave an update on the Asset Adequacy Testing Actuarial Guideline. He said the Asset Adequacy Testing Actuarial Guideline was part of a coordinated NAIC effort regarding the oversight of the increase in private equity and complex assets in the life insurance industry. He explained that the Task Force is focused on aspects related to reserve adequacy, and it is working to help ensure life insurers involved in complex assets will be able to pay claims even if those assets do not perform as expected.

Mr. Andersen said the Task Force met March 31 to discuss comments on a first draft of an actuarial guideline that would provide documentation and sensitivity testing requirements on life insurers engaged in such activity. He said he expects that a guideline will be adopted by the NAIC at the Summer National meeting. He explained that partly due to the aggressive timeframe, some of the more controversial aspects that were in the first draft, including application of guardrails that could directly affect the financials of some insurers, will likely be deferred to later discussions that are not part of the aggressive 2022 time frame.
Mr. Andersen explained that the resulting documentation and sensitivity tests that will likely be included in the 2022 guideline adoption will provide information to state insurance regulators, including: 1) analysis of the risks of the complex assets; 2) details underlying the assumptions on how those assets will perform; 3) expectations on the sophistication of the company models matching the complexity of the assets; and 4) assurance that any counterparty risk related to reinsurance deals are considered and documented. He said he anticipates movement to turn the first draft into a final draft that is ready for adoption over the next several weeks. He said Committee members should follow the activities of the Task Force if they are interested in the topic.

Mr. Weber gave an update on the Indexed-Linked Variable Annuity Actuarial Guideline. He explained that in the summer of 2021, the Life Insurance and Annuities (A) Committee directed the Task Force to set up a subgroup to study index-linked variable annuities (ILVAs) with the charge to: “Provide recommendations and changes, as appropriate, to nonforfeiture, or interim value requirements related to index-linked variable annuities.”

Mr. Weber explained that ILVAs, also known as registered index-linked annuities (RILAs), have become very popular over the past five to 10 years. He said they fill a space in the market between fixed indexed annuities and traditional variable annuities. He said ILVAs are filed in the states as variable annuity products and are exempted from the Standard Nonforfeiture Law for Individual Deferred Annuities (#805). He said the main issue the Subgroup is trying to address is that if a product is exempted from the consumer protection of nonforfeiture requirements as a variable product, then it must behave like a variable product. It is important that values provided at surrender of an ILVA are consistent with how a variable product provides surrender values. Mr. Weber said to that end, the Subgroup exposed a proposed actuarial guideline in November 2021. He said many comments were received and incorporated into a second draft exposed April 1 for a 30-day public comment period.

Mr. Birnbaum said indexed universal life (IUL) insurers are using unrealistic crediting rates with unrealistic expectations. He said state insurance regulators tried to reign them in, most recently with Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest (AG 49) and then Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A), but insurers continue to game the system and illustrate unrealistic and deceptive policy accumulations. He said these discreet fixes are not solving the problem. He said the problem is the illustrations; they do not show risk. He said annuity illustrations requirements do not cap crediting rates, so insurers turn to bespoke indexes created by investment banks by data mining historical experience to falsely present potential future earnings. He said some illustrations show investment returns higher than the cost of a loan, which falsely suggest that it makes sense for people to borrow money to invest in life insurance products. He said insurance producers become de facto investment advisors. He said the Committee needs to address illustrations and engage experts in consumer disclosures to address these issues.

Mr. Boerner made a motion, seconded by Mr. Chupp, to adopt the report of the Life Actuarial (A) Task Force. The motion passed unanimously.

5. Discussed Next Steps for the Life Insurance Online Guide (A) Working Group

Director French gave a brief history of the Life Insurance Online Guide (A) Working Group. She explained that the Working Group initially considered developing an online resource that could allow for a deep dive into complex content in a way that would not be possible in paper format. She also said the Working Group struggled with how best to structure the content, as well as how it might look and function.

Director French said the idea of a decision tree came up, but while a decision tree could be a great in theory, it is, for several reasons, beyond the scope of what the Working Group or even the NAIC can undertake. She said her goal is to come up with something achievable.
Director French explained that the details about life insurance are state-specific. She also said the NAIC is not where people are going to go to find out about life insurance, nor can the NAIC provide any advice about what life insurance to purchase. She said people need to go to their state or an insurance producer.

Director French asked Laura Kane (NAIC) to give an overview of what is on the NAIC website. She explained that information about what is currently on the NAIC website will enable the Committee to better consider what content should be added to the website and what the Working Group can reasonably achieve under its charge.

Ms. Kane gave an overview of the statistics collected for the life insurance pages on the NAIC website. She said there have been 23,147 unique page views over the past year. She explained the breakdown of the percentage of those who viewed the pages. She said 13% were age 18–24, 21% were age 25–34, 23% were age 35–44, 20% were age 45–54, 13% were age 55–64, and 10% were age 65 or older. Of those, the 23% that were age 35–44 spent the most time on page, the 13% that were age 18–24 spent the second-most amount of time, and the 10% who were age 65 or older spent the least amount of time.

Ms. Kane explained that the purpose of the consumer pages is to: 1) educate consumers about the purpose of each insurance type; 2) guide consumers to know what to ask a licensed agent; 3) remind consumers to check their state’s department of insurance (DOI) website to confirm that the agent and the company are licensed in the state; and 4) let consumers know their state DOI is there to help with any questions or issues. She summarized the information that is on the web pages and identified information that she found on some other DOI websites that might be good to consider including on the NAIC website. For example, Kansas has good shopping tips, Nevada has a good “Understand the products you are buying” section, New York has a good statement of purpose around life insurance, and Texas has a good chart comparing the major types of life insurance. Ms. Kane mentioned that the NAIC could consider linking to a glossary of terms, as well as translating the Buyers Guide to Spanish and other languages.

Director French asked for volunteers to work with her staff and Ms. Kane to participate on the Working Group to update the NAIC web pages on life insurance.

6. **Heard an Update on Workstream Four of the Special (EX) Committee on Race and Insurance**

Director French updated the Committee on Workstream Four of the Special (EX) Committee on Race and Insurance. She explained that she is the Workstream Four co-chair, along with Commissioner Caride. She said the Workstream will be focusing its efforts on the marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays. She said the plan is to schedule some presentations focusing on this issue.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met March 24, 2022. The following Working Group members participated: Grace Arnold, Chair (MN); Nathan Houdek, Vice Chair (WI); Jason Lapham (CO); Russ Gibson (IA); Cynthia Amann (MO); Chris Aufenthie (ND); Lori Barron (OH); and David Hippen (WA).

1. **Adopted its Feb. 23 Minutes**

Commissioner Arnold said the first agenda item was to adopt the Accelerated Underwriting (A) Working Group’s Feb. 23 meeting minutes. During this meeting, the Working Group reviewed comments on the Jan. 25 draft of the accelerated underwriting (AU) in life insurance educational report.

Ms. Amann made a motion, seconded by Mr. Aufenthie, to adopt the Working Group’s Feb. 23 minutes (Attachment One-A).

2. **Discussed Comments Received on the March 4 Draft of the AU in Life Insurance Educational Report**

Commissioner Arnold reminded the Working Group that during its Feb. 23 meeting, the Working Group discussed comments on the Jan. 25 draft of the AU in life insurance educational report. As a result of the comments received on the Jan. 25 draft and the discussions during the Feb. 23 meeting, the report was revised, and the March 4 draft was exposed for a 14-day public comment period ending March 18. Commissioner Arnold said that several interested parties had submitted written comments on the March 4 draft, which are posted on the Working Group’s web page.

   a. **University of Georgia**

Brenda J. Cude (University of Georgia) briefly summarized her comment letter. She said that she is concerned that the paper makes no mention of the great need for consumer information and education about AU, yet the paper indirectly makes the case for the need to inform and educate consumers on this topic. She said, at a minimum, she would like the Working Group to consider a charge for the future that could involve creating some language that state insurance departments could use to inform and educate consumers. She also said that these materials could be useful for other educators, as well to help consumers understand this topic. She said she envisions a Working Group similar to the Consumer Information (B) Subgroup to work on consumer-facing materials.

   b. **ACLI**

David Leifer (American Council of Life Insurers—ACLI) briefly summarized the ACLI comments. He said that the ACLI had some minor language suggestions to the paper. He explained that one suggestion was to repeat the language within the definition of AU that says “which may include the use of non-traditional, non-medical data” to other places in the paper where it is not explicitly included.
### c. Academy

Sue Bartholf (American Academy of Actuaries—Academy) said that the Academy’s Life Underwriting and Risk Classification Work Group has been following the work of this Working Group and appreciates that this paper is a high-level synthesis of the presentations provided to the Working Group. She said that the Academy remains concerned that because it is a summary, it does not necessarily capture all of the variations in accelerating underwriting and the different perspectives of those commenting. She said that given that this paper has the potential to become a resource for policymakers, regulators, and others, the Academy has submitted the following language for inclusion in the opening paragraph to explicitly call out the limitations of the paper:

*This paper is a high-level summary of the comments provided to and work done by the Accelerated Underwriting (A) Working Group. It is not intended to be a comprehensive document and does not address all the differences and nuances of accelerated underwriting programs or all underwriting practices used by life insurers. It is a point-in-time paper of the rapidly evolving underwriting process.*

Commissioner Arnold said she appreciates the Academy’s comments and that there are a number of places in the paper that contextualize the information as being representative of this point in time. She said that the Working Group understands that these processes are evolving.

### d. Pilotbird

Evgeny Aleksandrov (Pilotbird) said he had submitted comments suggesting that the potential benefits of AU to consumers should have more emphasis in the paper.

### e. CEJ

Birny Birnbaum (Center for Economic Justice—CEJ) said that the draft report did not fulfill its charge to “[c]onsider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, drafting guidance for the states.” He said the definition in the paper does not focus on external data; rather, it incorrectly says that AU may include nontraditional, non-medical data, when that is in fact the distinguishing feature of AU. He said that if all insurers were doing was applying machine learning (ML) and artificial intelligence (AI) to traditional medical data, that would represent an evolution—not the revolution he is seeing.

Mr. Birnbaum also said the report offers no guidance to the states and references only that states and regulators should be guided by current law related to fair trade practices and unfair discrimination and develop and update relevant laws to adapt to developing practices to avoid unfair trade practices and unfair discriminatory practices. He said these statements suggest that no specific guidance, authorities, or resources are needed. He said the report is six years too late to be meaningful or useful. He said the report represents a lack of insight after six years of study. He recommended the Working Group discard the report and refocus efforts on addressing its charge.

Mr. Birnbaum asked for feedback regarding the Working Group’s thinking with respect to the comments he submitted in the form of questions at the last national meeting. He said that the Working Group has not been transparent in its decision-making. He asked why, in particular, the Working Group was not recommending that states apply the same requirements they apply to consumer credit information.

Commissioner Arnold said that the Working Group hopes, as its next work product, to develop regulatory guidance that builds on the report. She said that the drafting group did discuss Mr. Birnbaum’s comments and will likely
have future conversations that Mr. Birnbaum is welcome to participate in as it considers what is feasible with current resources.

f. University of Connecticut School of Law

Peter Kochenburger (University of Connecticut School of Law) said he understands that the paper is not likely to be abandoned, but he said he is interested in the reasoning behind why some of Mr. Birnbaum’s comments were not included in the paper. He said he is pleased to hear the work is going to continue and asked about the process and whether there was a timeline.

Commissioner Arnold said she anticipates that if the Life Insurance and Annuities (A) Committee adopts the Report, there would then be a discussion of next steps for the Working Group at the Life Insurance and Annuities (A) Committee meeting at the Spring National Meeting. She anticipated that next steps would include work for the remainder of this year.

3. Adopted the March 4 Draft of the AU in Life Insurance Educational Report

Commissioner Arnold said that she appreciates all the comments, but the Working Group is not planning to make any additional changes to the paper.

Ms. Amann made a motion, seconded by Commissioner Houdek, to adopt the March 4 draft of the AU in life insurance educational report (Attachment Two). The motion passed unanimously.

Commissioner Arnold said that the plan is to have the paper go through a final editorial review to fix any grammatical or typographical errors. The Life Insurance and Annuities (A) Committee will consider the paper for adoption at the upcoming Spring National Meeting. Once adopted, it will become a Committee work product, be part of the NAIC Proceedings, and posted on the Life Insurance and Annuities (A) Committee page.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met Feb. 23, 2022. The following Working Group members participated: Grace Arnold, Chair (MN); Nathan Houdek, Vice Chair (WI); Jason Lapham (CO); Russ Gibson (IA); Cynthia Amann (MO); Chris Aufenthie (ND); Lori Barron (OH); and Lichiou Lee (WA).

1. **Discussed Comments Received on the Jan. 25 Draft Accelerated Underwriting in Life Insurance Educational Report**

Commissioner Arnold explained that she will be chairing the Working Group in 2022 along with Commissioner Houdek as vice chair. She reminded the Working Group that it last met Dec. 6, 2021, to discuss the Nov. 8, 2021, draft Accelerated Underwriting in Life Insurance Educational Report. As a result of the comments received on the Nov. 8, 2021, draft and the discussions during the Dec. 6, 2021, call, the report was revised; and the Jan. 25 draft Accelerated Underwriting in Life Insurance Educational Report (Attachment One-A1) was exposed for a public comment period ending Feb 11. Commissioner Arnold explained that the purpose of the virtual meeting today is to discuss comments received on the latest draft.

   a. **Academy Comment**

   Linda Lankowski (American Academy of Actuaries—Academy) explained that the Life Underwriting and Risk Classification Work Group of the Academy submitted a comment letter on the Jan. 25 draft Accelerated Underwriting in Life Insurance Educational Report. She highlighted a couple of main points that are raised in the Academy comment letter. She explained that the revisions made to the footnote in the report involving Actuarial Standard of Practice (ASOP) No. 12 need some additional revisions. She explained that the bullet point referencing ASOP No. 12 describes a practice that would not be allowed under ASOP No. 12. The letter suggests revising the current bullet that says, “Non-traditional data may be used to predict mortality, but the actual or reasonably anticipated experience may not correlate to risk of insurance loss” to say, “In accordance with ASOP No. 12, an actuary needs to demonstrate that a relationship between a risk characteristic and an expected outcome exists. This standard applies for any data used, traditional or non-traditional.” Ms. Lankowski also mentioned that not all accelerated underwriting (AU) programs are discussed with actuaries and data scientists, and underwriters do not have standards of practice like actuaries do.

   Ms. Lankowski said the Academy comment letter reiterates a couple of points included in the Academy’s previous letter regarding recommendations that indicate that they refer to state insurance regulators’ and form reviewers’ current responsibilities when they would actually be new requirements. She also said this paper, and the definition in particular, is likely to be used in other contexts, and it is particularly important to get it right. She said AU uses traditional and non-traditional data, and the definition of AU needs to accurately reflect that.

   b. **ACLI Comment**

   David Leifer (American Council of Life Insurers—ACLI) gave some brief highlights of the ACLI comment letter. He said the comment letter suggests having a more thorough discussion of traditional underwriting before turning to AU and comparing the two.
Mr. Leifer also mentioned that the ACLI continues to have concerns about the definition of AU in life insurance included in the most recent draft of the report. He explained that the ACLI believes that this definition will be used by other groups and in other contexts, which makes its accuracy particularly important. He said the following definition in the Jan. 25 draft is a little too broad:

Accelerated underwriting is life insurers’ use of big data, artificial intelligence and machine learning to underwrite life insurance in an expedited manner. For example, a process to replace traditional underwriting and allow some applications to have certain medical requirements, e.g., paramedical exams and fluid collection, waived. What distinguishes accelerated underwriting from traditional life insurance underwriting is the use of non-traditional, non-medical data using predictive models or machine learning.

Mr. Leifer said the ACLI is concerned that this definition may bring in things that are not commonly understood to be AU. He said the ACLI prefers the definition in the Nov. 8, 2021, draft, with a very minor tweak, to the version in the current draft, which would read:

Accelerated underwriting in life insurance is a process to replace traditional underwriting and allow some applications to have certain medical requirements, e.g., paramedical exams and fluid collection, waived. The process generally uses predictive models or machine learning algorithms to analyze data pertaining to the applicant, which may includes both traditional and non-traditional underwriting data provided by the applicant directly, as well as data obtained through external sources.

Commissioner Arnold asked for the ACLI to share the specific things the current definition of AU may include that it should not. She explained that one of the challenges in drafting a definition of AU is that there does not appear to be a common understanding of what AU is or how it is used in practice, so specifics regarding what the ACLI sees as the practical implication of the current definition would be helpful. Mr. Leifer said he would share specifics with Jennifer R. Cook (NAIC) following the meeting.

c. **CEJ Comments**

Birny Birnbaum (Center for Economic Justice—CEJ) opposed the ACLI proposal to return to the Nov. 8, 2021, definition of AU. He said the ACLI proposal does not define what AU is but rather addresses the purpose of AU. He disagreed with the ACLI comment that the Jan. 25 definition is overly broad. He said the Nov. 8, 2021, definition is not useful in the context of educating state insurance regulators and stakeholders about AU to find a basis for recommendations for insurers and state insurance regulators regarding the use of AU. He said the proposed definition serves no purpose other than to promote AU. He said the proposed ACLI definition fails to identify the key distinguishing factors between traditional underwriting and AU, which is the use of new sources of data intended to be used with predictive modeling.

Mr. Birnbaum asked why the Working Group is not making recommendations based on its research. He said state insurance regulators need to improve their capabilities and authorities to address some of the issues that have arisen with AU in the same way that state insurance regulators who work on homeowners and auto insurance have said they need new authorities and resources. He posed the following questions to understand the Working Group’s thinking and start a discussion:

1. Why are you not recommending that states apply the same requirements for the use of consumer credit information in life insurance as those found for personal auto and homeowners, including filing of models for review and limitations on certain types of consumer data, such as medical debt?
2. Why are you not recommending that states routinely require life insurers to report the sources and uses of non-medical information in underwriting so state insurance regulators, and policymakers, stay current on insurer practices?

3. Why are you not recommending that states require life insurers to file AU models with state insurance regulators for review prior to use?

4. Why have you not identified the use of biometric information as a topic of particular concern given the racial bias in facial recognition and other biometric tools? As a corollary, why have you not discussed the Illinois Biometric Information Privacy Act (BIPA) as a model for consumer protection regarding insurers’ collection, use, and handling of biometric information?

5. Why are you not recommending that the NAIC expand the scope of its algorithmic assessment resource to include the review of AU models?

6. Why are you not recommending a requirement for insurers to test their AU models for racial bias, particularly given the industry’s history of race-based pricing and the racial bias found in various types of non-traditional data?

7. Why are you not recommending that at least the federal Fair Credit Reporting Act (FCRA) consumer protections—i.e., disclosure, access, error correction, recalculation—be applied to all data sources used in AU?

8. Why are you not recommending robust data collection to enable state insurance regulators to examine how insurers’ use of AU affects the availability and affordability of insurance, particularly in traditionally underserved communities and markets?

9. Why are you not recommending new training for state market conduct personnel regarding oversight of insurers’ AU practices? As a corollary, why are you not recommending that the Market Conduct Examination Guidelines (D) Working Group develop standards and procedures for the market conduct examinations you suggest related to AU?

10. Finally, what is the basis for your conclusion that existing authorities and resources are sufficient for consumer protection?

Commissioner Arnold said the questions Mr. Birnbaum posed provide the Working Group with a lot to consider with respect to future work. She reiterated that the educational paper was purposefully narrowly focused on the current state and making basic recommendations. She said the Working Group hopes to get additional information from the Big Data and Artificial Intelligence (H) Working Group survey looking into AU in life insurance, which would provide some additional information for the Accelerated Underwriting (A) Working Group and inform future work.

Mr. Birnbaum said he has been struck by the movement of this issue around to different working groups within the NAIC, and he asked the Working Group, as the subject matter experts (SMEs), to address the issue of AU in life insurance. He also asked the Working Group to advise the Market Conduct Annual Statement Blanks (D) Working Group to finish the AU edits to the life insurance Market Conduct Annual Statement (MCAS) it is holding pending a final definition by the Accelerated Underwriting (A) Working Group. He said the Working Group needs to explain that there may be slightly different definitions depending on the context in which they are being used, but if the edits are not finished by June 1, data will not be collected until 2025.
d. **Comment from Consumer Representatives**

Brendan Bridgeland (Center for Insurance Research—CIR) and Peter Kochenburger (University of Connecticut School of Law) submitted a joint comment letter. Mr. Bridgeland said a current flaw of the paper, in his and Mr. Kochenburger’s opinion, is that there are not enough recommendations. He said he supports the list of questions mentioned by Mr. Birnbaum. He mentioned that the paper states that state insurance regulators should be guided by current law, and it almost seems to suggest that this as an optional practice. The comment letter suggests adding the following language to point to the need for additional action, “When examining accelerated underwriting practices, regulators should be guided by current laws related to fair trade practices and unfair discrimination, and also recognize that the use of big data and artificial intelligence over the last five years has demonstrated that these standards need to be updated to meet these new challenges, and perhaps new regulatory tools added.” He said state insurance regulators should avoid playing catch-up to the practices in the marketplace.

Mr. Bridgeland also suggested that certain practices should be called out as requiring a heightened level of caution. He specifically mentioned that criminal history data has inherent racial bias, and facial analysis and facial recognition programs have a particular potential to lead to unfair outcomes. He mentioned the documentary film “Coded Bias” that the NAIC screened in March 2021, which explored the racial bias of facial recognition technology.

Commissioner Arnold said the educational paper will be revised based on the comments submitted and the discussion today. She said what she hopes will be a final draft of the paper will be exposed for a two-week public comment period limited to new issues and errors of fact. She said the Working Group will meet to consider adoption of the revised educational paper, and it plans to bring it to the Life Insurance and Annuities (A) Committee for its consideration at the Spring National Meeting.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
DRAFT January 25, 2022

Revision marks show changes from the Nov. 8, 2021 Draft
Comments should be sent to Jennifer Cook at jcook@naic.org by close of business February 11, 2022.

Accelerated Underwriting (A) Working Group
Ad Hoc Drafting Subgroup

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Introduction

In 2019, the National Association of Insurance Commissioners (NAIC) established the Accelerated Underwriting (A) Working Group to consider the use of external data and data analytics in accelerated life insurance underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, draft guidance for the states. In addition, the 2021 charges of the Special Committee on Race and Insurance direct the working group to include an assessment of and recommendations, as necessary, regarding the impact of accelerated underwriting on minority populations. A more detailed procedural background can be found in the appendix. This paper is the output of over a year’s work by regulators to understand the current state of the industry and its use of accelerated underwriting. It summarizes what the Working Group has learned over the past year, contextualizes that learning and the topic of accelerated underwriting within other NAIC work and standard regulatory product evaluation processes, and makes recommendations for regulators and insurers when evaluating accelerated underwriting.

Accelerated underwriting in life insurance may provide potential benefits to both consumers and insurers, if applied in a fair and non-discriminatory manner. In order to fairly deliver the benefits of more convenient and cost-effective processes, regulators and insurers should be guided by current law related to fair trade practices and unfair discrimination. Regulators and insurers should continue to monitor accelerated underwriting practices as they develop to avoid unfairly discriminatory practices. Much of the discussion in this paper is framed in these general terms. The Working Group believes the charge to specifically address the impact on minority populations is included in these terms, and we have provided examples to illustrate the impact on minority populations. Future work products of the Working Group may address the charge from the Special Committee on Race and Insurance in more detail.

What is Accelerated Underwriting?

Throughout this paper, we use the term accelerated underwriting in life insurance. We propose the following as a definition:

Accelera ted underwriting is life insurance insurers’ use of big data, artificial intelligence and machine learning to underwrite life insurance in an expedited manner. For example, is a process to replace traditional underwriting and allow some applications to have certain medical requirements, e.g., paramedical exams and fluid collection, waived. The process generally uses predictive models or machine learning algorithms to analyze data pertaining to the applicant, which includes both What distinguishes accelerated underwriting from traditional life insurance underwriting is and the use of non-traditional underwriting data provided by the applicant directly, as well as data obtained through external sources, non-medical data using predictive models or machine learning.

Predictive models examine data sets for patterns to predict and assign the risk category, e.g., a model developer enters data points (potentially hundreds of thousands), and the model finds patterns and identifies future
predictions of risk and assigns an insured to a risk category. Machine learning algorithms are a process or set of rules executed to solve an equation, e.g., a life insurance underwriter uses a set of rules to place an individual insured in a particular risk category. The ‘learning’ part of machine learning means that those programs change how they process data over time, much as humans change how they process data by learning. Machine learning often falls into two groups: supervised or unsupervised. The difference between the two is whether the program is directed to analyze patterns or is self-automated.

Predictive models or machine learning trains a system to make judgments when exposed to data that is unfamiliar to serve as a substitute for human-centric decision making. These are both subcategories of artificial intelligence, which should not be confused with a static rule-based algorithm.

Life insurance underwriting is the process of determining eligibility and classifying applicants into risk categories to determine the appropriate rate to charge for transferring the financial risk associated with insuring the applicant. Traditional life insurance underwriting involves, among other elements, assessing the applicant’s physical health, along with other financial and behavioral elements, then determining whether an applicant is eligible for coverage and the risk class to which that individual belongs. Accelerated underwriting relies on non-traditional, non-medical data used within predictive models or machine learning algorithms to perform some of the tasks of an underwriter. The exact parameters of the application of accelerated underwriting vary by insurer.

Presentations made to the Working Group indicated that life insurers use accelerated underwriting in primarily two ways: 1) Accelerated underwriting is used to triage applicants, where unsuccessful applicants are re-routed to traditional underwriting, and successful ones continue through the accelerated underwriting process; or 2) Accelerated underwriting is used to rate applicants based on risk categories.

Most predictive or machine learning algorithms used in life insurance underwriting are in their second or third generation. The COVID-19 pandemic sped up the adoption of accelerated underwriting in the industry as both consumers and insurers looked for options to purchase and write policies that relied more on technology and involved less in-person contact. This has highlighted the need for ongoing monitoring of the machine learning algorithms—both their development and their uses in the marketplace.

Presentations made to the Working Group indicated that adverse underwriting decisions are sometimes reviewed by human underwriters. Companies presenting to the Working Group stated that the accelerated underwriting process is less cumbersome, costs less than traditional underwriting, it expedites the process and requires less

1 For a more detailed discussion of predictive models in property and casualty insurance, see the Casualty Actuarial and Statistical (C) Task Force Regulatory Review of Predictive Models White Paper, Adopted by the Property and Casualty Insurance (C) Committee on Dec. 8, 2020.
2 The Big Data and Artificial Intelligence (EX) Working Group developed a survey to conduct analysis on private passenger automobile (PPA) insurers’ use and governance of big data, as used in an artificial intelligence (AI) and machine learning (ML) system. The survey is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. This analysis will help inform the Working Group in completing its long-term goals of developing guidance and recommendations to update the existing regulatory framework for the use of big data and AI, including how to monitor and oversee the industry’s compliance with the NAIC’s AI principles. The survey work may be expanded to other lines of insurance as needed, such as life insurance and homeowners insurance. For the purposes of the survey only, AI/ML is defined as, “an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result.” This is different from a standard algorithm that consists of a process or set of rules executed to solve an equation or problem in a pre-determined fashion, and evolving algorithms are considered a subset of AI/ML.
consumer involvement in the purchase and improves the underwriting experience for consumers, shortens issue times, and increases policy acceptance rates. 3

General Discussion of Issues and Recommendations

Increasing automation of life insurance underwriting – Life insurers reliance on an increasingly automated underwriting process that uses non-traditional, non-medical data presents new regulatory challenges. Regulators must ensure that the process is fair, transparent, and secure. With regard to accelerated underwriting in life insurance, this concern pertains to input data, the predictive model or machine learning algorithm, and the results of the process. One particular challenge is the potential for unfair discrimination. Due to the fact accelerated underwriting relies on non-traditional, non-medical data and predictive models or machine learning algorithms, it may lead to unexpected or unfairly discriminatory outcomes even though the input data may not be overtly discriminatory. It is critical to test the conclusions up front, on the back end, as well as, randomly, to ensure the machine learning algorithm does not produce unfairly discriminatory ratings or ones that are not actuarially sound. Testing can also be important in determining if a machine learning algorithm is accurate across demographic categories. Such scrutiny is especially important when behavioral data is utilized. Behavioral data may include gym membership, one’s profession, marital status, family size, grocery shopping habits, wearable technology, and credit attributes. Although medical data has a scientific linkage with mortality, behavioral data may lead to questionable conclusions as correlation may be confused with causation without reasonable explanation.

Recommendations

Consistent with the AI Principles approved by the NAIC in 20204, the use of accelerated underwriting in life insurance should be fair and transparent to regulators, consumers and policymakers. Companies should be accountable for operating in compliance with applicable laws, and the process and data companies used needs to be secure. To accomplish these objectives, regulators should dialogue with consumers, life insurers, and third-party vendors to determine if consumer data is being used in problematic or unfair ways or generating unfair outcomes.

Insurers and other parties involved in accelerated underwriting in life insurance should:

- Take steps to ensure data inputs are transparent, accurate, reliable, and the data itself does not have any unfair bias.
- Ensure that the use of external data sources, algorithms or predictive models are based on sound actuarial principles with a valid explanation or rationale for any claimed correlation or causal connection.
- Ensure that the predictive models or machine learning algorithm within accelerated underwriting has an intended outcome and that outcome is being achieved.

4 See National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI) – Fair and Ethical a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, rate making standards, advertising decisions, claims practices, and solvency. b. Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and Remedies for such consequences when they occur.
• Ensure that the predictive models or machine learning algorithm achieve an outcome that is not unfairly discriminatory.
• Be able to provide the reason(s) for an adverse underwriting decision to the consumer and all information upon which the insurer based its adverse underwriting decision.
• Take steps to protect consumer privacy and ensure consumer data is secure.
• Have a mechanism in place to correct mistakes if found.
• Produce information upon request as part of regular rate and policy reviews or market conduct examinations.
Input data

Predictive models or machine learning algorithms within the accelerated underwriting process rely heavily on data and multiple variables. Examples of the variables used by some accelerated underwriting models include customer disclosures, prescription history, digital health records, credit attributes, medical information bureau data, public records, motor vehicle reports, smartphone apps, consumer activity wearables, claim acceleration tools, individual consumer risk development systems, purchasing history, behavior learned through cell phone usage, and social media. Because accelerated underwriting relies on predictive models or machine learning algorithms that use non-traditional, non-medical data, it may lead to unexpected or unfairly discriminatory outcomes, even though the input data may be facially neutral.

Traditional Data

Traditional data used in life insurance underwriting includes data collected through a traditional underwriting process. This data may include the following:

- Application data, e.g., medical records, prescription questions, vocation questions, financial profile
- Tele-interview
- Medical records
- Data from the Medical Information Bureau (MIB) \(^5\)
- Data from Motor Vehicle Records
- Prescription drug history
- Public records, e.g., criminal records, bankruptcy records, civil litigation, etc.
- Paramedical or medical exam, including EKG’s in some instances
- Fluids, e.g., blood, urine, swab/saliva test to determine tobacco usage
- Financial and tax information

Considerations for use of Traditional Data

- Traditional data has a long and established history in the life insurance industry. Carriers, producers, and consumers are generally familiar with the process.
- Traditional data has a history of usage by insurance carriers. Trained underwriters and producers have years of experience and often understand the process well.
- The relationship of the traditional data elements to the risk is well established and consumers generally understand how most of the elements impact their risk classification or premium charged.
- State statutes and case laws were developed based on the use of traditional data containing consumer protections created under the assumption that this was the type of data collected or reviewed during an underwriting process.
- Presentations made to the Working Group represented that time and costs associated with obtaining and reviewing some types of traditional data are significant.

FCRA Data

\(^5\) This data is subject to the Fair Credit Reporting Act (FCRA).
Some data used in traditional and accelerated underwriting is subject to the federal Fair Credit Reporting Act (FCRA), which protects the privacy of consumer report information. If an insurer uses data subject to FCRA in its underwriting, which means applicants:

1. Should have a right to be told if this information is used to deny insurance, and
2. Have the ability to request the data a consumer reporting agency is providing to an insurer, and
3. Have the right to ask a consumer reporting agency to correct any errors in the data.

Considerations for use of FCRA Data
- FCRA data is readily available.
- FCRA data is updated regularly.
- FCRA data is already used in life and property/casualty lines of business.
- There is existing regulation and oversight by the Federal Trade Commission (FTC) and Consumer Financial Protection Bureau (CFPB).
- Not all FCRA data is useful/relevant to life insurance underwriting.
- If there is a dispute about findings the accuracy of FCRA data, a consumer will have to obtain additional information and formally dispute these findings.
- FCRA data is extensive and accessing such data may result in access to non-usable credit attributes. In other words, significantly more data may be collected than is needed to determine risk.
- As additional rating factors are introduced via insurance scores or with specific data elements, unfair discrimination, including disparate impact, may be introduced or amplified.
- FCRA data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.6

Non-traditional Data

Non-traditional data used in life insurance underwriting may include the following:
- Public records, e.g., assessor data, genealogy records, criminal records, court filings, voter information
- Property/casualty data from adjacent carrier(s)
- Marketing and social data, e.g., shopping habits, mortgage amount/lender, occupation and education, and social media, etc.
- Professional licenses
- Biometric data, e.g., voice recognition analysis, used to determine smoking status, facial analysis, and other analytics based on personal physical features and characteristics
- Facial recognition
- Wearable devices

Considerations for use of Non-traditional Data
- Non-traditional data may be used to predict mortality, but there may not be a reasonable explanation for that correlation the actual or reasonably anticipated experience may not correlate to risk of insurance loss.7

6 See Actuarial Standards of Practice (ASOP) No. 12
7 See Actuarial Standards of Practice (ASOP) No. 12, Section 3.2.1 (“The actuary should select risk characteristics that are related to expected outcomes. A relationship between a risk characteristic and an expected outcome, such as cost, is demonstrated if it can be shown that the variation in actual or reasonably anticipated experience correlates to the risk characteristic.”)
• As additional rating factors are introduced via insurance scores or with specific data elements, disparate impact across and between demographic groups may be introduced or amplified.
• Non-traditional data may not have the same consumer protections as FCRA and traditional data. For example:
  o There may not be a clear path for consumers to know how data affected their application and how inaccurate data may be corrected.
  o The type and purpose of data accessed are not required to be disclosed to the consumer.
  o There may be privacy concerns about the extent of the use of non-traditional data.

**FCRA Data**

Some data used in traditional and accelerated underwriting is subject to the federal Fair Credit Reporting Act (FCRA), which protects the privacy of consumer report information. If an insurer uses data subject to FCRA in its underwriting, applicants:

1. Have a right to be told if this information is used to deny insurance,
2. Have the ability to request the data a consumer reporting agency is providing to an insurer, and
3. Have the right to ask a consumer reporting agency to correct any errors in the data.

**Considerations for use of data subject to FCRA:**

- FCRA data is readily available.
- FCRA data is updated regularly.
- FCRA data is already used in life and property/casualty lines of business.
- There is existing regulation and oversight by the Federal Trade Commission (FTC) and Consumer Financial Protection Bureau (CFPB).
- Not all FCRA data is useful/relevant to life insurance underwriting.
- If there is a dispute about the accuracy of FCRA data, a consumer has to obtain additional information and formally dispute these findings.
- FCRA data is extensive and accessing such data may result in access to non-usable credit attributes. In other words, significantly more data may be collected than is needed to determine risk.
- As additional rating factors are introduced via insurance scores or with specific data elements, unfair discrimination, including disparate impact, may be introduced or amplified.
- FCRA data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.⁸

**Recommendations**

Existing regulations apply to accelerated underwriting programs in the same way as traditional underwriting programs. State Departments of Insurance (DOIs) have broad regulatory authority to make inquiries into the processes and procedures of life insurers in order to investigate potential unfair trade practices. Complaints about underwriting practices are opportunities for DOIs to review a life insurer’s use of accelerated underwriting and data collection methods. Additional DOI actions may include market conduct and on-site examinations as appropriate under existing authority.

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⁸ See Actuarial Standards of Practice (ASOP)
Specifically, examiners may:

- Review the life insurer’s underwriting practices and underwriting guidelines during an examination or upon initial submission of the policy rates and forms and confirm the proper use of the data elements.
- Request that explanation provided to the consumer for any negative action taken by the life insurer adequately informs the consumer as to why a particular action was taken without the consumer having to make additional inquiries.
- Request information about source data regardless of whether the data or score is provided by a third party.

Form and rate reviewers may:

- Request that the life insurer provides information about how a predictive model or machine learning algorithm will be used.
- Consider requiring the filing of models used to analyze data.
- Consider questioning the extent to which data elements correlate to applicant risk.
- Request information about source data regardless of whether the data or score is provided by a third party.

Life insurers and third-party vendors have a responsibility to understand the data they are using. To accomplish this, life insurers should conduct post-issue audits and data analysis and make these audits and analysis available to regulators upon request. For example, analyses such as evaluating claims and lapse rates may be helpful. Life insurers and third-party vendors should ensure data inputs are accurate and reliable.

Life insurers and third-party vendors should ensure that the external data sources, algorithms, or predictive models are developed with sufficient internal controls and oversight and based on sound actuarial principles with a valid explanation or rationale for any claimed correlation and causal connection.

Data Privacy

Data privacy—a consumer’s ability to retain control over what data can be shared about them and with whom—is not a concern unique to accelerated underwriting in life insurance. Protecting consumer privacy is an issue across all lines of insurance and is the subject of the NAIC Privacy Protections (D) Working Group, formed in 2019 under the parent committee of Market Regulation and Consumer Affairs (D) Committee.

The Working Group’s charge is to review the state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models and other existing federal or state statutes.  

9 The Working Group has focused its reviews on the Insurance Information and Privacy Protection Model Act #670, and the Privacy of Consumer Financial and Health Information Regulation Model Act #672 – both drafted in response to the enactment of GLBA, and #668 – the Insurance Data Security Model Act, enacted in 2019/20. With a great deal of research assistance from NAIC Legal Staff, the Working Group prepared a gap analysis – upon which it continues to work. The Working Group is also reviewing the consumer data privacy protections other than those already in these models, such as the numerous provisions contained in federal acts such as the Fair Credit Reporting Act (FCRA), the Gramm-Leach Bliley Act (GLBA), the Health Insurance Portability and Affordability Act (HIPAA), Electronic Health Records (EHR), etc. The Working Group is also analyzing the various provisions of recently enacted legislation, such as California’s Consumer Privacy Act (CCPA) and its Consumer Data Privacy Regulation (CCPR), Virginia’s and Colorado’s recently enacted Consumer Privacy Protection laws, certain provisions of the European General Data Protection Regulation (GDPR), the NAIC’s Record...
The primary focus of the Working Group is on the six consumer data privacy rights or types of consumer data privacy protections identified in the NAIC’s Member adopted *Strategy for Consumer Data Privacy Protections* policy statement. The secondary focus is on issues such as notice requirements and standards, disclosure of information collected, disclosure of shared information, requirements to disclose sources of information, requirements to disclose business purposes, and a requirement to disclose third party involvement. The current assignments for the Working Group are intended to create a framework for the policy statement: defining the parameters of these consumer rights by offering suggested definitions, examples of consumer risks, and what may not be protected in federal laws or not covered under NAIC Model laws.

The Privacy Protections Working Group’s policy statement will address the following consumer privacy rights:  
1) Right to opt-out of data sharing  
2) Right to opt-in of data sharing  
3) Right to correct information  
4) Right to delete information  
5) Right to data portability  
6) Right to restrict the use of data  

The Accelerated Underwriting (A) Working Group will continue to watch the work of this group. If at any point issues unique to accelerated underwriting arise, we will endeavor to address them in a future work product.

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For purposes of the Working Group’s paper, the use of the term “right” should be read as a basic protection, or, denoting access to making a request and not as a guarantee of having the requested right acted upon in the manner as the consumer requests.

For purposes of the Working Group’s paper there is a distinction between an individual’s data and information that results from the use of this data, e.g., the insurance score that results from the use of an algorithm.
Appendix A: Additional Procedural Background

At the 2019 NAIC Summer National Meeting, the Life Insurance and Annuities (A) Committee discussed a referral it had received from the Big Data (EX) Working Group. The Big Data Working Group had discussed the use of predictive models in accelerated underwriting in life insurance, instead of medical examinations and the collection of fluids. The Big Data Working Group agreed that the issue would be most appropriately addressed by the life insurance subject matter experts and voted to refer the issue of the use of external data and data analytics in accelerated underwriting in life insurance to the Life Insurance and Annuities (A) Committee (Committee).12

The Committee discussed the referral and acknowledged that there are a multitude of issues surrounding insurers’ use of data models and data analytics; issues that extend into many areas of insurance and overlap with the work of several groups at the NAIC. In addition to the Big Data (EX) Working Group, there is the Innovation and Technology (EX) Task Force, the Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group. The Life Actuarial Task Force was also looking at the use of accelerated underwriting in life insurance from an actuarial perspective, including looking at any potential impact on insurer solvency.

The Committee agreed that an effort to delve into accelerated underwriting in life insurance would need to be narrowly focused while taking into account the work of these other NAIC groups touching on the same topic.

Robert Muriel (IL) chaired the Working Group and Grace Arnold (MN) was the vice-chair. The following were Working Group members: Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Cynthia Amann (MO); Rhonda Ahrens and Laura Arp (NE); Ross Hartley and Chris Aufenthie (ND); Lori Barron (OH); Elizabeth Kelleher Dwyer (RI); Lichiou Lee (WA); Mark Afable (WI). In January 2021, Commissioner Afable became chair of the Working Group and the rest of the membership remained the same.

The Working Group met for the first time on Oct 2, 2019, and developed a work plan to accomplish its charge. The work plan contemplated the Accelerated Underwriting (A) Working Group progressing through three phases with the goal of completing its charge by the 2020 Fall National Meeting. The first phase was focused on information-gathering. The second phase focused on identifying the issues and deciding on a work product, with the final phase devoted to drafting.

During the information gathering phase, the Working Group heard 15 presentations from varying stakeholders, including an academic (Professor Patrick Brockett13), insurance companies, consulting firms (Deloitte and Milliman), a consumer advocate (Birny Birnbaum—CEJ), the American Academy of Actuaries, lawyers from 2 Illinois law firms (Foley & Lardner and Edelson), a machine learning assurance company (Monitaur), and a data analytics company (Verisk). Several of the presentations were held in regulator-only meetings when requested by presenters in order to share proprietary and confidential company-specific information.

Regulators from the Working Group volunteered to participate in two ad hoc groups to tackle the second and third phases of its work plan: There was an ad hoc NAIC liaison group to ensure awareness of and coordination with any work, including guidelines or protocols, developed by other NAIC groups, past and present, that related

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13 Gus Wortham Chair in Risk Management and Insurance at the University of Texas at Austin and Editor, North American Actuarial Journal.
to the Working Group. There was also an ad hoc drafting group that agreed to take the information gathered, identify issues, recommend and draft a work product for review and approval by the Working Group.

In November 2020, the ad hoc drafting group shared with the Accelerated Underwriting (A) Working Group a proposed draft outline for an educational report exploring accelerated underwriting in life insurance to provide guidance to regulators, industry, and consumer advocates, and other stakeholders. In February 2021, the ad hoc groups merged.


Artificial Intelligence/Machine Learning (AI/ML)

AI/ML describes an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result. This is different from a standard algorithm in that an algorithm is a process or set of rules executed to solve an equation or problem in a pre-determined fashion. Evolving algorithms are considered a subset of AI/ML.

Artificial Intelligence / Machine Learning Systems include:

• Systems that adapt and adjust to new data and experience without manual human intervention.
• Systems that arrive at results for which the outcomes and the stepwise approach toward the outcomes were not configured in advance by a human programmer.
• Systems that dynamically respond to conditions in the external environment without the specific nature of such responses being known in advance to the designers of the systems.
• Systems that utilize neural networks and/or deep-learning algorithms, such as supervised, semi-supervised, and unsupervised learning algorithms.
• Systems that engage in automatic speech recognition, facial recognition, image recognition, text recognition, natural language processing, generation of customer-specific recommendations, automated customer communications (e.g., chatbots with non-preprogrammed prompts), autonomous or semi-autonomous vehicle operation or data gathering, or any other approach that does not require either preprogramming or a manual human intervention in every instance of an action or decision.
• Systems that automatically generate adaptive responses based on interactions with a consumer or third party.
• Systems that determine which data elements to rely upon, in a non-preprogrammed fashion, among a variety of possible alternatives.

Artificial Intelligence / Machine Learning Systems are not:

• Static “scorecards” that deterministically map consumer or other risk characteristics to treatments or decisions. (However, an AI/ML system may use the output of such static “scorecards” as input data for the AI/ML system to consider.)
• Systems with solely preprogrammed decision rules (e.g., “If A, then B” applied invariably in all situations).
• Tables of point or factor assignments in rating plans.
• Static rate making and/or predictive modeling methodologies, including linear regression, generalized linear modeling (GLM), or generalized additive modeling (GAM). Purely informational static databases, such as databases used to obtain reference amounts for claim settlements, or static databases pertaining to consumer characteristics or experience, regardless of the...
amount of information in the database. However, if AI/ML is used to create a static predictive model, that AI/ML system is considered within the scope of this survey.

- Deterministic “phone trees” that navigate consumers through pre-recorded voice prompts.
- Any approach that an insurer could have realistically utilized in the year 2000 or prior.

**AI/ML Use Descriptions and/or Explanations**

**Underwriting: AI/ML Uses**

- Automated Approval: Approving an application without human intervention on that particular application.
- Automated Denial: Denying an application without human intervention on that particular application.
- Underwriting Tier Determination: Decisions regarding the criteria to use to establish specific named or numbered categories (called tiers) which utilize combinations of attributes that affect an insurer’s underwriting decision.
- Company Placement: Decisions regarding which of several affiliated companies within an insurance group will accept an individual risk.
- Input into Non-Automated Approval Decision: Providing data, analysis, or recommendations regarding a decision to approve an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically approve the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
- Input into Non-Automated Denial Decision: Providing data, analysis, or recommendations regarding a decision to deny an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically deny the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
- Automate Processing Thru the Agency Channel: Enabling agencies to receive certain information about applicants automatically without specifically requesting that information and/or to provide quotes to the applicants and/or recommend a decision regarding the application to the agent without being based on preprogrammed decision rules.
DRAFT March 4, 2022
Adopted by the Life Insurance and Annuities (A) Committee on April 7, 2022
Adopted by Accelerated Underwriting Working Group on March 24, 2022

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Ad Hoc Drafting Subgroup

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What is Accelerated Underwriting?

Throughout this paper, we use the term accelerated underwriting in life insurance. For purposes of this paper, we based our work on the following definition:

Accelerated underwriting is the use of big data, artificial intelligence, and machine learning to underwrite life insurance in an expedited manner. The process generally uses predictive models and machine learning algorithms to analyze applicant data, which may include the use of non-traditional, non-medical data, provided either by the applicant directly or obtained through external sources. The process is typically used to replace all or part of traditional underwriting in life insurance and to allow some applications to have certain medical requirements waived, such as paramedical exams and fluid collection.

Predictive models examine data sets for patterns to predict and assign the risk category, e.g., a model developer enters data points (potentially hundreds of thousands), and the model finds patterns and identifies future
predictions of risk and assigns an insured to a risk category.¹ Machine learning algorithms are a process or set of rules executed to solve an equation², e.g., a life insurance underwriter uses a set of rules to place an individual insured in a particular risk category. The ‘learning’ part of machine learning means that those programs change how they process data over time, much as humans change how they process data by learning. Machine learning often falls into two groups: supervised or unsupervised. The difference between the two is whether the program is directed to analyze patterns or is self-automated.

Predictive models or machine learning trains a system to make judgments when exposed to data that is unfamiliar to serve as a substitute for human-centric decision making. These are both subcategories of artificial intelligence, which should not be confused with a static rule-based algorithm.

Life insurance underwriting is the process of determining eligibility and classifying applicants into risk categories to determine the appropriate rate to charge for transferring the financial risk associated with insuring the applicant. Traditional life insurance underwriting involves, assessing the applicant’s physical health, along with other financial and behavioral elements, then determining whether an applicant is eligible for coverage and the risk class to which that individual belongs. Accelerated underwriting relies both on traditional and non-traditional, non-medical data used within predictive models or machine learning algorithms to perform some of the tasks of an underwriter. The exact parameters of the application of accelerated underwriting vary by insurer.

Presentations made to the Working Group indicated that life insurers use accelerated underwriting in primarily two ways: 1) Accelerated underwriting is used to triage applicants, where unsuccessful applicants are re-routed to traditional underwriting, and successful ones continue through the accelerated underwriting process; or 2) Accelerated underwriting is used to rate applicants based on risk categories.

Most predictive or machine learning algorithms used in life insurance underwriting are in their second or third generation. The COVID-19 pandemic sped up the adoption of accelerated underwriting in the industry as both consumers and insurers looked for options to purchase and write policies that relied more on technology and involved less in-person contact. This has highlighted the need for ongoing monitoring of the machine learning algorithms—both their development and their uses in the marketplace.

Presentations made to the Working Group indicated that adverse underwriting decisions are sometimes reviewed by human underwriters. Companies presenting to the Working Group stated that the accelerated underwriting process is less cumbersome, costs less than traditional underwriting, it expedites the process and requires less

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¹ For a more detailed discussion of predictive models in property and casualty insurance, see the Casualty Actuarial and Statistical (C) Task Force Regulatory Review of Predictive Models White Paper, Adopted by the Property and Casualty Insurance (C) Committee on Dec. 8, 2020.

² The Big Data and Artificial Intelligence (EX) Working Group developed a survey to conduct analysis on private passenger automobile (PPA) insurers’ use and governance of big data, as used in an artificial intelligence (AI) and machine learning (ML) system. The survey is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. This analysis will help inform the Working Group in completing its long-term goals of developing guidance and recommendations to update the existing regulatory framework for the use of big data and AI, including how to monitor and oversee the industry’s compliance with the NAIC’s AI principles. The survey work may be expanded to other lines of insurance as needed, such as life insurance and homeowners insurance. For the purposes of the survey only, AI/ML is defined as, “an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result.” This is different from a standard algorithm that consists of a process or set of rules executed to solve an equation or problem in a pre-determined fashion, and evolving algorithms are considered a subset of AI/ML.

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consumer involvement in the purchase, improves the underwriting experience for consumers, shortsens issue times, and increases policy acceptance rates.  

General Discussion of Issues and Recommendations

Life insurers reliance on an increasingly automated underwriting process that uses non-traditional, non-medical data presents new regulatory challenges. Regulators must ensure that the process is fair, transparent, and secure. With regard to accelerated underwriting in life insurance, this concern pertains to input data, the predictive model or machine learning algorithm, and the results of the process. One particular challenge is the potential for unfair discrimination. Due to the fact accelerated underwriting relies on non-traditional, non-medical data and predictive models or machine learning algorithms, it may lead to unexpected or unfairly discriminatory outcomes even though the input data may not be overtly discriminatory. It is critical to test the conclusions up front, on the back end, as well as, randomly, to ensure the machine learning algorithm does not produce unfairly discriminatory ratings or ones that are not actuarially sound. Testing can also be important in determining if a machine learning algorithm is accurate across demographic categories. Such scrutiny is especially important when behavioral data is utilized. Behavioral data may include gym membership, one’s profession, marital status, family size, grocery shopping habits, wearable technology, and credit attributes. Although medical data has a scientific linkage with mortality, behavioral data may lead to questionable conclusions without reasonable explanation.

Recommendations

Consistent with the Artificial Intelligence Principles approved by the NAIC in 2020, the use of accelerated underwriting in life insurance should be fair and transparent to regulators, consumers, and policymakers. Companies must operate in compliance with applicable laws, and the process and data companies use need to be secure. To accomplish these objectives, regulators should dialogue with consumers, life insurers, and third-party vendors to determine if consumer data is being used in problematic or unfair ways or generating unfair outcomes.

Insurers and other parties involved in accelerated underwriting in life insurance should:

- Take steps to ensure data inputs are transparent, accurate, reliable, and the data itself does not have any unfair bias.
- Ensure that the use of external data sources, algorithms or predictive models are based on sound actuarial principles with a valid explanation or rationale for any claimed correlation or causal connection.
- Ensure that the predictive models or machine learning algorithm within accelerated underwriting has an intended outcome and that outcome is being achieved.
- Ensure that the predictive models or machine learning algorithm achieve an outcome that is not unfairly discriminatory.

4 See National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI) – Fair and Ethical a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, rate making standards, advertising decisions, claims practices, and solvency. b. Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and remediates for such consequences when they occur.
• Be able to provide the reason(s) for an adverse underwriting decision, whether the decision is based on data subject to FCRA or not, to the consumer and all information upon which the insurer based its adverse underwriting decision.
• Take steps to protect consumer privacy and ensure consumer data is secure.
• Have a mechanism in place to correct mistakes if found.
• Produce information upon request as part of regular filing submissions reviews or market conduct examinations.

Input data

Predictive models or machine learning algorithms within the accelerated underwriting process rely heavily on data and multiple variables. Examples of the variables used by some accelerated underwriting models include customer disclosures, prescription history, digital health records, credit attributes, medical information bureau data, public records, motor vehicle reports, smartphone apps, consumer activity wearables, claim acceleration tools, individual consumer risk development systems, purchasing history, behavior learned through cell phone usage, and social media. Because accelerated underwriting relies on predictive models or machine learning algorithms that use non-traditional, non-medical data, it may lead to unexpected or unfairly discriminatory outcomes, even though the input data may be facially neutral.

Traditional Data

Traditional data used in life insurance underwriting includes data collected through a traditional underwriting process. This data may include the following:
• Application data, e.g., medical records, prescription questions, vocation questions, financial profile
• Tele-interview
• Medical records
• Data from the MIB (formerly known as Medical Information Bureau) 5
• Data from Motor Vehicle Records
• Prescription drug history
• Public records, e.g., criminal records, bankruptcy records, civil litigation, etc.
• Paramedical or medical exam, including EKG’s in some instances
• Fluids, e.g., blood, urine, swab/saliva test to determine tobacco usage
• Financial and tax information

Considerations for use of Traditional Data
• Traditional data has a long and established history in the life insurance industry. Carriers, producers, and consumers are generally familiar with the process.
• Traditional data has a history of usage by insurance carriers. Trained underwriters and producers have years of experience and often understand the process well.
• The relationship of the traditional data elements to the risk is well established and consumers generally understand how most of the elements impact their risk classification or premium charged.

5 This data is subject to the Fair Credit Reporting Act (FCRA).
State statutes and case laws were developed based on the use of traditional data containing consumer protections created under the assumption that this was the type of data collected or reviewed during an underwriting process.

Presentations made to the Working Group represented that time and costs associated with obtaining and reviewing traditional data are significant.

Non-traditional Data

Non-traditional data used in life insurance underwriting may include the following:

- Public records, e.g., assessor data, genealogy records, court filings, voter information
- Property/casualty data from adjacent carrier(s)
- Marketing and social data, e.g., shopping habits, mortgage amount/lender, occupation and education, and social media, etc.
- Professional licenses
- Biometric data, e.g., voice analysis, facial analysis, and other analytics based on personal physical features and characteristics
- Wearable devices

Considerations for use of Non-traditional Data

- Per Actuarial Standard of Practice (ASOP) No. 12, an actuary needs to demonstrate that a relationship between a risk characteristic and an expected outcome exists. This standard applies for any data used, traditional or non-traditional. Consumers may not generally understand how non-traditional data elements impact their risk classification or premium charged.
- As additional rating factors are introduced via insurance scores or with specific data elements, disparate impact across and between demographic groups may be introduced or amplified.
- Non-traditional data may not have the same consumer protections as FCRA and traditional data. For example:
  - There may not be a clear path for consumers to know how data affected their application and how inaccurate data may be corrected.
  - The type and purpose of data accessed are not required to be disclosed to the consumer.
  - There may be privacy concerns about the extent of the use of non-traditional data.

FCRA Data

Some data\(^7\) used in traditional and accelerated underwriting is subject to the federal Fair Credit Reporting Act (FCRA), which protects the privacy of consumer report information. If an insurer uses data subject to FCRA in its underwriting, applicants:

1. Have a right to be told if this information is used to deny insurance or take other adverse action\(^8\),
2. Have the ability to request the data a consumer reporting agency is providing to an insurer, and
3. Have the right to ask a consumer reporting agency to correct any errors in the data.

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\(^7\) FCRA applies to consumer reports. Please see 15 U.S. Code § 1681a(d).

\(^8\) FCRA defines adverse action, in part, as “a denial or cancellation of an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of insurance[].” 15 U.S. Code § 1681a(k).
Considerations for use of data subject to FCRA:

- FCRA data is readily available.
- FCRA data is updated regularly.
- FCRA data is already used in life and property/casualty lines of business.
- There is existing regulation and oversight by the Federal Trade Commission (FTC) and Consumer Financial Protection Bureau (CFPB).
- Not all FCRA data is useful/ relevant to life insurance underwriting.
- If there is a dispute about the accuracy of FCRA data, a consumer has to obtain additional information and formally dispute these findings.
- FCRA data is extensive and accessing such data may result in access to non-usable credit attributes. In other words, significantly more data may be collected than is needed to determine risk.
- As additional rating factors are introduced via insurance scores or with specific data elements, unfair discrimination, including disparate impact, may be introduced or amplified.

Recommendations

Existing regulations apply to accelerated underwriting programs in the same way as traditional underwriting programs. State Departments of Insurance (DOIs) have broad regulatory authority to make inquiries into the processes and procedures of life insurers in order to investigate potential unfair trade practices. Complaints about underwriting practices are opportunities for DOIs to review a life insurer’s use of accelerated underwriting and data collection methods. Additional DOI actions may include market conduct and on-site examinations as appropriate under existing authority.

Specifically, examiners may:

- Review the life insurer’s underwriting practices and underwriting guidelines during an examination or upon initial submission of the policy rates and forms and confirm the proper use of the data elements.
- Request that explanation provided to the consumer for any negative action taken by the life insurer adequately informs the consumer as to why a particular action was taken without the consumer having to make additional inquiries.
- Request information about source data regardless of whether the data or score is provided by a third party.

Form and rate reviewers may:

- Request that the life insurer provides information about how a predictive model or machine learning algorithm will be used.
- Consider requiring the filing of models used to analyze data.
- Consider questioning the extent to which data elements correlate to applicant risk.
- Request information about source data regardless of whether the data or score is provided by a third party.

Life insurers and third-party vendors have a responsibility to understand the data they are using. To accomplish this, life insurers should conduct post-issue audits and data analysis and make these audits and analysis available to regulators upon request. For example, analyses such as evaluating claims and lapse rates may be helpful. Life insurers and third-party vendors should ensure data inputs are accurate and reliable.
Life insurers and third-party vendors should ensure that the external data sources, algorithms, or predictive models are developed with sufficient internal controls and oversight and based on sound actuarial principles with a valid explanation or rationale for any claimed correlation and causal connection.

**Data Privacy**

Data privacy—a consumer’s ability to retain control over what data can be shared about them and with whom—is not a concern unique to accelerated underwriting in life insurance. Protecting consumer privacy is an issue across all lines of insurance and is the subject of the NAIC Privacy Protections (D) Working Group, formed in 2019 under the parent committee of Market Regulation and Consumer Affairs (D) Committee.

The Working Group’s charge is to review the state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models and other existing federal or state statutes. 9

The primary focus of the Working Group is on the six consumer data privacy rights or types of consumer data privacy protections identified in the NAIC’s Member adopted Strategy for Consumer Data Privacy Protections policy statement. The secondary focus is on issues such as notice requirements and standards, disclosure of information collected, disclosure of shared information, requirements to disclose sources of information, requirements to disclose business purposes, and a requirement to disclose third party involvement. 9

The current assignments for the Working Group are intended to create a framework for the policy statement: defining the parameters of these consumer rights by offering suggested definitions, examples of consumer risks, and what may not be protected in federal laws or not covered under NAIC Model laws.

The Privacy Protections Working Group’s policy statement will address the following consumer privacy rights: 10

1) Right to opt-out of data sharing
2) Right to opt-in of data sharing
3) Right to correct information
4) Right to delete information
5) Right to data portability

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9 The Working Group has focused its reviews on the Insurance Information and Privacy Protection Model Act #670, and the Privacy of Consumer Financial and Health Information Regulation Model Act #672 – both drafted in response to the enactment of GLBA, and #668 – the Insurance Data Security Model Act, enacted in 2019/20. With a great deal of research assistance from NAIC Legal Staff, the Working Group prepared a gap analysis — upon which it continues to work. The Working Group is also reviewing the consumer data privacy protections other than those already in these models, such as the numerous provisions contained in federal acts such as the Fair Credit Reporting Act (FCRA), the Gramm-Leach Bliley Act (GLBA), the Health Insurance Portability and Affordability Act (HIPAA), Electronic Health Records (EHR), etc. The Working Group is also analyzing the various provisions of recently enacted legislation, such as California’s Consumer Privacy Act (CCPA) and its Consumer Data Privacy Regulation (CCPR), Virginia’s and Colorado’s recently enacted Consumer Privacy Protection laws, certain provisions of the European General Data Protection Regulation (GDPR), the NAIC’s Record Retention Model Regulation and the NAIC’s Unfair Claims Practice Model Act (UCPA). There are a lot of jurisdictional issues that remain to be sorted through.

10 For purposes of the Working Group’s paper, the use of the term “right” should be read as a basic protection, or, denoting access to making a request and not as a guarantee of having the requested right acted upon in the manner as the consumer requests.
6) Right to restrict the use of data\textsuperscript{11}

The Accelerated Underwriting (A) Working Group will continue to watch the work of this group. If at any point issues unique to accelerated underwriting arise, we will endeavor to address them in a future work product.

\textsuperscript{11} for purposes of the Working Group’s paper there is a distinction between an individual’s data and information that results from the use of this data, \textit{e.g.}, the insurance score that results from the use of an algorithm.
Appendix A: Additional Procedural Background

At the 2019 NAIC Summer National Meeting, the Life Insurance and Annuities (A) Committee discussed a referral it had received from the Big Data (EX) Working Group. The Big Data Working Group had discussed the use of predictive models in accelerated underwriting in life insurance, instead of medical examinations and the collection of fluids. The Big Data Working Group agreed that the issue would be most appropriately addressed by the life insurance subject matter experts and voted to refer the issue of the use of external data and data analytics in accelerated underwriting in life insurance to the Life Insurance and Annuities (A) Committee (Committee).¹²

The Committee discussed the referral and acknowledged that there are a multitude of issues surrounding insurers’ use of data models and data analytics; issues that extend into many areas of insurance and overlap with the work of several groups at the NAIC. In addition to the Big Data (EX) Working Group, there is the Innovation and Technology (EX) Task Force, the Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group. The Life Actuarial Task Force was also looking at the use of accelerated underwriting in life insurance from an actuarial perspective, including looking at any potential impact on insurer solvency.

The Committee agreed that an effort to delve into accelerated underwriting in life insurance would need to be narrowly focused while taking into account the work of these other NAIC groups touching on the same topic.

Robert Muriel (IL) chaired the Working Group and Grace Arnold (MN) was the vice-chair. The following were Working Group members: Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Cynthia Amann (MO); Rhonda Ahrens and Laura Arp (NE); Ross Hartley and Chris Aufenthie (ND); Lori Barron (OH); Elizabeth Kelleher Dwyer (RI); Lichiou Lee (WA); Mark Afable (WI). In January 2021, Commissioner Afable became chair of the Working Group and the rest of the membership remained the same.

The Working Group met for the first time on Oct 2, 2019, and developed a work plan to accomplish its charge. The work plan contemplated the Accelerated Underwriting (A) Working Group progressing through three phases with the goal of completing its charge by the 2020 Fall National Meeting. The first phase was focused on information-gathering. The second phase focused on identifying the issues and deciding on a work product, with the final phase devoted to drafting.

During the information gathering phase, the Working Group heard 15 presentations from varying stakeholders, including an academic (Professor Patrick Brockett¹³), insurance companies, consulting firms (Deloitte and Milliman), a consumer advocate (Birny Birnbaum—CEJ), the American Academy of Actuaries, lawyers from 2 Illinois law firms (Foley & Lardner and Edelson), a machine learning assurance company (Monitaur), and a data analytics company (Verisk). Several of the presentations were held in regulator-only meetings when requested by presenters in order to share proprietary and confidential company-specific information.

Regulators from the Working Group volunteered to participate in two ad hoc groups to tackle the second and third phases of its work plan: There was an ad hoc NAIC liaison group to ensure awareness of and coordination with any work, including guidelines or protocols, developed by other NAIC groups, past and present, that related to the Working Group. There was also an ad hoc drafting group that agreed to take the information gathered, identify issues, recommend and draft a work product for review and approval by the Working Group.

¹³ Gus Wortham Chair in Risk Management and Insurance at the University of Texas at Austin and Editor, North American Actuarial Journal.
In November 2020, the ad hoc drafting group shared with the Accelerated Underwriting (A) Working Group a proposed draft outline for an educational report exploring accelerated underwriting in life insurance to provide guidance to regulators, industry, and consumer advocates, and other stakeholders. In February 2021, the ad hoc groups merged.


Artificial Intelligence/Machine Learning (AI/ML)

AI/ML describes an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result. This is different from a standard algorithm in that an algorithm is a process or set of rules executed to solve an equation or problem in a pre-determined fashion. Evolving algorithms are considered a subset of AI/ML.

Artificial Intelligence / Machine Learning Systems include:

- Systems that adapt and adjust to new data and experience without manual human intervention.
- Systems that arrive at results for which the outcomes and the stepwise approach toward the outcomes were not configured in advance by a human programmer.
- Systems that dynamically respond to conditions in the external environment without the specific nature of such responses being known in advance to the designers of the systems.
- Systems that utilize neural networks and/or deep-learning algorithms, such as supervised, semi-supervised, and unsupervised learning algorithms.
- Systems that engage in automatic speech recognition, facial recognition, image recognition, text recognition, natural language processing, generation of customer-specific recommendations, automated customer communications (e.g., chatbots with non-preprogrammed prompts), autonomous or semi-autonomous vehicle operation or data gathering, or any other approach that does not require either preprogramming or a manual human intervention in every instance of an action or decision.
- Systems that automatically generate adaptive responses based on interactions with a consumer or third party.
- Systems that determine which data elements to rely upon, in a non-preprogrammed fashion, among a variety of possible alternatives.

Artificial Intelligence / Machine Learning Systems are not:

- Static “scorecards” that deterministically map consumer or other risk characteristics to treatments or decisions. (However, an AI/ML system may use the output of such static “scorecards” as input data for the AI/ML system to consider.)
- Systems with solely preprogrammed decision rules (e.g., “If A, then B” applied invariably in all situations).
- Tables of point or factor assignments in rating plans.
- Static rate making and/or predictive modeling methodologies, including linear regression, generalized linear modeling (GLM), or generalized additive modeling (GAM). Purely informational static databases, such as databases used to obtain reference amounts for claim settlements, or static databases pertaining to consumer characteristics or experience, regardless of the...
amount of information in the database. However, if AI/ML is used to create a static predictive model, that AI/ML system is considered within the scope of this survey.

- Deterministic “phone trees” that navigate consumers through pre-recorded voice prompts.
- Any approach that an insurer could have realistically utilized in the year 2000 or prior.

**AI/ML Use Descriptions and/or Explanations**

- **Underwriting**: AI/ML Uses
  - Automated Approval: Approving an application without human intervention on that particular application.
  - Automated Denial: Denying an application without human intervention on that particular application.
  - Underwriting Tier Determination: Decisions regarding the criteria to use to establish specific named or numbered categories (called tiers) which utilize combinations of attributes that affect an insurer’s underwriting decision.
  - Company Placement: Decisions regarding which of several affiliated companies within an insurance group will accept an individual risk.
  - Input into Non-Automated Approval Decision: Providing data, analysis, or recommendations regarding a decision to approve an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically approve the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
  - Input into Non-Automated Denial Decision: Providing data, analysis, or recommendations regarding a decision to deny an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically deny the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
  - Automate Processing Thru the Agency Channel: Enabling agencies to receive certain information about applicants automatically without specifically requesting that information and/or to provide quotes to the applicants and/or recommend a decision regarding the application to the agent without being based on preprogrammed decision rules.
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Life Actuarial (A) Task Force
Virtual Meeting (in lieu of meeting at the 2022 Spring National Meeting)
March 31, 2022

The Life Actuarial (A) Task Force met March 31, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ted Chang and Ahmad Kamil (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Charles Santana (DE); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen and Ben Slutske (MN); Chlora Lindley-Myers represented by William Leung and John Rehagen (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. **Adopted its March 17, March 10, March 3, Feb. 24, Feb. 17, Feb. 10, Feb. 3, and Jan. 27 Minutes**

The Task Force met March 17, March 10, March 3, Feb. 24, Feb. 17, Feb. 10, Feb. 3, and Jan. 27. During these meetings, the Task Force took the following action: 1) disbanded the Guaranteed Issue (GI) Life Valuation (A) Subgroup; 2) adopted its 2021 Fall National Meeting minutes; 3) adopted amendment proposal 2021-11, which adds a section for other guidance and requirements for assumptions to VM-21, Requirements for Principle-Based Reserves for Variable Annuities; 4) adopted amendment proposal 2022-01, which clarifies the treatment of the pre-reinsurance ceded reserve and the reserve credit for retrocessions; 5) forwarded a proposal to the Blanks (E) Working Group; 6) exposed amendment proposal 2022-02, which revises language in VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, including explicit cross-references to the VM-21; 7) exposed amendment proposal 2022-03, which updates cross-references and improves consistency between VM-20, Requirements for Principle-Based Reserves for Life Products and VM-21; 8) exposed amendment proposal 2022-04, which proposes updates to the VM-20 prescribed swap spreads guidance in light of the London Interbank Offered Rate (LIBOR) transition to Secured Overnight Financing Rate (SOFR); and 9) exposed models for field testing the economic scenario generator (ESG).

Mr. Chupp made a motion, seconded by Mr. Leung, to adopt the Task Force’s March 17 (Attachment One), March 10 (Attachment Two), March 3 (Attachment Three), Feb. 24 (Attachment Four), Feb. 17 (Attachment Five), Feb. 10 (Attachment Six), Feb. 3 (Attachment Seven), and Jan. 27 (Attachment Eight) minutes. The motion passed unanimously.

2. **Adopted the Report of the Longevity Risk (E/A) Subgroup**

Mr. Andersen made a motion, seconded by Mr. Weber, to adopt the report of the Longevity Risk (E/A) Subgroup (Attachment Nine). The motion passed unanimously.

3. **Adopted the Report of the Variable Annuities Capital and Reserves (E/A) Subgroup**

Mr. Andersen made a motion, seconded by Mr. Weber, to adopt the report of the Variable Annuities Capital and Reserves (E/A) Subgroup (Attachment Ten). The motion passed unanimously.
4. **Adopted the Report of the Experience Reporting (A) Subgroup**

Mr. Andersen made a motion, seconded by Mr. Weber, to adopt the report of the Experience Reporting (A) Subgroup (Attachment Eleven). The motion passed unanimously.

5. **Adopted the Report of the VM-22 (A) Subgroup**

Mr. Slutsker said the Subgroup has not met since the middle of 2021. He said a proposal for a revised VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, received from the Annuity Reserves and Capital Working Group (ARCWG) of the American Academy of Actuaries (Academy), was exposed in July 2021. He said the Subgroup plans to meet April 13 to discuss plans for addressing the exposure comments. The planned approach is provided in the Subgroup report. Mr. Slutsker noted that the Subgroup has two drafting groups actively working on the development of appropriate assumptions for the VM-22 standard projection amount (SPA) and a separate drafting group working on the development of pension risk transfer assumptions.

Mr. Slutsker made a motion, seconded by Mr. Chupp, to adopt the report of the VM-22 (A) Subgroup (Attachment Twelve). The motion passed unanimously.

6. **Adopted the Report of the Index-Linked Variable Annuity (A) Subgroup**

Mr. Weber said the Subgroup’s charge is to provide recommendations and changes to nonforfeiture interim value requirements for index-linked variable annuities (ILVAs). He said the products are filed as variable contracts and, therefore, should behave as such. He said that while the initially recommended guideline proposal was very prescriptive, the current proposal (Attachment Thirteen) allows a company to determine interim values in any manner it chooses, as long as the company demonstrates that the interim values are materially consistent with the principles of the guideline. He said the current proposal will be exposed after the Task Force meeting.

Mr. Weber made a motion, seconded by Mr. Leung, to adopt the report of the Index-Linked Variable Annuity (A) Subgroup, including its March 9 (Attachment Fourteen), March 2 (Attachment Fifteen), and Feb. 16 (Attachment Sixteen) minutes. The motion passed unanimously.

7. **Adopted the Report of the IUL Illustration (A) Subgroup**

Mr. Andersen said the Indexed Universal Life (IUL) Illustration (A) Subgroup discussed comments on the exposure of the early analysis of the effectiveness of Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold on Or After December 14, 2020 (AG 49-A) during its Feb. 24 meeting. He said there is consensus that AG 49-A has effectively addressed previously identified IUL product designs, including multipliers and buyouts. He said it is thought that newly developed product designs, such as those with volatility-controlled indices, still need to be addressed. He said there is evidence that some products with uncapped volatility-controlled indices illustrate more favorably than traditional IUL with capped Standard & Poor’s (S&P’s) 500 indices. He said the Subgroup will meet in the second quarter to develop recommendations to address this issue. The recommendations will be forwarded to the Task Force for consideration.

Mr. Andersen made a motion, seconded by Mr. Chupp, to adopt the verbal report of the IUL Illustration (A) Subgroup. The motion passed unanimously.
8. **Adopted Amendment Proposal 2022-02**

Ms. Hemphill said amendment proposal 2022-02 clarifies the reporting documentation language in VM-31. She said the language now parallels language in VM-21.

Mr. Leung made a motion, seconded by Mr. Chupp, to adopt amendment proposal 2022-02 (Attachment Seventeen). The motion passed unanimously.

9. **Adopted Amendment Proposal 2022-03**

Ms. Hemphill said amendment proposal 2022-03 updates cross references and revises language to maintain consistency between VM-20 and VM-21.

Mr. Leung made a motion, seconded by Mr. Chupp, to adopt amendment proposal 2022-03 (Attachment Eighteen). The motion passed unanimously.

10. **Re-Exposed Amendment Proposal 2020-12**

Ms. Hemphill said revisions were made to the previously exposed version of amendment proposal 2020-12 (Attachment Nineteen) to reflect comments submitted by the Academy and the American Council of Life Insurers (ACLI). She said the Academy comment letter (Attachment Twenty) agreed with the general principle of having the company reflect its hedging strategy but recommended revising VM-21 to replace the E-factor approach with the methodology used in VM-20. She said implementing that change would require a large structural change that is beyond the scope of the proposal and would have a major impact on some companies. Consequently, the Task Force rejected the recommendation.

Ms. Hemphill said the second Academy recommendation removes optionality for liquidating hedges when the elimination is not consistent with the company investment strategy. The third Academy recommendation is to remove the 1.0 limitation on the E-factor for hedging strategies that are less than 6 months old. She said revisions to the amendment proposal were made to incorporate these recommendations.

Ms. Hemphill said the ACLI comment letter (Attachment Twenty-One) requested a longer path to implementation to allow companies more preparation time. She noted that the amendment proposal was initially exposed 14 months ago, and the Task Force has been consistent in communicating its intent to address the key issues. She also indicated that discussion of the implementation timeline is premature for this re-exposure.

The second ACLI comment requests that indexed credit derivative programs be reflected in the principle-based reserving (PBR) models. Ms. Hemphill said the issue is beyond the scope of the proposal. She mentioned that the Valuation Manual (VM)-22 (A) Subgroup is working on that issue. She said when the Subgroup’s work is complete, it could be considered for VM-21.

Ms. Hemphill said the ACLI’s comment on the on the E-factor was similar to the Academy’s E-factor comment and will be covered by the response provided to the Academy. She said the remaining ACLI comments, except the recommended change to the carve-out for future hedging strategies, are reflected in the revisions being considered for re-exposure. She verbally walked through a detailed review of the changes to the proposal.

Craig Morrow (Academy) said the Academy prefers the VM-20 approach to hedge assets because the VM-21 approach requires bifurcation of the hedging strategy into that which applies to existing hedge assets and that which applies to future hedge assets. He said such bifurcation may not be possible. He said the Academy is also
concerned that the VM-21 approach assumes that CTE-70 (adjusted) is greater than CTE-70 (best efforts), which does not consistently hold true.

Ms. Hemphill agreed with the Academy comments but reiterated that the change required to address the issue is outside of the scope of the proposal. Brian Bayerle (ACLI) asked if the VM-22 language to address indexed crediting will be available for inclusion in this proposal. Ms. Hemphill said the VM-22 changes will be added to VM-21 through a separate amendment proposal.

Mr. Leung made a motion, seconded by Mr. Wallman, to re-expose amendment proposal 2020-12 (Attachment Twenty-Two) for a 30-day public comment period ending April 29. The motion passed unanimously.

11. Discussed Comments on the Proposed AAT Actuarial Guideline Exposure

Mr. Andersen said activities related to the involvement of life insurers with private equity firms and complex assets has increased in the last few years. He said several NAIC groups have initiated projects to address the potential issues arising from the increased activities, including the valuation of complex assets, accounting issues, and capital charges. He said the Task Force focus is on reserves and asset adequacy issues, with ensuring reserve sufficiency even when the complex assets do not perform as expected being a key aspect of its focus. He noted that the private equity funding has often been tied to offshore reinsurance activity, which can affect the risks and the reserves.

Mr. Andersen said the Task Force exposed the first draft of an asset adequacy testing (AAT) guideline (Attachment Twenty-Three) in February, with a goal of having the guideline in place for yearend 2022. He summarized the comments received from the ACLI (Attachment Twenty-Four), the Utah Insurance Department (Attachment Twenty-Five), Lombard International (Attachment Twenty-Six), John Hancock (Attachment Twenty-Seven), Western & Southern Financial Group (Attachment Twenty-Eight), Northwestern Mutual (Attachment Twenty-Nine), Equitable (Attachment Thirty), New York Life (Attachment Thirty-One), Everlake Life (Attachment Thirty-Two), and the Academy (Attachment Thirty-Three). He focused the discussion on: 1) guardrails and assumed net yields; 2) modeling of reinsurance ceded to assuming companies that do not submit an actuarial opinion and memorandum to state insurance regulators; and 3) the scope of assets. He said other issues, such as improving the clarity and organization of the draft guideline, as well as the handling of equities, will be addressed in a subsequent draft.

Mr. Yanacheak expressed concern that the guardrail is dependent upon the current U.S. Department of the Treasury (Treasury Department) yield curve instead of using current market rates. He said he is additionally concerned about implementing a guardrail without having studied its impact. Mr. Andersen said using the Treasury curve is intended to avoid penalizing companies that have purchased assets with expected returns that are higher than the current market. He suggested deferring discussion of that aspect of the guardrail. Mr. Leung suggested using a sensitivity test and deferring the implementation of the guardrail.

Mr. Boston, Ms. Eom, and Mr. Weber expressed support for having a sensitivity test applied to both current and reinvestment assets. Mr. Carmello expressed support for applying the guardrail to current assets and reinvestments. Mr. Tsang expressed support for having a sensitivity test on current assets and a guardrail on assumed reinvestment asset yields. Mr. Wallman said the guardrail should be applied on a company-by-company basis and not included in the guideline. Mr. Andersen said, based on the comments provided, most Task Force members favor using sensitivity tests to identify net yield outliers. He said that after studying the year-end 2022 results, state insurance regulators can decide whether to pursue Valuation Manual revisions to implement guardrails.
Mr. Andersen said a section of the guideline addresses reinsurance arrangements where a business issued by a U.S. domiciliary company is ceded to an offshore reinsurer that is not subject to state insurance regulations, and in many cases does not provide asset adequacy testing to state insurance regulators. He said that if the asset adequacy testing is not performed on that business by the assuming company, the guideline requires that it be performed by the ceding company. He said some comment letters expressed the concern that such a regulatory change would be too much too soon, and it may be disruptive to the other reinsurance initiatives, such as the Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance (Covered Agreement) and qualified reciprocal jurisdictions. He said other comment letters supported the revision, noting the increase in reinsurer activity associated with complex assets and private equity firms.

Mr. Leung said the most recent revisions to Actuarial Standard of Practice (ASOP) No. 11, Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports, strengthen the documentation and reporting requirements for reinsurance risks, including adding a requirement for disclosing those risks in the actuarial memorandum. He suggested that requiring companies to follow ASOP No. 11 will address the issues to which Mr. Andersen referred. Mr. Andersen noted that ASOP No. 11 is referenced in the proposed actuarial guideline. Mr. Rehagen said he is concerned that the proposed guideline broadly addresses the issue in a manner that may affect all reinsurance transactions with non-U.S. insurers, possibly in violation of the Covered Agreement. He voiced his support for requiring companies to follow ASOP No. 11 instead of using the language in the proposed actuarial guideline. Mr. Andersen said that given the need to have the guideline effective for yearend 2022 and the desire to avoid violating the Covered Agreement, pointing to ASOP No. 11 may be the best solution for the short-term.

Mr. Andersen said companies are concerned that too many of their assets may be considered within the scope of the revised guideline. He said the guideline has been revised to specify which assets can be excluded. He asked Task Force members if the guideline should exclude vanilla junk bonds among the assets that are in scope because such assets are not complex. Mr. Carmello opined that the guideline should continue to include junk bonds. Mr. Chang suggested narrowing the scope will allow the guideline to focus on the more complex assets. Ms. Eom agreed that the scope should be more limited. Mr. Andersen said the decisions made during the Task Force discussion will be reflected in a revised guideline, which will be exposed for public comment in a few days.

12. Heard an Update on the ESG

Scott O’Neal (NAIC) presented a slide deck (Attachment Thirty-Four) on the status of the ESG. The first part of the presentation discussed an ESG field test scheduled to begin in June. He said the Treasury model, equity model, and corporate model comprise the three components of the ESG that will be field tested. He said there are two GEMS Treasury model calibrations being field tested: 1) the Conning calibration with a generalized fractional floor; and 2) an alternative calibration, developed by the Academy Economic Scenario Generator Work Group (ESGWG), with a shadow floor. He said the recommendation for the equity model is to use the existing GEMS equity model, including the equity-Treasury linkage. The calibration of the equity model will also be changed to account for changes made to the Treasury model and to align the fund returns on a risk/reward basis. He said the GEMS corporate model will be used in its existing form.

Mr. O’Neal noted that significant impacts to reserves and capital were observed in the Academy variable annuity model office results. He identified characteristics of the GEMS equity model that may be potential drivers of the reserve and capital differences and discussed how the model office results may be changed by lowering volatility parameters. He highlighted the differences in the calibration of the expected mean equity returns and standard deviations in the GEMS model and the currently prescribed Academy Interest Rate Generator (AIRG) as key factors in the variation in wealth ratios seen in the model office results. In particular, he noted that the higher steady state volatility of the GEMS equity model leads to returns that produce a wider distribution of wealth ratios in
both tails of the distribution. He said the equity-Treasury linkage and the low interest rate environment assumption also contribute to lower expected returns in the early projection period, which lowers the entire distribution of returns. He shared that setting the GEMS equity model using the 16.1% volatility of the current AIRG model results in a significant increase in the year 30 gross wealth factor in the low return tail of the scenario distribution. He concluded that if state insurance regulators desire to improve model office results, the next step would be to determine an appropriate volatility level.

Mr. O’Neal said that while it is difficult to identify historically strong relationships between equities and treasury bonds, the equity-Treasury linkage is based on the theory that investors demand equity returns in excess of those offered by risk-free assets to compensate for the additional risk. He said several commenters have noted that the linkage could cause reserve and capital volatility. He said that issue will be studied further in model office testing and field testing. He noted that the ability of the GEMS equity model jump process to capture large equity market movements will also be evaluated in the field test.

Jason Kehrberg (ESGWG) discussed the responses (Attachment Thirty-Five) to questions on the March 17 presentation to the Task Force of Academy model office results. He caveated that the model office results are based on simplified products and investment strategies of a single cell using time zero reserves and, therefore, are limited.

Albert Zlogar (ESGWG) presented new variable annuity model office results (Attachment Thirty-Six) reflecting new Conning scenario sets added since the March 17 presentation. He said the new scenario sets have been recalibrated to lower volatility. He said that change resulted in lower ratios of reserves to cash value. He noted that the cumulative wealth ratio results seem to indicate that further discussion of the equity-Treasury linkage may be needed.

13. Heard an Update on SOA Research and Education

Dale Hall (Society of Actuaries—SOA) gave a presentation (Attachment Thirty-Seven) on SOA research. He informed the Task Force that the SOA Preferred Mortality Project Oversight Group (PM POG) is being replaced by the SOA, Academy, Life Actuarial (A) Task Force, ACLI, and NAIC Communications group. He said the group’s scope will extend beyond issues related to preferred mortality to now cover all life insurance and annuity valuation needs.

Mr. Hall shared data from recently prepared SOA reports, including reports on group annuity mortality, overall U.S. population mortality, individual life COVID-19 claims, and group life COVID-19 mortality.

14. Heard an Update on the Recent Activities of the Academy LPC

Ben Slutsker (Academy Life Practice Council [LPC]) gave a presentation (Attachment Thirty-Eight) on the LPC’s recent activities. He highlighted Academy accomplishments, such as the recent Academy webinars. He mentioned the upcoming Spring 2022 Life Policy Update webinars and a Fall 2022 webinar on VM-31 reviews. He said recent Academy activities include model office testing for the ESG, proposing an amendment facilitating the transition from LIBOR to SOFR, and presenting the Life Risk-Based Capital (E) Working Group with recommendations for updated C-2 mortality factors. He noted that the LPC has published a new version of the VM-21 Variable Annuity Practice Note.

Donna Claire (LPC Life Experience Committee) said the Life Experience Committee will assist practicing actuaries and state insurance regulators in the determination of what to consider when developing principle-based assumptions for life insurance and annuity products. She said the committee will work with the Task Force, the
SOA, and the Actuarial Standards Board (ASB) with respect to appropriate changes to the *Valuation Manual*, mortality tables, practice notes, and standards of practice.

Having no further business, the Life Actuarial (A) Task Force adjourned.

SharePoint/NAICSupportStaffHub/Member Meetings/Spring 2022/TF/LifeActuarial/NationalMeeting/LATFSpring 2022 Minutes
1. Exposed Recommended Models for ESG Field Testing

Pat Allison (NAIC) said over the last year, a drafting group has been working to provide a recommendation for scenario sets to use in field testing a new prescribed economic scenario generator (ESG) to the Task Force and the Working Group. She said the Recommended Models for ESG Field Testing presentation provides high-level recommendations on the Treasury, Equity, and Corporate models for the field test. She noted that the last page of the presentation deck includes links to documentation and additional information, and further details (e.g., scenarios, scenario statistics, etc.) will be provided shortly.

Ms. Allison said the Equity model is linked to the Treasury model by the short Treasury rate. She said due to changes in the Treasury model, the Equity model calibration must also be updated. Additionally, she said a Sharpe ratio approach with a 5% corridor will be used to set the expected returns for the diversified international equity, aggressive international equity, and U.S. aggressive equity indices because the initially observed expected returns for those categories appear to be low. She noted that the Corporate model needs a calibration update to maintain its risk/reward consistency with the Treasury returns. The remainder of the presentation comprised an overview of each of the three models.

The Task Force and the Working Group agreed, without objection, to expose the Recommended Models for ESG Field Testing presentation (Attachment One-A) for a 21-day public comment period ending April 7.

2. Heard an Update on the Academy Model Office

Jason Kehrberg (American Academy of Actuaries—Academy) said the Academy has developed separate model offices for universal life with secondary guarantees (ULSG) and variable annuities (VA). He said the Academy was asked to use the models to test the impact of selected economic scenario sets on statutory reserves and capital. The Task Force was presented with an overview of the model offices on its March 3 call.
Mr. Kehrberg said the current presentation (Attachment One-B) focuses on the model office results for the selected economic scenario sets. He said the ULSG reserves were calculated based on the yield curve as of December 2020. He noted that the Academy chose to run the unfloored Conning calibration even though it was previously determined earlier that only the floored calibration would be considered in the final analysis. He said the reserve based on the Academy Interest Rate Generator (AIRG) was expected to be low relative to the Conning calibrations because the AIRG generated higher rates. He pointed out that although the reserves for the Conning calibration with the generalized fractional floor and the American Council of Life Insurers (ACLI) reference model were similar in amount, that does not imply that the underlying scenario sets are similar. He said one of the preliminary conclusions from the ULSG model office is that due primarily to the “low for long” requirements, the effect of any of the scenario sets on reserves is expected to be very large.

Albert Zlogar (Academy) discussed the VA model office update. He said the results are like the ULSG results in that the AIRG produced the lowest reserve and the Conning calibrations produced much higher reserve amounts mostly due to the low equity return scenarios. He encouraged participants to take time to review the conclusions.

Having no further business, the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group adjourned.

https://NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/LATF Calls/03 17/Mar 17 Minutes.docx
Agenda

1. Background
2. Summary of Recommended ESG Models for Field Testing
3. Overview of Recommended Treasury, Equity, and Corporate Models
4. Links to Additional Resources
5. Questions and Comments

Appendices:
- Appendix 1: Generalized Fractional Floor
- Appendix 2: Treasury Model Acceptance Criteria
Background

- For over a year, regulators on the ESG Drafting Group have been meeting with subject-matter experts to develop a recommendation to the Life Actuarial (A) Task Force and the Life RBC (E) Working Group for scenario sets to use in field testing a new prescribed ESG for reserves and capital calculations.

- This presentation provides their high-level recommendations on the Treasury, Equity, and Corporate models to include in field testing.

- The ESG field test is planned to begin during the first week of June, so it is necessary to bring more regulators and interested parties into the discussions. These recommendations will be exposed for comment until close of business April 7th, 2022.

- Links to documentation and additional information are included on slide 9 of this presentation. After the updates noted on slide 4 have been made, scenario files will be added to Conning’s website and links to additional resources will be added to slide 9 (e.g., scenario statistics).

Summary of Recommended ESG Models for Field Testing

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<td>Treasury</td>
<td>1. Field test two GEMS® Treasury model candidates</td>
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<td>a. Conning Calibration and Generalized Fractional Floor</td>
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<td></td>
<td>b. Alternative Calibration and Shadow Floor</td>
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<tr>
<td></td>
<td>i. Note: The Alternative Calibration will be adjusted ahead of field testing</td>
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<tr>
<td>Equity</td>
<td>2. Utilize the existing GEMS® equity model with equity-Treasury linkage based on the short Treasury rate for field testing. Additionally, apply the following calibration updates:</td>
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<tr>
<td></td>
<td>a. Update the equity model calibration to account for changes made to the Treasury model</td>
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<td></td>
<td>b. Apply a Sharpe-ratio approach with a 5% corridor to set the expected returns for the diversified international equity, aggressive international equity, and US aggressive equity indices</td>
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<tr>
<td>Corporate</td>
<td>3. Include GEMS® corporate model in initial field testing with the calibration updated for consistency with other generated returns on a risk/reward basis.</td>
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Overview of Recommended Treasury Models for Field Test

Model #1. Conning Calibration and Generalized Fractional Floor
• The Conning calibration, paired with a floor, was designed to meet the acceptance criteria that were chosen by regulators for the Treasury scenarios.
• A generalized fractional floor (see Appendix 1) has been applied to the scenarios resulting from the Conning calibration to reduce the frequency and severity of negative interest rates.

Pros:
• Achieves the acceptance criteria for “Low for Long” Treasury rates while also producing a significant representation of high interest rates
• The generalized fractional floor with a 40 BP threshold and a 20% factor allows for significant control of negative interest rates without severe compression of the scenario distribution in early projection years

Cons:
• The calibration generates more frequent and severe negative interest rates than several commenters feel is reasonable
• The highest rate produced in the set of 10,000 scenarios is 39%
• The frequency of yield curve inversions is elevated vs. history, and inversions can persist for many years
• For scenarios that are inverted, the average level of inversions is significantly higher than historical average levels of inversion

*Across 10,000 scenarios projected for 100 years, 0.16% of 1 year UST rates are between 20-25% and 0.03% are greater than 25%. Over the first 30 years, 1.6% of scenarios have rates of 20% or more.

Model #2. Alternative Calibration and Shadow Floor
• The Alternative Calibration was designed to produce realistic term premiums and yield curve behavior over time and fit a wide variety of historical yield curves. It was also adapted to meet regulator objectives.
• A shadow-rate floor methodology has been applied to reduce the frequency and severity of negative interest rates produced by the Alternative Calibration.

Pros:
• Significantly closer alignment of inversion frequencies and levels between scenarios and historical data
• Shadow floor methodology is specifically designed to preserve the arbitrage-free scenario property

Cons:
• Compressed distribution of scenarios in the earlier projection periods
• Less reflection of high interest rate scenarios
• High negative rate frequency in early years
Overview of Recommended Equity Model for Field Test

GEMS® Equity Model with Equity-Treasury Linkage

- The GEMS® Equity Model is designed to produce realistic equity return behavior and includes volatility clustering, jumps in returns that are more frequent during volatile periods, dividend cash flows that are negatively correlated with price returns, and fat return distribution tails.
- The GEMS® Equity Model also includes a linkage to the Treasury model, which produces lower average cumulative equity returns when interest rate levels are lower and vice-versa.

Pros:
- The GEMS® Equity Model is able to produce scenarios that capture the key dynamics that impact equity returns
- The equity-Treasury linkage will produce scenarios that adequately capture the risk of low equity returns paired with a low interest rate environment
- The equity-Treasury linkage reflects that investors typically demand equity returns in excess of those offered by risk-free assets to compensate for bearing risk.

Cons:
- The inclusion of a linkage between Treasury rate levels and equity returns may add significant volatility and procyclicality to period-to-period calculations of reserves and capital
- Higher starting levels of interest rates will produce scenarios with less reflection of low equity returns paired with low or high interest rate scenarios
- Some commenters believe this linkage to the Treasury model is a simplification not supported by historical data or economic research and may not promote sound risk management

Overview of Recommended Corporate Model for Field Test

GEMS® Corporate Model

- The GEMS® Corporate Model captures the key dynamics that influence bond returns, including stochastic spreads, credit rating transitions, and defaults.
- The bond fund returns produced by the GEMS® Corporate Model will be used to model policyholder separate account investments in bond funds and general account insurer investments in bond funds, where applicable.

Pros:
- The GEMS® Corporate model is able to produce scenarios that reflect the key dynamics of bond fund returns
- Does not require buildout of a separate corporate model

Cons:
- Due to the proprietary nature of the GEMS® Corporate model, full documentation of the model will not be available to the public

Note: An alternative corporate model has been discussed at the ESG Drafting Group meetings and is currently being developed.
Links to Additional Resources - as of 3/17/22

Field Test Candidate Scenario Charts and Statistics:
• These will be added after the updates noted on slide 4 have been made.

ESG Landing Page on Conning Website:
• This site contains previous NAIC scenario releases along with model documentation, information on exposures, a FAQ document, and more.
• This site will be used to deliver scenario files once the ESG is implemented.

Documentation:
• Q&A Document
• Treasury Model Documentation
• Corporate Model Documentation
• Equity Model Documentation

Questions and Comments
Please contact Scott O’Neal (soneal@naic.org) with questions or comments.
Appendix 1: Generalized Fractional Floor

- The Conning GEMS Treasury model has the capability of producing negative interest rates, which have been a feature prevalent in other countries currently and in recent history.
- While the basic formula for the generalized fractional floor (see below) is relatively simple, the implementation of the floor in the Conning Calibration is more complex. In this particular implementation, the Treasury model is fit to an implicit yield curve that is chosen such that the actual yield curve is matched at time zero after the floor has been applied.
- Applying a generalized fractional floor methodology to the scenarios from the Conning Treasury calibration allows for increased control of the frequency and severity of negative interest rates.
- After testing, Conning has chosen a threshold value of 40 BPs and a factor of 20% to reduce the frequency and severity of negative interest rates while ensuring that other regulator objectives, such as low for long, are met.

**Generalized Fractional Floor Formula:**

- If Unfloored Rate < Adjustment Threshold,
  - Floored Rate = Adjustment Threshold + Factor * (Unfloored Rate - Adjustment Threshold)
- Otherwise,
  - Floored Rate = Unfloored Rate

**Example:**

Unfloored Rate = -1%  Threshold = 40BPs  Factor = 20%
Floored Rate = 0.4% + 20%*(-1% - 0.4%) = 0.12%

Appendix 2: Treasury Model Acceptance Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Acceptance Criteria</th>
</tr>
</thead>
</table>
| 1.   | Low For Long | a) At least 10% of scenarios should have a 10-year geometric average of the 20-year UST that is below 1.45%*  
|      |           | b) At least 5% of scenarios should have a 30-year geometric average of the 20-year UST that is below 1.45%* |
| 2.   | Prevalence of High Rates, Upper Bound on Treasury Rates | a) The scenario set should reasonably reflect history, with some allowance for more extreme high and low interest rate environments  
|      |           | b) Upper Bound:  
|      |           | i. 20% is >= 99th percentile on the 3M yield fan chart, and no more than 5% of scenarios have 3M yields that go above 20% in the first 30 years  
|      |           | ii. 20% is >= 99th percentile on the 10Y yield fan chart, and no more than 5% of scenarios have 10Y yields that go above 20% in the first 30 years |

*1.45% was the current level of the 20-year UST at 12/31/20.
Appendix 2: Treasury Model Acceptance Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Acceptance Criteria</th>
</tr>
</thead>
</table>
| 3.   | Lower Bound on Negative Interest Rates, Arbitrage Free Considerations | Apply the following guidance for negative rates:  
   a) All maturities could experience negative interest rates  
   b) Interest rates may remain negative for multi-year time periods  
   c) Rates should generally not be lower than -1.5% |
| 4.   | Initial Yield Curve Fit, Yield Curve Shapes in Projection, and Steady State Yield Curve Shape | a) Review initial actual vs. fitted spot curve differences for a sampling of 5 dates representing different shapes and rate levels for the entire curve and review fitted curves qualitatively to confirm they stylistically mimic the different actual yield curve shapes  
   b) The frequency of different yield curve shapes in early durations should be reasonable considering the shape of the starting yield curve (e.g. a flatter yield curve leads to more inversions).  
   c) The steady state curve has normal shape (not inverted for short maturities, longer vs shorter maturities, or between long maturities) |
Background

- The Academy’s Economic Scenario Working Group (ESWG) developed two model offices (Universal Life with Secondary Guarantees (ULSG) and Variable Annuities (VA))
- The National Association of Insurance Commissioners’ (NAIC’s) ESG Drafting Group asked the ESWG to use its model offices to test the impact of selected economic scenario sets on statutory reserves and capital
- Statutory reserves and capital are expected to increase under the NAIC’s new “low-for-long” interest rate criteria (which the AIRG does not meet)
- The ESWG provided an overview of its model offices on the 3/3/22 LATF call
- This 3/17/22 presentation to LATF provides actual model office results for the economic scenario sets that have been selected by the Drafting Group
  - ULSG/VM-20
  - VA/VM-21
- The ESWG is available to run additional economic scenario sets through its model offices as needed
Update on ULSG/VM-20 Model Office ESG Testing

Jason Kehrberg, MAAA, FSA

Agenda for VM-20 Model Office Update

1. Changes and New Info
2. December 2020 Stochastic Reserves
3. Scenario Reserve Distributions
4. Sample Scenario Projections
5. December 2019 Stochastic Reserves
6. Preliminary Conclusions
7. Caveats
VM-20 Model Office – Changes Since 3/3/22

- Guaranteed minimum crediting rate = 2% (was 3.25%; done to be more in line with current ULSG products, many of which use 1%)
- Units increased so premiums = $12,000 each anniversary (was $8,507; a scaling choice that won’t impact comparisons between results)
- Borrowing rate = 105% of 1-year Treasury rate to be consistent with GPVAD discount rate (was 3-month Treasury rate + 1%)
- No other changes since 3/3/22

VM-20 Model Office – Additional Info

- Using a single model point issued on the valuation date to a female non-smoker age 45
- Using annual reinvestment frequency
  - Cash flows within year accumulate with interest at 3-month Treasury rate
- Assuming investment expense of 10 basis points (provided for completeness since not in 3/3/22 overview presentation; not a key assumption)
- Solving for starting assets solved within 0.1% of reserve
December 2020 Stochastic Reserves

<table>
<thead>
<tr>
<th>Scenario Set</th>
<th>Stochastic Reserve</th>
<th>Initial Reserve / $12K Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy Interest Rate Generator (AIRG)</td>
<td>18,511</td>
<td>154%</td>
</tr>
<tr>
<td>Conning Oct21 Calibration (Unfloored)</td>
<td>39,193</td>
<td>327%</td>
</tr>
<tr>
<td>Conning with Generalized Fractional Floor</td>
<td>31,812</td>
<td>265%</td>
</tr>
<tr>
<td>Strommen with Shadow Rate Model Floor</td>
<td>28,556</td>
<td>238%</td>
</tr>
<tr>
<td>ACLI Reference Model v1.1</td>
<td>31,659</td>
<td>264%</td>
</tr>
</tbody>
</table>

Scenario Reserve Distributions

- Note: Conning (Unfloored) line goes as high as 536,865, but graph is cut off to help with the scale
Sample Scenario Projections

- The graphs on the next 6 slides are samples of a good scenario, followed by the worst* scenarios for each of the 5 scenario sets
  - *Only 1,000 out of 10,000 scenarios were run
- Each scenario has the same general pattern of flows:
  - Premiums collected in early years builds up the asset base
  - Deaths and lapses over time decrease the incoming premiums and increase the outgoing claims
- Blue line is the projection of total assets
- Black line (dotted) is the Discount rate = 105% of 1 Year Treasury rate (prescribed)
- Orange line is a present value to valuation date of (-total assets)
  - Referred to as the “Present value of accumulated deficiencies” (PVAD)
  - The maximum PVAD referred to as the Greatest PVAD (GPVAD)

Sample Good Scenario

- Assets remain positive, and PVAD remains lower than the negative of starting assets

Starting Assets = 18,511

GPVAD = -18,511

Scenario Reserve = 0
AIRG, Worst Scenario

Starting Assets = 18,511
GPVAD = 34,424
Scenario Reserve = 55,935

- Relatively higher 1-Year Treasury discount rates reduces the GPVAD

Conning (Unfloored), Worst Scenario

Starting Assets = 39,202
GPVAD = 497,663
Scenario Reserve = 536,865

- Very negative 1-Year discount rates over many years leads to extremely large GPVAD
Conning (with GFF), Worst Scenario

- This scenario has several years where the GA asset portfolio is earning less than the 2% minimum crediting

**Starting Assets = 31,828**

**GPVAD = 195,913**

**Scenario Reserve = 227,741**

Strommen, Worst Scenario

- Similar to the last slide, but a little less asset deficiency

**Starting Assets = 28,561**

**GPVAD = 163,055**

**Scenario Reserve = 191,616**
ACLI Reference, Worst Scenario

Starting Assets = 31,666
GPVAD = 160,211
Scenario Reserve = 191,877

- Similar to the last 2 slides, but discount rates remain near 0%

December 2019 Stochastic Reserves

<table>
<thead>
<tr>
<th>Scenario Set</th>
<th>Stochastic Reserve</th>
<th>% Change vs. 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy Interest Rate Generator (AIRG)</td>
<td>15,200</td>
<td>-17.9%</td>
</tr>
<tr>
<td>Conning Oct21 Calibration (Unfloored)</td>
<td>TBD</td>
<td>N/A</td>
</tr>
<tr>
<td>Conning with Generalized Fractional Floor</td>
<td>TBD</td>
<td>N/A</td>
</tr>
<tr>
<td>Strommen with Shadow Rate Model Floor</td>
<td>TBD</td>
<td>N/A</td>
</tr>
<tr>
<td>ACLI Reference Model v1.1</td>
<td>22,786</td>
<td>-28.0%</td>
</tr>
</tbody>
</table>
Preliminary Conclusions

- Impact to reserves expected to be very large under any of the scenario sets considered
  - Primarily due to the new “low-for-long” requirements, which are not present in the current AIRG
  - High premiums used in this model office is very conservative and limits the value of the secondary guarantee
  - Lower premiums would strengthen the secondary guarantee and make the product riskier, which would be expected to produce even greater impacts
- Conning’s unfloored scenarios produces some extreme scenario reserves
  - Primarily due to discounting deficiencies at 105% of 1-Year Treasury, which can be extremely negative

Caveats

- Intended as an illustrative single data point (single model point issued on valuation date; no future sales) for assessing materiality and relative impact to reserve levels and volatility from a change to the scenarios
- Selected ULSG product has exposure to interest rates only, no exposure to equity or bond fund returns
- Not intended to:
  - Cover wide variety of life products available on the market
  - Reflect a full distribution of issue ages / genders within the given product
  - Thoroughly test all the underlying assumptions
  - Be used as a basis for assessing appropriateness of an Economic Scenario Generator
Update on VA/VM-21 ESG Model Office Testing

Albert Zlogar, MAAA, FSA

Agenda for VA Model Office Update

1. Product specification and model updates since 3/3/22
2. Listing of product specifications and assumptions
3. VM-21 Reserve and C3P2 Total Asset Requirement (TAR) method description
4. Sample Scenario Reserve calculations
5. Summary of results – all scenario sets
6. Preliminary conclusions
7. Large Cap Equity Fund return comparisons
8. Scenario reserve distributions
9. Preliminary sensitivity testing
10. Caveats
VM-21 Model Office – Changes Since 3/3/22

- Guaranteed Lifetime Withdrawal Benefit (GLWB) maximum lifetime withdrawal percentages by attained age band at income election were reduced at ages 70+ to be more in line with current products. The attained age 70 percentage used for these tests was reduced from 5.50% to 5.00%.
- Model refinement made to more accurately calculate discounting of accumulated asset deficiencies to calculate GPVAD (refined net earned rate vector on additional assets (NAER), etc.)
- No other changes since 3/3/22
- The current product specifications and assumptions used for these test results are shown in the next 4 slides

Product Specifications

- Variable Annuity with a GLWB and Guaranteed Minimum Death Benefit (GMDB) (details on next slide)
- Seven-year surrender charge period
- Single model point issued to age 60 male on the valuation date with single premium of $100,000
- Premium/fund allocation: all of the single premium is invested in separate account funds, allocated 80% U.S. large cap equity and 20% long term U.S. corporate bond funds
  - Monthly fund rebalancing to maintain 80/20 mix.
Product Specifications

<table>
<thead>
<tr>
<th>Variable Annuity Base contract</th>
<th>GLWB</th>
<th>GMDB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue age</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Single premium at issue</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>Fund allocation</td>
<td>80% US large cap equity / 20% US LT Corp bond, rebalanced monthly</td>
<td></td>
</tr>
<tr>
<td>M&amp;E risk charges (annld.)</td>
<td>1.30% (applied to fund value)</td>
<td></td>
</tr>
<tr>
<td>Inv mgmt fee (annld.)</td>
<td>0.75% (half of this fee comes back to company as guaranteed revenue sharing)</td>
<td></td>
</tr>
<tr>
<td>Surrender charge period</td>
<td>7 years</td>
<td></td>
</tr>
<tr>
<td>SC % of deposit</td>
<td>8, 7, 6, 5, 4, 3, 2%</td>
<td></td>
</tr>
</tbody>
</table>

1. Prorata reduction in guaranteed benefit base for any WDs taken in excess of (a) or (b), where (a) is the annual 10% free WD amount prior to income election, and (b) is the GLWB guaranteed annual withdrawal amount after income election. Upon income election, the fund value reduces dollar for dollar as WD’s are taken until fund value exhausts to zero. Excess WD’s taken above the lifetime WD amount cause a prorata reduction in the Benefit Base and effect the income amount.

<table>
<thead>
<tr>
<th>Guaranteed Benefits</th>
<th>GLWB</th>
<th>GMDB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Base Rollup %</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Rollup period</td>
<td>10 years</td>
<td>Up to age 80</td>
</tr>
<tr>
<td>Ratchet or reset</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Withdrawals</td>
<td>Pro-rata</td>
<td>Pro-rata</td>
</tr>
<tr>
<td>Rider charge (annld.)</td>
<td>1.20%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

2. GLWB withdrawal rate %

3. Benefits based on Max [actual fund value, premium accum. at 5% compounded] after this period if time allows, may test a ratchet benefit enhancement (max anniv value) calculated on the roll-up benefit base, deducted monthly from fund value

4. Guaranteed Minimum Benefit base stops accumulating at 5% after this period of income election, which defines the lifetime max annual income amount.

5. 5-year waiting period from issue required prior to income election.

6. Benefits taken above the lifetime WD amount cause a prorata reduction in the Benefit Base and effect the income amount.

Liability Assumptions

- Used VM-21 prescribed Additional Standard Projection Amount (ASPA) assumptions for lapse, mortality and expense (broadly reflects average industry experience):
  - Lapse rates decrease as guaranteed benefit is more in the money and zero when fund value exhausts, and reflect policy duration (pre/post SC period, ultimate)
    - In-the-moneyness(t) for GLWB defined as GAPV future income benefit(t) > current fund value(t)
    - GAPV discount rate is 10 year US T-bond as of the valuation date
  - Mortality 2012 IAM, improvement scale G2, VM-21 ASPA Fx factors
  - Expense: $100 per policy + $7e per fund value annual maintenance & overhead

- Exception to prescribed ASPA assumptions used for GLWB income election:
  - Instead of ASPA-WD delay cohort method (many multiple election date cohorts), assumed 100% election at end of contract year 10 (highest guaranteed benefit base roll-up duration), at attained age 70 in this case
  - Assumed 100% of maximum GLWB withdrawal percentage (applied to max of EoY 10 fund value or benefit base) is taken as lifetime income amount at year 10 election
  - Both of the above (timing and amount) are more conservative than prescribed and industry experience and were assumed for initial modeling convenience and time constraints
    - Industry experience shows multiple election dates occur as well as < 100% of max WD rate taken

- No other partial withdrawals, Required Minimum Distributions (RMDs) or non-conforming/excess withdrawals assumed other than the GLWB withdrawals
Asset Assumptions

- Starting asset amount = separate account cash surrender value
- No starting general account investments, and there is initial borrowing of the SA surrender charge amount to top-up separate account to the full $100k deposit – borrowed at initial 7-year bond rate with monthly P&I paydown
- General account investment/reinvestment strategy:
  - Invest positive cash flows in 50%/50% mix of AA/A non-callable corporate bonds
    - Use prescribed tables (from VM-20) for spreads (current and long term) and default costs
    - 9 basis points (bp) annual investment expense
  - Bond maturity mix 1 to 30 years; starts longer and shortens over time to maintain reasonable match to liability cash flows
  - If there is a shortfall, borrow at same strategy/rates as reinvestment (“negative assets approach”), therefore borrowing rates are the same as reinvestment rates
- Initially no hedging or reinsurance was modeled, as there has not been time to reflect this.
- Monthly model time steps, 40 projection years (when no material liabilities remain)
- 10,000 scenarios were run for each scenario set

VM-21 Reserve Method Description

- Reserve and C3P2 Risk-Based Capital (RBC) and TAR calculated per VM-21:
- Reserve = Stochastic Reserve + Additional Standard Projection Amount (ASPA), where
  - Stochastic Reserve = Conditional Tail Expectation (CTE)70 of 10,000 Scenario Reserves
  - Scenario Reserve for this model segment = Max (aggregate cash surrender value (CSV), Starting Assets + Greatest Present Value of Accumulated Deficiencies (GPVAD))
  - Starting assets = CSV, so scenario GPVAD is portion of reserve held in general account to ensure all guaranteed liability cash flows and expenses (in excess of those funded by separate account) are paid off to the end of the projection for the scenario
  - Discount rates to calculate GPVAD = net earned rates on additional available assets invested up front to back the GPVAD (NAER)
  - ASPA = add-on to stochastic reserve if base assumptions are less conservative than prescribed assumptions (not applicable for these tests, i.e., ASPA=0, since assumptions used are not less conservative than prescribed)
- C3P2 RBC uses macro tax adjustment (MTA) method in these tests:
  - C3 amount = max(0, 25% * ((CTE98 + ASPA - Statutory Reserve) x (1-Federal Income Tax (FIT) rate) – (Statutory Reserve - Tax Reserve) x FIT rate)))
Sample Scenario Reserve Calculations

Before discussing the full scenario set results, it is useful to review the mechanics and key amounts of the scenario reserve calculation.

The next 3 slides discuss and show graphs of this detail for 2 of the 3,000 scenario reserves comprising the CTE70 stochastic reserve.

Sample Scenario Reserve Calculations

- The next 2 slides and graphs illustrate the calculations for high and low scenario reserve amounts (driven by scenario fund returns, interest rates, investment yields and borrowing costs).
- Each has the same general pattern of starting and projected asset amounts and flows, particularly for the CTE70 scenarios:
  - Green line is the separate account assets (fund value); starts at deposit and grows or declines based on scenario fund returns net of fees, and as fund value is released on surrender, death and GLWB withdrawal payments while fund value is positive.
  - Blue line is the general account assets/deficiencies prior to the scenario reserve assets added in. Starts negative (initial SA SC borrowing) and grows in early years as fee income is invested (net of expenses and some GMDB and GLWB claims in excess of fund value released). Then declines after separate account fund value exhausts and continuing GMDB + GLWB claims and expenses are paid out. Declines below zero (accumulated deficiency) for many of the CTE70 scenarios.
  - Orange line is the PV of the blue line assets and deficiencies, discounted at the net earned rates on additional assets (NAER). The greatest of the projected year-end PV of negative of the deficiencies (GPVAD) is the scenario reserve needed to be invested up front to eliminate the blue line projection year-end deficiencies.
  - Yellow line is the new projection of the blue line general account assets but now including the initial scenario reserve assets and shows the projected year-end deficiencies have been eliminated.
- Tables of separate account returns and NAER discount rates driving the results are also shown.
High Reserve Scenario

Separate account assets exhaust after 12 years. Must add general account assets ($41,793) up front to fund future guaranteed income & death benefits and expenses.

Low Reserve Scenario

Separate account assets last for 20 years. Must add relatively small amount of general account assets ($1,004) up front to fund future guaranteed income & death benefits and expenses.
Summary of Results – All Scenario Sets

The next 2 slides summarize the:
• Stochastic CTE70 reserves and
• C3 Phase 2 Total Assets Required (TAR)

For the following scenario sets tested:
1. AIRG scenarios
2. ACLI reference SLV model (version 1)
3. Conning GEMS with Generalized Fractional Floor (GFF)
4. Strommen with Shadow Rate Floor (version 4B)
5. Conning GEMS unfloored 12/31/2020 valuation date scenarios developed in October 2021

In addition, a “hybrid” set of scenarios was tested for 3, 4 and 5 above, by replacing the U.S. large cap equity fund scenarios with the AIRG U.S. large cap equity fund scenarios (as an initial simplistic rough test to get a feel for impact of removing the equity risk premium linkage to overnight UST scenario rates).

Summary of Results - CTE70 Reserves

<table>
<thead>
<tr>
<th>Scenario Set (used full 10,000)</th>
<th>Reserves (gen. acct. resv is excess over CSV)</th>
<th>12/31/2019 CTE70 Reserve</th>
<th>Ratio to CSV</th>
<th>12/31/2020 CTE70 Reserve</th>
<th>Ratio to CSV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Academy Interest Rate Generator (AIRG)</td>
<td></td>
<td>95,854</td>
<td>103.3%</td>
<td>98,491</td>
<td>106.1%</td>
</tr>
<tr>
<td>2 ACLI Reference Model V1.0</td>
<td></td>
<td>96,146</td>
<td>103.6%</td>
<td>98,515</td>
<td>106.2%</td>
</tr>
<tr>
<td>3 Conning with Generalized Fractional Floor</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>4 Strommen with Shadow Rate Model Floor</td>
<td>TBD</td>
<td>107,860</td>
<td>116.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Conning Oct21 Calibration (Unfloored)</td>
<td>TBD</td>
<td>110,825</td>
<td>119.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 hybrid</td>
<td>Conning with GFF, using AIRG equity scens</td>
<td>97,406</td>
<td>105.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 hybrid</td>
<td>Strommen with SRF, using AIRG equity scens</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 hybrid</td>
<td>Conning Oct 21 unfl, using AIRG equity scens</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hybrid scenario results are a simplistic initial rough test to get an initial feel for the impact of removing the equity risk premium linkage to scenario short term overnight UST rates.
Summary of Results – C3P2 TAR

<table>
<thead>
<tr>
<th>VA with GLWB and GMDB</th>
<th>C3P2 TAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario Set (used full 10,000)</strong></td>
<td><strong>12/31/2019 C3P2 TAR</strong></td>
</tr>
<tr>
<td>1 Academy Interest Rate Generator (AIRG)</td>
<td>99,268</td>
</tr>
<tr>
<td>2 ACLI Reference Model V1.0</td>
<td>99,769</td>
</tr>
<tr>
<td>3 Conning with Generalized Fractional Floor</td>
<td>TBD</td>
</tr>
<tr>
<td>4 Stroemmen with Shadow Rate Model Floor</td>
<td>TBD</td>
</tr>
<tr>
<td>5 Conning Oct21 Calibration (Unfloored)</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>3 hybrid</strong></td>
<td>Conning with GFF, using AIRG equity scen</td>
</tr>
<tr>
<td><strong>4 hybrid</strong></td>
<td>Stroemmen with SRF, using AIRG equity scen</td>
</tr>
<tr>
<td><strong>5 hybrid</strong></td>
<td>Conning Oct 21 unfloored, using AIRG equity scen</td>
</tr>
</tbody>
</table>

Hybrid scenario results are a simplistic initial rough test to get an initial feel for the impact of removing the equity risk premium linkage to scenario short term overnight UST rates.

Preliminary Conclusions

- Impact to reserves is very large under the 3 Conning ESG scenario sets (Oct unfloored, GFF, Stroemmen SRF) relative to current AIRG or ACLI reference model.
- Ratios of reserves and TAR to CSV are significantly higher - general account reserves are almost triple the AIRG & ACLI reserves for GEMS GFF and Stroemmen SRF, and more than triple using the GEMS unfloored set.
- The 3 Conning scenario sets have lower equity returns at 12/31/2020 in part due to very low (zero and negative) short overnight rates, as Conning’s equity risk premium (ERP) used in the return scenario generation is linked to overnight interest rate. The AIRG and ACLI reference equity return ESGs do not have this linkage.
- Specifically the GEMS Large Cap expected equity return is roughly the Overnight Rate plus a fixed ERP. The link happens at every node of the simulation, so the short-term expected equity return is constantly changing. Early year very low and negative Overnight simulated rates can materially reduce the simulated equity returns. As the average yields rise in these scenarios, there will be a general rise in the average Large Cap return, but the overall impact cumulative appears to be lower returns as shown on slide 36 which compares left tail equity returns across the sets (left tail more relevant for this particular product).
- At 12/31/2019 the short term rates were >100bp higher than at 12/31/2020, so it will be interesting to see these 2019 results when scenarios are available.
  - Would expect to see potential “artificial”/non-economic changes in reserves and TAR 2019 versus 2020 using Conning scenarios just due to this rate linkage impact on equity scenarios, and
  - Higher procyclical volatility with rate linkage – e.g., in force blocks at 12/31/2019 will be deeper in money at 12/31/2020 and the 2020 equity return scenarios would have been significantly lower than 12/31/2019.
- May result in higher hedge costs depending on hedging target (e.g., if hedging statutory results).
Preliminary Conclusions

- Reserves and TAR for the 3 Conning scenario sets also higher due to the “low for long” interest rate requirements, which are not present in the current AIRG.

- Initial impressions are that for the Conning scenarios (GEMS GFF, Stroommen SRF, Oct unfloored), the low equity return scenarios are more of a driver of the large reserve and TAR impacts than the low for long interest rate scenarios for this particular product, but still analyzing all of the scenario results to confirm (these tests were only just recently run).

- (Although as noted on prior slide the overnight interest rates are one of the drivers of the equity returns)

- For example the “hybrid” scenario results shown (using Conning GEMS GFF interest rate and LT corporate bond fund returns but using AIRG equity returns) have reserve and TAR amounts that are very similar to the AIRG and ACLI reference model results.

Comparison of Equity Scenarios

<table>
<thead>
<tr>
<th>U.S. Large Cap equity total return scenarios 12/31/2020 - annualized cumulative geometric mean returns (derived using cumulative wealth ratios)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>percentile</strong></td>
</tr>
<tr>
<td><strong>Conning GEMS with GFF 12/31/2020</strong></td>
</tr>
<tr>
<td>50.00%</td>
</tr>
<tr>
<td>10.00%</td>
</tr>
<tr>
<td>5.00%</td>
</tr>
<tr>
<td>2.50%</td>
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<tr>
<td>0.50%</td>
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<tr>
<td><strong>min</strong></td>
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<tr>
<td><strong>mean</strong></td>
</tr>
<tr>
<td><strong>AIRG 12/31/2020 (same as 11/31/2019)</strong></td>
</tr>
<tr>
<td>50.00%</td>
</tr>
<tr>
<td>10.00%</td>
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<tr>
<td>5.00%</td>
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<td>2.50%</td>
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<tr>
<td>0.50%</td>
</tr>
<tr>
<td><strong>min</strong></td>
</tr>
<tr>
<td><strong>mean</strong></td>
</tr>
<tr>
<td><strong>Stroommen 48k with SRF 12/31/2020</strong></td>
</tr>
<tr>
<td>50.00%</td>
</tr>
<tr>
<td>10.00%</td>
</tr>
<tr>
<td>5.00%</td>
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<td><strong>AIRG 12/31/2020 (same as 11/31/2019)</strong></td>
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<td><strong>mean</strong></td>
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</tbody>
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Scenario Reserve Distributions

Highest 3,000 Scenario Reserves (avg = CTE70 reserve) Conning GEMS w GFF 12.31.20 scenario set

Highest 3,000 Scenario Reserves (avg = CTE70 reserve) Strommen 4B w SRF 12.31.20 scenario set

Strommen 4B set has one outlier scenario with very negative Equity returns, causing the highest $229k reserve outlier.

Preliminary Sensitivity Tests

<table>
<thead>
<tr>
<th>Sensitivity Tests for one scenario</th>
<th>EoY 40 accumulated deficiency</th>
<th>annualized NAER disc rate over 40 years</th>
<th>EoY 40 accumulated deficiency</th>
<th>annualized NAER disc rate over 40 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Conning GFF scenario #8623 (base case)</td>
<td>(182,096)</td>
<td>41,793</td>
<td>3.75%</td>
<td>GPVAD</td>
</tr>
<tr>
<td>2 +25bp parallel shift up all UST rates</td>
<td>(187,776)</td>
<td>38,933</td>
<td>4.00%</td>
<td>GPVAD</td>
</tr>
<tr>
<td>3 -25bp parallel shift down all UST rates</td>
<td>(176,485)</td>
<td>44,861</td>
<td>3.49%</td>
<td>GPVAD</td>
</tr>
<tr>
<td>4 +25 bp higher equity fund total returns (80% alloc)</td>
<td>(180,449)</td>
<td>41,415</td>
<td>3.75%</td>
<td>GPVAD</td>
</tr>
<tr>
<td>5 +25bp rate shift and +25bp equity returns</td>
<td>(186,006)</td>
<td>38,566</td>
<td>4.00%</td>
<td>GPVAD</td>
</tr>
</tbody>
</table>

Initial comments:

2 Accumulated deficiency is worse when rates are higher due to higher borrowing costs, but GPVAD (general account reserve) is lower. Some of this can be caused by differences in NAER vector for the initial GPVAD investment ("additional assets") and the ongoing emerging average earned rates and borrowing rates on the other general account assets from fee income investments and deficiency borrowing. Thus can have a lower reserve (higher NAER) even though ending deficiency is worse. Still reviewing.

3 Accumulated deficiency is less when rates are lower due to lower borrowing costs, but GPVAD (general account reserve) is higher.

2 & 3 Thus the reserve impact is slightly asymmetric for UST sensitivity ($3,068 higher reserve for test 3 versus $2,861 lower reserve for test 2).

4 Relatively low favorable impact of the higher equity returns for this scenario - separate account still declines quickly to zero even after adding +25bp to very low returns. Also the required rebalancing to maintain 80/20 fund mix dampens the beneficial effect of the higher equity fund return sensitivity as it moves some of the higher return to the LT corporate bond fund each month.

5 Combined impact is close to sum of the parts tests 2+4.

Note - similar sensitivity impacts for other scenarios will be different - depending on level of general and separate account assets, etc. More analysis to come, using different scenarios and other sensitivities.
Caveats

- Intended as an illustrative single data point (single representative model point issued on valuation date; no future sales; not an in-force block) for assessing materiality and relative impact to reserve levels and volatility from a change to the scenarios
  - Companies should consider testing their own products using their own models.

- Not intended to:
  - Cover wide variety of products available on the market
  - Reflect a full distribution of issue ages / genders within the given product
  - Reflect different starting in-force block conditions (guaranteed benefit moneyness, etc.)
  - Thoroughly test all the underlying assumptions
  - Be used as a basis for assessing appropriateness of an Economic Scenario Generator

Questions?

- Please contact Devin Boerm at boerm@actuary.org
The Life Actuarial (A) Task Force met March 10, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ted Chang, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Eric Dunning and Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. **Exposed Amendment Proposal 2022-04**

   Alan Routhenstein (American Academy of Actuaries—Academy) gave a presentation (Attachment Two-A) on the Academy proposal for replacing swap spreads based on the London Interbank Offered Rate (LIBOR) with those based on the Secured Overnight Financing Rate (SOFR). The swap spreads are used for the modeled reserve asset and derivative calculations under VM-20, Requirements for Principle-Based Reserves for Life Products; VM-21, Requirements for Principle-Based Reserves for Variable Annuities; and VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities.

   Mr. Routhenstein said there are three questions for the Task Force and commenters to consider: 1) Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the amendment proposal address this)?; 2) What is the practical number of spread adjustment parameters to use?; and 3) Should the NAIC consider payment frequency and day count enhancements to improve accuracy?

   Pat Allison (NAIC) said the current Valuation Manual language allows for the transition from LIBOR to SOFR, but it does not seem to allow for publishing both sets of rates. She agreed to request the NAIC Legal Department offer an opinion on whether the NAIC has the authority to publish both sets of rates.

   Mr. Leung made a motion, seconded by Mr. Chou, to expose amendment proposal 2022-04 (Attachment Two-B), including the questions for commenter consideration and some minor reference clarifications, for a 44-day public comment period ending April 22. The motion passed unanimously.

2. **Adopted Amendment Proposal 2022-01**

   Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Two-C) supports the adoption of amendment proposal 2022-01. Sheldon Summers (Claire Thinking) said his comment letter (Attachment Two-D) points out that the retrocessionaire in a coinsurance agreement does not have the right to increase premiums in the same way the initial yearly renewable term (YRT) reinsurer would. He recommends setting $\frac{1}{2} cx$ as the reserve floor but requiring modeling for the deterministic and stochastic reserves if the coinsurance retrocessionaire believes the initial YRT reinsurer has less of an incentive to increase the YRT reinsurance premium rates on a timely basis due to the risk being transferred via the coinsurance treaty.
Ms. Hemphill said while she understands the comments, she believes that modeling the retrocession with the current VM-20 requirements would result in a reserve that is not materially different from the $\frac{1}{2} cx$ treatment, and the intent was to clarify the current requirements. Mr. Slutsker concurred. He said the intent of the proposal was to clarify the process in place for retrocessions. He expressed an openness to considering a broader scope in the future.

Mr. Slutsker made a motion, seconded by Mr. Chupp, to adopt amendment proposal 2022-01 (Attachment Two-E). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
APF 2022-__: SWAP SPREADS AND LIBOR TRANSITION TO SOFR – UPDATED VM-20 PRESCRIBED SWAP SPREADS GUIDANCE IN LIGHT OF THE LONDON INTER-BANK OFFERED RATE (LIBOR) TRANSITION TO THE SECURED OVERNIGHT FINANCING RATE (SOFR)

Life Actuarial Task Force (LATF) March 10, 2022

Academy Disclaimer

- The presenter’s statements and opinions are their own and do not necessarily represent the official statements or opinions of the Actuarial Board for Counseling and Discipline (ABCD), Actuarial Standards Board (ASB), any boards or committees of the American Academy of Actuaries, or any other actuarial organization, nor do they necessarily express the opinions of their employers.
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   3) 1c - How were Spread Adjustments defined in Bloomberg calculations?
   4) 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used?

Questions for discussion:

1) Q1: Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)?
2) Q2: What is the practical number of Spread Adjustment parameters to use?
3) Q3: Should we consider Payment Frequency and Day Count enhancements to improve accuracy?

Executive Summary (1 of 2)

- Background
  - Swap spreads are used for VM modeled reserve asset and derivative calculations under VM-20, VM-21 and VM-22
  - Bank regulators and a group of private market participants called Alternative Reference Rates Committee (ARRC) have agreed that for interbank USD interest rate swaps executed after 2021, the floating rate needs to be based on an index other than the London Interbank Offered Rate (LIBOR), with similar changes for swaps in other currencies
  - During 2021 the swap market evolved such that the definition of a standard n-year interest rate swap changed in January 2022 to be a SOFR swap (for which the floating rate is based on SOFR) from the historical LIBOR swap (for which the floating rate is LIBOR)
  - As a result, VM-20 instructions for how the NAIC will calculate and publish swap spreads needs to be updated for Current Benchmark Swap Spreads (published monthly) and Long-Term Benchmark Swap Spreads (published quarterly)
  - The Academy is recommending that LATF consider exposing this APF for 30-45 days and adopting shortly thereafter, so the NAIC can start publishing updated spread tables that could be used for 2022 valuations
  - The attached APF is proposing updates to these three VM-20 sections:
    - Section 9.F.8.d Procedure for Setting Prescribed Gross Asset Spreads
    - Appendix 2.F Current Benchmark Swap Spreads
    - Appendix 2.G Long-Term Benchmark Swap Spreads
Executive Summary (2 of 2)

- The APF proposes that
  - 3-month LIBOR be replaced with 3-month SOFR swap rate
  - 6-month LIBOR be replaced with 6-month SOFR swap rate
  - 1-year LIBOR swap rate be replaced with 1-year SOFR swap rate
  - ...
  - 30-year LIBOR swap rate be replaced with 30-year SOFR swap rate

- Because there aren’t 15 years of historical SOFR Swap data for the NAIC to use to calculate Long-Term Benchmark Swap Spreads, the APF proposes an estimation formula
  - Estimated historical current SOFR swap rate = corresponding LIBOR swap rate – Spread Adjustment

- Question 1 on slides 21-22 discusses: Should the NAIC should start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)?
- Questions 2 & 3 on slides 23-27 discuss: Should the APF should be refined to increase calculation accuracy at the cost of increased complexity?

Where are Swap Spreads applicable?

- Examples of assets and derivative instruments for which the updated swap spread guidance would be applicable include
  - Floating rate corporate bonds and floating rate asset backed securities
  - Interest rate swaps (e.g., insurer receives a fixed rate and pays a floating rate)
  - Interest rate caps (e.g., insurer receives the excess if any of a floating rate over a specified fixed rate)
  - Interest rate floors (e.g., insurer receives the excess if any of a specified fixed rate over a floating rate)
  - Swap options (e.g., insurer has the right to enter an interest rate swap)

- Also, some companies use swap spreads to define swap curves used to calculate derivative portfolio and liability benchmark market values at each node in cash flow projection models
Highlights of NAIC Staff’s 8/12/21 deck (1 of 2)

- Companies with LIBOR in one or more contracts will need to take action, which varies by contract type
- Future LATF Actions Needed
  - Identify the replacement for LIBOR.
  - Adopt the replacement for LIBOR when the NAIC determines that LIBOR is no longer effective. This will enable the NAIC to begin publishing the 3-month and 6-month rates.
  - Amend the Valuation Manual to specifically identify the replacement for 3-month and 6-month USD LIBOR.
  - Determine whether the process for calculating Long Term Benchmark Swap Spreads needs to be changed, given that there is no 15-year history for LIBOR’s replacement.

Highlights of NAIC Staff’s 8/12/21 deck (2 of 2)

- Key Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Date Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/26/21</td>
<td>Interdealer trading conventions changed to trade SOFR linear swaps in place of USD LIBOR.</td>
</tr>
<tr>
<td>7/29/21</td>
<td>The Alternative Reference Rates Committee (ARRC) formally recommended CME Group’s forward looking SOFR Term Rates. CME Term SOFR rates are now published daily in 1-month, 3-month and 6-month tenors.</td>
</tr>
<tr>
<td>1/1/22</td>
<td>1-week and 2-month USD LIBOR will no longer be published (the Valuation Manual does not reference these).</td>
</tr>
<tr>
<td>7/1/23</td>
<td>All other USD LIBOR tenors (i.e., overnight, 1, 3, 6, and 12 month) will no longer be published.</td>
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### Academy Additions to NAIC Staff’s 8/12/21 Key Dates (1 of 2)

<table>
<thead>
<tr>
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<th>Title</th>
<th>Academy Description</th>
<th>Link</th>
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<td>10/8/20</td>
<td>Bloomberg as vendor for ISDA</td>
<td>IBOR Fallback Rate Adjustments Rule Book</td>
<td>Sets out the formulae and definitions to calculate Spread Adjustments</td>
<td><a href="https://data.bloomberglp.com/professional/sites/10/IBOR-Fallback-Rate-Adjustments-Rule-Book.pdf">https://data.bloomberglp.com/professional/sites/10/IBOR-Fallback-Rate-Adjustments-Rule-Book.pdf</a></td>
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<tr>
<td>3/5/21</td>
<td>Bloomberg as vendor for ISDA</td>
<td>IBOR Fallbacks Technical Notice – Spread Fixing Event for LIBOR</td>
<td>Publishes Spread Adjustments to be used on and after 3/5/2021</td>
<td><a href="https://assets.bbhub.io/professional/sites/10/IBOR-Fallbacks-LIBOR-Cessation_Announcement_20210301.pdf">https://assets.bbhub.io/professional/sites/10/IBOR-Fallbacks-LIBOR-Cessation_Announcement_20210301.pdf</a></td>
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<tr>
<td>10/15/21</td>
<td>CFTC’s MRAC</td>
<td>CFTC’s MRAC Subcommittee on Interest Rate Benchmark Reform Responses to Frequently Asked Questions (FAQs) on “SOFR First” for Non-Linear Derivatives</td>
<td>Q&amp;A to facilitate trading of SOFR swaptions, caps and floors. Clarifies that ICE will commence publishing of the USD SOFR ICE Swap Rate when available</td>
<td><a href="https://www.cftc.gov/media/6636/MRAC_SOFRFirstTransitionFAQs_NonLinear101521/download">https://www.cftc.gov/media/6636/MRAC_SOFRFirstTransitionFAQs_NonLinear101521/download</a></td>
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### Academy Additions to NAIC Staff’s 8/12/21 Key Dates (2 of 2)

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<tbody>
<tr>
<td>12/13/21</td>
<td>Bloomberg as vendor for ISDA</td>
<td>Fact Sheet - IBOR Fallbacks</td>
<td>Describes Spread Adjustment calculations, including a Sample Calculation in Appendix 1</td>
<td><a href="https://assets.bbhub.io/professional/sites/10/Factsheet-IBOR-Fallbacks_V4_Dec2021.pdf">https://assets.bbhub.io/professional/sites/10/Factsheet-IBOR-Fallbacks_V4_Dec2021.pdf</a></td>
</tr>
</tbody>
</table>
Detailed Summary of APF’s enhancements to NAIC Staff recommendations

- Continue to calculate NAIC prescribed swap spreads as the average of those calculated by JP Morgan and Bank of America, based on methodologies specified in the APF
- Identify the replacements for 3m & 6m LIBOR as 3m & 6m SOFR swap rates
- Identify the replacements for 1y to 30y LIBOR swap spreads as 1y to 30y SOFR swap spreads
- In order to prescribe Long-Term Benchmark Swap Spreads, estimate historical current SOFR swap spreads over 15 years using Spread Adjustments published by Bloomberg (rather than estimate historical SOFR based on the 7/15/19 FRB “Historical Proxies” publication – discussed on slides 16-19)
- Define for each maturity “m” and historical business day “u” before 2022:
  - historical current SOFR swap spread(m,u) = historical current LIBOR swap spread(m,u) – Spread Adjustment(m,u)
- Define Spread Adjustment(m,u) either as (discussed in detail on slides 14-15):
  - Two parameters published by Bloomberg on 3/5/2021 (6-month Spread Adjustment for m = 6 months, and 3-month Spread Adjustment for all other values of m); or
  - Official values or estimates of about 7,500 parameters published by Bloomberg (6-month and 3-month parameters for each of about 250 business days per year, over 15 years)
- Facilitate appointed actuary use of NAIC prescribed SOFR swap spreads also for 2022 valuation dates

Appendix 1 – A deep dive on the Academy’s rationale for this APF

- 1a - Why does the APF add over 4 pages to VM-20?
- 1b - Why is the 3-month Spread Adjustment being proposed for estimating 1-year to 30-year SOFR swap spreads?
- 1c - How were Spread Adjustments defined in Bloomberg calculations?
- 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used?
Appendix 1a - Why does the APF add over 4 pages to VM-20?

- This APF addresses technical issues with the LIBOR transition to SOFR
  - Because the timing for how SOFR is determined & published is different than for LIBOR, 3-month and 6-month LIBOR cannot be replaced with 3-month and 6-month SOFR, but instead:
    - 3-month LIBOR needs to be replaced in VM-20 with the 3-month SOFR swap rate, and
    - 6-month LIBOR needs to be replaced in VM-20 with the 6-month SOFR swap rate
  - Because SOFR swaps are replacing LIBOR swaps, VM-20 needs to specify how estimated historical current SOFR swap spreads are determined, so there is 15 years of historical data to calculate Long Term Benchmark Swap Spreads
- This APF provides two alternative definitions of Spread Adjustment, and when one of them is chosen by LATF, the other will be deleted and the revised APF should be about ½ page shorter
- This APF provides transition year guidance for valuation dates during 2022 (see slides 21-22) to facilitate appointed actuary use of NAIC prescribed SOFR swap spreads also for 2022 valuation dates, and the guidance includes about 1.25 pages of drafting

Appendix 1b - Why is the 3-month Spread Adjustment being proposed for estimating 1-year to 30-year SOFR swap spreads?

- The historical market convention for LIBOR swaps was for floating rate payments to be 3-month LIBOR paid on a quarterly basis
- Bank regulators and the ARRC agreed to define Spread Adjustment (in https://data.bloomberglp.com/professional/sites/10/LIBOR-Fallback-Rate-Adjustments-Rule-Book.pdf) to equate
  - A stream of n-month LIBOR payments; and
  - A stream of n-month SOFR payments + Spread Adjustment(n-month)
- Thus, by subtracting a 3-month Spread Adjustment from 1-year to 30-year historical LIBOR swap spreads over a period of time, we estimate using swap industry definitions the 1-year to 30-year historical SOFR swap spreads that would have been applicable over such time period
Appendix 1c - How were Spread Adjustments defined in Bloomberg calculations?

- The definition in the IBOR Fallback Rate Adjustments Rule Book specifies that (for USD n-month Spread Adjustments)
  - For dates after 3/5/2021, Spread Adjustments equal those of 3/5/2021
  - On or prior to 3/5/2021, Spread Adjustment = the 5-year median (over a “median period”) of the difference between n-month LIBOR and estimated n-month SOFR determined on a compounded in-arrears basis
  - The “median period” for business day “u” ends n months and two business days before “u” and starts 5 years earlier
- The example in Appendix 1 of this 12/14/21 Bloomberg document illustrates the calculation:

Ap. 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used? (1 of 4)

- We contemplated that perhaps, rather than use the IBOR Fallback Rate Adjustments Rule Book 5-year mean approach, instead either
  - We use a 15-year median, mean or conditional mean might be more consistent with the 15-year prescribed observation period used for calculating Long Term Benchmark Swap Spreads; or
  - We estimate historical SOFR using the approach in FRB’s 7/15/19 “Historical Proxies” paper, and then calculate estimated 3-month and 6-month SOFR swap rates and SOFR swap spreads
- Such calculations required a basic principles approach starting with raw data, and involved several steps including attempts to match results published by the FRB and Bloomberg
Ap. 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used? (2 of 4)

- As a 1st step, we obtained actual SOFR data starting with April 2018, and then estimated older historical SOFR using:
  - This regression formula (SOFR = Survey Rate + 0.38 * (GCF - Survey Rate - 0.05)) from a 7/15/19 FRB paper found at https://www.federalreserve.gov/econres/notes/feds-notes/historical-proxies-for-the-secured-overnight-financing-rate-20190715.htm; and
  - Data from these websites:
    - FRBNY Repo “Survey Rate” from https://www.newyorkfed.org/markets/opsolicy/operating_policy_180309
    - “GCF” (General Collateral Financing) Repo Index rate from https://www.dtcc.com/charts/dtcc-gcf-repo-index

- As a 2nd step, we prepared the estimated SOFR graph below (replicating Figure 4 in the 7/15/19 FRB paper) and exactly matched FRB’s calculation of SOFR Index as of 12/31/21, giving us confidence in our SOFR calculations.

Ap. 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used? (3 of 4)

- As a 3rd step, we extracted data to let us directly estimate historical LIBOR spreads and SOFR spreads:
  - LIBOR data from http://iborate.com/usb-libor/; and

- As a 4th step, we tried to replicate Bloomberg’s 3-month and 6-month Spread Adjustment calculations as of 3/5/21, and came sufficiently close as follows:

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<td>0.42820%</td>
</tr>
<tr>
<td>Difference</td>
<td>-0.0048%</td>
<td>-0.00418%</td>
</tr>
</tbody>
</table>

- As a 5th step, we extracted 7 to 10y Treasury and Investment Grade Corporate yield data from these websites to estimate which dates were included as of yearend 2021 in the NAIC’s conditional mean calculations:
  - Corporate: https://fred.stlouisfed.org/series/BAMLC4AOC710YEY
Ap. 1d - What alternative ways to estimate historical SOFR swap spreads were considered & why were they not used? (4 of 4)

- As a 6th step, we calculated 15-year means, medians and conditional means as of 12/31/21 of daily Spread Adjustments that were estimated based on the IBOR Fallback Rate Adjustments Rule Book, with results relative to the 3/5/21 Bloomberg factors within 4 bps for 3-month and within 6 bps for 6-month, and we concluded that was not a big enough difference to warrant a departure from the Bloomberg 3/5/21 Spread Adjustments. Below are summary statistics.

<table>
<thead>
<tr>
<th>Spread Adjustment Summary Stats</th>
<th>3-month</th>
<th>6-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>15y Mean</td>
<td>0.23274%</td>
<td>0.37077%</td>
</tr>
<tr>
<td>15y Median</td>
<td>0.22091%</td>
<td>0.37183%</td>
</tr>
<tr>
<td>Cond1 Mean</td>
<td>0.35535%</td>
<td>0.38538%</td>
</tr>
</tbody>
</table>

- As a 7th step, we also estimated historical 3m and 6m SOFR swap spreads and rates using our estimated historical SOFR Index calculated based on https://www.newyorkfed.org/markets/reference-rates/additional-information-about-reference-rates#sofr_ai_calculation_methodology. We concluded that in a vacuum such approach had some merits (e.g. fewer 2021 negative rates and spreads) vs. the Spread Adjustment approach in the IBOR Fallback Rate Adjustments Rule Book, but was undesirable because it was much more complicated and its estimated historical SOFR Index approach would be inconsistent with the Rule Book, which has been adopted and likely reflected in numerous insurers’ swap agreements.

Questions for discussion

- Q1: Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)?

- Q2: What is the practical number of Spread Adjustment parameters to use?

- Q3: Should we consider Payment Frequency and Day Count enhancements to improve accuracy?
Q1: Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)? (1 of 2)

The Issue:
- The 2022 VM was finalized in July 2021, and requires the NAIC to publish
  - Current Benchmark LIBOR swap spreads (monthly)
  - Long-Term Benchmark Swap Spreads (quarterly)
- The market evolved dramatically since then, where:
  - In 2021 Q4 SOFR swaps trading volume overtook LIBOR swaps trading volume
  - In 2022 all (or almost all) swaps trading is SOFR swaps
- For valuations during 2022 for insurers with assets or derivatives affected by the LIBOR transition to SOFR
  - Some insurers will have already transitioned models to use SOFR swap spreads
  - Some insurers will need more time, with models still based on LIBOR swap spreads
  - A LATF declaration that 3m & 6m LIBOR are replaced with 3m & 6m SOFR swap rates will alone not provide sufficient clarity
  - The 2022 VM did not contemplate that 1y to 30y swap spreads also need to transition from LIBOR to SOFR swaps
  - At some point the NAIC might no longer have enough data to publish benchmark LIBOR swap spreads
  - The VM doesn’t specify how the NAIC might calculate prescribed Long-Term Benchmark Swap Spreads based on SOFR swaps
  - Appointed actuaries will need to utilize more judgment than for 2023 valuation dates (when this APF becomes effective)
- It would help companies and regulators if in 2022 both LIBOR and SOFR swap spreads are published

Q1: Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)? (2 of 2)

1. The Academy’s proposed APF provides clarity for 2022 valuation dates
   A. Require the NAIC to publish
      i. Benchmark LIBOR swap spreads to the extent the data is still available
      ii. Benchmark SOFR swap spreads once the data becomes available
   B. Specify how the NAIC will calculate Long Term Benchmark SOFR Swap Spreads
2. Potential alternatives that LATF might consider
   A. A revised APF could be silent on 2022 and let actuaries use judgment: Delete the “during 2022” guidance, change “on or before Dec 31, 2021” guidance to be “before 2023” guidance, and don’t specify what the NAIC should publish for 2022 (NAIC would publish LIBOR and SOFR swap spreads as suggested by “1” above, without a VM-20 requirement to do so)
   B. Same as “2.A”, but with a different parenthetical: (as implied by 2022 VM drafting, NAIC would switch, on a transition date it determines and announces, from publishing LIBOR swap spreads to publishing SOFR swap spreads as required for 2023)
   C. Same as “2.A” or “2.B”, but provide some guidance in an Actuarial Guideline, the VM-20 Practice Note and/or some other form of guidance provided by LATF

What approach does LATF prefer?
Q2: What is the practical number of Spread Adjustment parameters to use? (1 of 3)

- Alternatives currently drafted within the APF are
  - 2 parameters: 0.26161% (3-month USD LIBOR Spread Adjustment) and 0.42826% (6-month USD LIBOR Spread Adjustment) published on 3/5/21 by Bloomberg in https://assets.bbhub.io/professional/sites/10/IBOR-Fallbacks-LIBOR-Cessation_Announcement_20210305.pdf, as the applicable on and after 3/5/21
    - 0.26161% would apply for 3-month SOFR swap spreads, and for 1y to 30y SOFR swap spreads
    - 0.42826% would apply for 6-month SOFR swap spreads
  - About 7,500 parameters: official or estimated 3-month and 6-month Spread Adjustments, as defined in https://data.bloomberg.com/professional/sites/10/IBOR-Fallback-Rate-Adjustments-Rule-Book.pdf (the “Rule Book”), for each business day (there are about 250 each year) over the 15-year prescribed observation period, noting that the parameters on 3/5/21 apply for the subsequent business days in 2021, where for each business day “u”
    - 3-month Spread Adjustment (“u”) would apply on “u” for 3-month SOFR swap spreads, and for 1y to 30y SOFR swap spreads
    - 6-month Spread Adjustment (“u”) would apply on “u” for 6-month SOFR swap spreads

- Note the APF states “have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank's SOFR swap spreads) on each business day over the prescribed observation period”

- The next page has data to help discuss whether the additional accuracy warrants the additional complexity

---

Q2: What is the practical number of Spread Adjustment parameters to use? (2 of 3)

- Graphic illustrations of business day Academy Approx. (7,500 parameters) vs Bloomberg 3/5/21 (2 parameters)

<table>
<thead>
<tr>
<th>3-month</th>
<th>6-month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomberg</td>
<td>0.26161%</td>
</tr>
<tr>
<td>5y Median</td>
<td>0.25713%</td>
</tr>
<tr>
<td>15y Max</td>
<td>0.36115%</td>
</tr>
<tr>
<td>15y Mean</td>
<td>0.32274%</td>
</tr>
<tr>
<td>15y Median</td>
<td>0.22091%</td>
</tr>
<tr>
<td>15y Min</td>
<td>0.16984%</td>
</tr>
</tbody>
</table>
Q2: What is the practical number of Spread Adjustment parameters to use? (3 of 3)

<table>
<thead>
<tr>
<th>Approach</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 parameters</td>
<td>Easier implementation for NAIC staff</td>
<td>Underestimates most Long Term Benchmark SOFR Swap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spreads by 1 to 3 basis points through 2033 (see graph)</td>
</tr>
<tr>
<td>7,500 parameters</td>
<td>More precise</td>
<td>Harder implementation for NAIC staff</td>
</tr>
</tbody>
</table>

![Average Future Val Date Impact (% on Swap Spreads of Level Spread Adjustment as an Approximation vs. Daily Spread Adjustments](image)

Q3 for discussion: Should we consider Payment Frequency and Day Count enhancements to improve accuracy? (1 of 2)

- Historically for prescribed benchmark swap spreads (for LIBOR swaps)
  - VM-20 has been silent on payment frequency and day count basis
  - The NAIC has been subtracting Treasury Yields from Swap Rates
  - For 1-year to 30-year maturities, “Semiannual, 30/360” (which is basically the same as bond-equivalent) has presumably been applicable
  - For 3-month and 6-month maturities, presumably the NAIC’s LIBOR data was quoted on an Actual/360 basis, though it is not clear whether the NAIC’s T-Bill data was quoted on a Bank Discount basis or on a Coupon Equivalent basis

- Prospectively for prescribed benchmark swap spreads (for SOFR swaps)
  - Accuracy would be improved if additional guidance were provided within the APF to ...
    - Specify the payment frequency and day count basis for prescribed SOFR swap spreads; and
    - Include additional steps, to be applied by the NAIC, to convert extracted data to the prescribed basis for SOFR swap spreads
  - However, this would make the APF more complex, increase the amount of work for NAIC staff, warrant a longer LATF exposure period, and lengthen the time until LATF adopts the APF
Q3 for discussion: Should we consider Payment Frequency and Day Count enhancements to improve accuracy? (2 of 2)

- To expedite APF adoption, the Academy recommends that for benchmark SOFR swap spreads
  - This APF should be not specify a payment frequency or day count basis
  - After adopting this APF, LATF should ask the Academy to research and recommend whether the APF should be refined
- Relevant historical background for LIBOR swap spreads
  - Quarterly, Actual/360 applies for 3-month LIBOR
  - Semiannual, Actual/360 applies for 6-month LIBOR
  - 3-month and 6-month T-Bills are often quoted on a Bank Discount basis or on a Coupon Equivalent basis
  - Quarterly, Actual/360 has historically applied for the floating rate payments on 1y to 30y LIBOR swaps
  - Semiannual, 30/360 has historically applied for the fixed rate payments on 1y to 30y LIBOR swaps
- Relevant background for SOFR swap spreads
  - Quarterly, Actual/360 applies for 3-month SOFR
  - Semiannual, Actual/360 applies for 6-month SOFR
  - Annual, Actual/360 is the new market convention for the floating rate on 1y to 30y SOFR swaps
  - Annual, Actual/360 is the new market convention for the fixed rate on 1y to 30y SOFR swaps

Questions?

- Contact: Devin Boerm (boerm@actuary.org)
In addition to commenting on the APF, commenters are also asked to provide feedback on the following questions presented in the Academy PowerPoint file (see the 3/10 LATF call materials):

1. Should the NAIC start publishing SOFR swap spreads in 2022 (and if so, how should the APF address this)?
2. What is the practical number of Spread Adjustment parameters to use? Should we consider Payment Frequency and Day Count enhancements to improve accuracy?

*Please send comments to Reggie Mazyck @ RMazyck@NAIC.Org by close of business on April 22nd, 2022.*
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
Alan Routhenstein, on behalf of the American Academy of Actuaries’ Life Reserves Work Group, Annuity Reserves and Capital Work Group, and Variable Annuity Reserves and Capital Work Group

Title of the Issue:
Swap Spreads and London Inter-Bank Offered Rate (LIBOR) transition to the Secured Overnight Financing Rate (SOFR) - Updated VM-20 prescribed swap spreads guidance in light of the LIBOR transition to SOFR.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

Proposed edits to VM-20 for LIBOR transition to SOFR are shown in the attached Appendix

4. State the reason for the proposed amendment? (You may do this through an attachment.)

   a. Bank regulators and a group of swap market participants have agreed that for interbank interest rate swaps executed after 2021, the floating rate needs to be based on an index other than LIBOR.
   b. During 2021 the swap market evolved such that the definition of a standard n-year interest rate swap changed in January 2022 to be a SOFR swap (for which the floating rate is based on SOFR) from the historical LIBOR swap (for which the floating rate is LIBOR).
   c. As a result, VM-20 instructions for how the NAIC will calculate and publish swap spreads needs to be updated for:
      i. Current Benchmark swap spreads (as of each month end); and
      ii. Long-Term Benchmark swap spreads (as of each quarter end)
   d. Given that 2022 is a transition year, it would be helpful for companies and regulators if the NAIC publishes both LIBOR and SOFR swap spreads to the extent data is available.
   e. The associated presentation provides further background and rationale for this proposal.

NAIC Staff Comments:
Appendix

Proposed amendments to VM-20 for APF 2022-[ ] on Swap Spreads and LIBOR transition to SOFR


d. Interest rate swap spreads over Treasuries shall be prescribed by the NAIC for use throughout the cash-flow model wherever appropriate for transactions and operations including, but not limited to, purchase, sale, settlement, cash flows of derivative positions and reset of floating rate investments. A current and long-term swap spread curve shall be prescribed for year one and years four and after, respectively, with yearly grading in between. In order to accommodate a banking industry decision to replace London Interbank Offered Rate (LIBOR) with Secured Overnight Financing Rate (SOFR), and given that the banking industry is implementing this transition during 2021 – 2023, the NAIC’s procedure to calculate swap spreads is distinct for each of the following three time periods:

i. For valuation dates and interim month-end dates on or before December 2021, the current prescribed curve shall be the LIBOR swap curve (for which 3-month and 6-month points represent spreads over Treasuries for 3-month and 6-month LIBOR), and the long term swap spread curve shall be calculated based on 15-year moving averages.

ii. For valuation dates and interim month-end dates during 2022, given that this year will be a transition year because the Life Actuarial (A) Task Force in early 2022 will have declared 3-month and 6-month SOFR swap rates as the replacements for 3-month and 6-month LIBOR for VM-20 benchmark swap spreads,

1) Current and long-term LIBOR swap spreads will continue to be prescribed and published to the extent the data is still available, and

2) Current and long term SOFR swap spreads will be prescribed and published, as described for a month-end date after 2022, once the data becomes available.

iii. For valuation dates and interim month-end dates after 2022, the current prescribed curve shall be the SOFR swap curve (for which 3-month and 6-month points represent spreads over Treasuries for the 3-month and 6-month SOFR swap rate, defined herein as the fixed rate one party pays at the end of three months or six months in exchange for receiving at such time 3-month or 6-month SOFR calculated on a compounded in arrears basis). Long term SOFR swap curve spreads, given that the SOFR swap market did not emerge before late 2021 and that SOFR is a new index for which there is no official data before April 2, 2018, shall be calculated based on 15 year moving averages of prescribed estimates of historical current SOFR swap spreads.

Deleted: The three month and six month points on the swap spread curves shall be the market observable values for these tenors. Currently, this shall be the corresponding

Deleted: When the NAIC determines LIBOR is no longer effective, the NAIC shall recommend a replacement to

Deleted: which

Deleted: effective upon adoption by the Task Force.
VM-20 Appendix 2.F Current Benchmark Swap Spreads:

1. Extract data from Bank of America and JP Morgan:
   a. For a month-end date on or before December 2021, for tenors of one-year to thirty-years, extract LIBOR swap spread data determined as of the last business day of the month by maturity. For Bank of America data, convert the swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the swap spread is provided for each maturity.
   
   b. For a month-end date during 2022,
      i. extract LIBOR swap data to the extent the data is available from both Bank of America and JP Morgan, and
      ii. once the data becomes available, have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank’s SOFR swap spreads) as described for a month-end date after 2022.
   
   c. For a month-end date after 2022, have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank’s SOFR swap spreads).
      i. For each maturity “m” = 0.25, 0.5, 1 … 30 years, and the last business day “u” of the month:
         1) \[ \text{SOFR swap spread}(m,u) = \text{SOFR swap rate}(m,u) - \text{Treasury yield}(m,u). \]
   
   [Drafting Note: 3-month and 6-month SOFR swap rates are defined herein as the fixed rate one party pays at the end of three months or six months in exchange for receiving at such time 3-month SOFR or 6-month SOFR, calculated on a compounded in arrears basis.]

2. Calculate benchmark spreads:
   a. For a month-end date on or before December 2021, average the Bank of America LIBOR swap spread with the JP Morgan LIBOR swap spread by maturity determined as of the last business day of the month.
   
   b. For a month-end date during 2022,
      i. average the LIBOR swap spread data by maturity as before 2022 to the extent the data continues to be available, and
      ii. average the SOFR swap spread data by maturity once the data becomes available.
   
   c. For a month-end date after 2022, average the Bank of America SOFR swap spread with the JP Morgan SOFR swap spread by maturity.

3. Publish the Current Benchmark Swap Spreads by maturity in a table:
   a. For a month-end during 2022, publish LIBOR swap spreads to the extent the data is still available, publish SOFR swap spreads once the data becomes available, and clarify in each column of published current swap spreads whether the spreads are LIBOR swap spreads or SOFR swap spreads.
   
   b. For a month-end after 2022, indicate in the publication that these are SOFR swap spreads.
VM-20 Appendix 2.G Long-Term Benchmark Swap Spreads:

1. Extract data from Bank of America and JP Morgan:
   a. For a quarterly valuation date on or before December 2021, extract data to calculate historical current LIBOR swap spreads. More specifically, extract daily LIBOR swap spread data over the prescribed observation period (rolling 15-year period) ending on the last business day of the quarter. For Bank of America data, convert the daily swap rate for each maturity to a swap spread by subtracting the corresponding maturity Treasury yield from the swap rate. For JP Morgan, the daily swap spread is provided for each maturity.
   b. For a quarterly valuation date during 2022,
      i. extract LIBOR swap data to the extent the data is still available from both Bank of America and JP Morgan, over the prescribed observation period (rolling 15 year period) ending on the last business day of the quarter, and
      ii. once the data becomes available, have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank’s SOFR swap spreads) on each business day over the prescribed observation period (rolling 15-year period) ending on the last business day of the quarter, as described for a quarterly valuation date after 2022 and before 2037.
   c. For a quarterly valuation date after 2022 and before 2037, have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank’s SOFR swap spreads) on each business day over the prescribed observation period (rolling 15-year period) ending on the last business day of the quarter, as follows:
      i. For each business day “u” after 2021 and within the prescribed observation period (rolling 15 year period),
         1) For each maturity “m” = 0.25, 0.5, 1 ... 30 years,
            a) SOFR swap spread(m,u) = SOFR swap rate(m,u) - Treasury yield(m,u).
      ii. For each business day before 2022 and within the prescribed observation period (rolling 15 year period), utilize Bloomberg’s 2021-03-05 published USD Spread Adjustments as follows:
         1) For each maturity “m” = 3 or 6 months, and business day “u” prior to 2022,
            a) SOFR swap spread(3 months,u) = LIBOR swap spread(3 months,u) - 0.26161\% (the USD 3-month Spread Adjustment)
            b) SOFR swap spread(6 months,u) = LIBOR swap spread(6 months,u) - 0.42826\% (the USD 6-month Spread Adjustment)
      ii. For each business day before 2022 and within the prescribed observation period (rolling 15 year period), utilize official or estimated 3-month and 6-month Spread Adjustments, as defined in the 2020-10-08 Bloomberg publication entitled “IBOR Fallback Rate Adjustments Rule Book”, applicable on each business day before 2022 as follows:
         1) For each maturity “m” = 0.25 or 0.5, and business day “u” prior to 2022,
1. a) SOFR swap spread(3 months, u) = LIBOR swap spread(3 months, u) - USD 3-month Spread Adjustment(u)
b) SOFR swap spread(6 months, u) = LIBOR swap spread(6 months, u) - USD 6-month Spread Adjustment(u)

2) For each maturity “m” = 1 … 30, and business day “u” prior to 2022,
a) SOFR swap spread(m, u) = LIBOR swap spread(m, u) - USD 3-month Spread Adjustment(u)

b) For a quarterly valuation date in or after 2037, have JP Morgan and Bank of America calculate SOFR swap spreads (or provide the components so that the NAIC can calculate the bank’s SOFR swap spreads), over the prescribed observation period (rolling 15-year period) ending on the last business day of the quarter, as follows:
   i. For each maturity “m” = 0.25, 0.5, 1 … 30 years,

   1) SOFR swap spread(m, u) = SOFR swap rate(m, u) - Treasury yield(m, u).

2. Calculate historical current swap curves:
   a. For quarterly valuation date on or before December 2021, average the daily Bank of America current LIBOR swap spread data with the daily JP Morgan current LIBOR swap spread data by maturity over the prescribed observation period (rolling 15 year period).

   b. For a quarterly valuation date during 2022,
      i. average the daily Bank of America current LIBOR swap spread data with the daily JP Morgan current LIBOR swap spread data by maturity over the prescribed observation period (rolling 15-year period), to the extent the data continues to be available, and
      ii. average the daily Bank of America current SOFR swap spread data with the daily JP Morgan current SOFR swap spread data by maturity over the prescribed observation period (rolling 15-year period), once the data becomes available.

   c. For a quarterly valuation date after 2022, average the daily Bank of America current SOFR swap spread data with the daily JP Morgan current SOFR swap spread data by maturity over the prescribed observation period (rolling 15-year period).

3. Calculate benchmark spreads as the 85% conditional mean for each of the 32 maturity categories (three-month, six-month, one-year, two-year, … 30-year)
   a. For a quarterly valuation date on or before December 2021, each LIBOR swap curve maturity calculation shall be using the same business trading days as were used in the 85% conditional mean for long-term bonds spreads.

   b. For a quarterly valuation date during 2022, each swap curve maturity calculation shall be using the same business trading days as were used in the 85% conditional mean for long-term bonds spreads, where
      i. LIBOR swap curve calculations shall be performed to the extent the data continues to be available, and
      ii. SOFR swap curve calculations shall be performed once the data becomes available.

   c. For a quarterly valuation date after 2022, each SOFR swap curve maturity calculation shall be using the same business trading days as were used in the 85% conditional mean for long-term bonds spreads.

4. Publish the Long-Term Benchmark Swap Spreads in a table.
   Among tables published on the NAIC website (See Subsection H):
   a. Table J shows Long-Term Benchmark Swap Spreads.
i. For valuation dates during 2022, publish LIBOR swap spreads to the extent the data is still available, publish SOFR swap spreads once the data becomes available, and clarify in each column of published long-term swap spreads whether the spreads are LIBOR swap spreads or SOFR swap spreads.

ii. For valuation dates after 2022, indicate in the publication that these spreads are SOFR swap spreads.
Brian Bayerle  
Senior Actuary

Colin Masterson  
Policy Analyst

March 3, 2022

Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Re: APF 2022-01

Dear Mr. Boerner:

The American Council of Life Insurers (ACLJ) appreciates the opportunity to submit feedback on the exposed APF 2022-01.

ACLJ is fully supportive of clarifying requirements for retrocessions of YRT business. We appreciate such commonsense clarifications within the Valuation Manual, and we welcome the adoption of this amendment by LATF during a future meeting.

Thank you for your consideration,

[Signature]

[Signature]

cc: Reggie Mazyck, NAIC
February 17, 2022

Mr. Mike Boerner  
Chair, Life Actuarial (A) Task Force  
National Association of Insurance Commissioners

Subject: APF 2022-01 – Clarifying Retrocessions

Dear Mr. Boerner,

My comment is with respect to the reserve that should be set up by the assuming party of a coinsurance agreement that retrocedes non-guaranteed YRT reinsurance business. Under APF 2022-01 this reserve would be ½ cx.

Whereas the reinsurer of a non-guaranteed YRT reinsurance agreement has the right to increase the YRT reinsurance premium rates, the reinsurer of a coinsurance agreement that is compliant with Appendix A-791 of the Accounting Practices and Procedures Manual will generally not have the right to increase the coinsurance reinsurance premiums.

I recommend having ½ cx as the reserve floor (assuming YRT reinsurance premiums are paid annually), but require modeling (for determining the DR and SR, as applicable) if the coinsurance treaty reinsurer believes the reinsurer of the YRT treaty may have less of an incentive to increase the YRT reinsurance premium rates on a timely basis due to its retrocession of the assumed business via the coinsurance treaty.

Sheldon Summers  
Claire Thinking, Inc.  
(661) 367-7392
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
Rachel Hemphill, Texas Department of Insurance
Ben Slutsker, Minnesota Department of Commerce

Title of the Issue:
Clarify retrocessions of YRT business.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20 Section 8.C.18
January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

In reviewing companies filing PBR in 2020 for retrocessions of YRT business, companies appropriately treated the pre-reinsurance reserve as 1/2cx and the reserve credit as 1/2cx following VM-20 Section 8.C.18’s instruction for handling non-guaranteed YRT or similar business. However, reviewing these filings raised that the Valuation Manual should be made more clear for such retrocessions. Note that if a company had instead been required to model these retrocessions that are dependent on the YRT, then following the requirements that they “project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements”, the company would have had to model cashflows consistent with the 1/2cx treatment for the underlying reinsurance (i.e., a partial year’s cashflows) and then modeled the retrocession terms applied to those partial year cashflows. This would have been unnecessary effort for materially the same result. The inefficiency of the alternative further supports clarifying that this is not the required treatment.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

W:\National Meetings\2010...\TF\LHA\
When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. This includes retrocession arrangements covering non-guaranteed YRT reinsurance and similar agreements. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar arrangements, actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.
The Life Actuarial (A) Task Force met March 3, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ted Chang, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Charles Santana (DE); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severyinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. **Agreed to the Forward Blanks Proposal for Changes to the VM-20 Reserves Supplement**

   Jennifer Frasier (NAIC) said Mr. Leung submitted a comment on the proposal for modifying the Life, Accident and Health/Fraternal annual statement blanks and instructions for the VM-20 Supplement. Mr. Leung suggested changing the term “not rejected” to “allowed” for consistency throughout the document. Ms. Frasier said the phrase “and the Supplemental Exhibits and Schedules Interrogatories (Quarterly Statement)” should be added to the sentence in the “Items to be Changed” section on page 1.

   The Task Force agreed, without objection, to forward the proposal (Attachment Three-A) to the Blanks (E) Working Group, after making the changes that Mr. Leung and Ms. Frasier suggested.

2. **Exposed Amendment Proposal 2022-02**

   Ms. Hemphill said amendment proposal 2022-02 clarifies the language in Section 3.F.9.h.ii of VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation. She said the revised language parallels the language in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, that the VM-31 language is intended to verify.

   Mr. Chupp made a motion, seconded by Mr. Weber, to expose amendment proposal 2022-02 (Attachment Three-B) for a 21-day public comment period ending March 23. The motion passed unanimously.

3. **Exposed Amendment Proposal 2022-03**

   Ms. Hemphill said amendment proposal 2022-03 provides cleanup, updates cross-references and improves the consistency between VM-20, Requirements for Principle-Based Reserves for Life Products, and VM-21.

   Mr. Chupp made a motion, seconded by Mr. Weber, to expose amendment proposal 2022-03 (Attachment Three-C) for a 21-day public comment period ending March 23. The motion passed unanimously.
4. **Heard an Academy Update on Model Office Testing**

Jason Kehrberg (American Academy of Actuaries—Academy) provided an overview (Attachment Three-D) of the economic scenario generator (ESG) model office testing. Al Zlogar (Academy) presented the model office specifications for a variable annuity product with a guaranteed lifetime withdrawal benefit and a guaranteed minimum death benefit. He said the model office testing will show the reserve, the risk-based capital (RBC), and the total asset requirement (TAR) calculated per VM-21. Mr. Kehrberg presented the model office specifications for VM-20 reserves. He said the Academy plans to share model office results during the Task Force’s March 17 meeting.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/LATF Calls/03 03/Mar 3 Minutes.docx
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<tr>
<td>DATE: ____________</td>
</tr>
<tr>
<td>CONTACT PERSON: Pat Allison</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8528</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:pallison@naic.org">pallison@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF: LATF</td>
</tr>
<tr>
<td>NAME: Mike Boerner, Chair</td>
</tr>
<tr>
<td>TITLE: ____________________</td>
</tr>
<tr>
<td>AFFILIATION: ____________________</td>
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<table>
<thead>
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<tr>
<td>ANNUAL STATEMENT [ ]</td>
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<tr>
<td>QUARTERLY STATEMENT [ ]</td>
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<tr>
<td>INSTRUCTIONS [ ]</td>
</tr>
<tr>
<td>CROSSCHECKS [ ]</td>
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<tr>
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<tr>
<td>[ ] Protected Cell</td>
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<td>[ ] Health (Life Supplement)</td>
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<table>
<thead>
<tr>
<th>IDENTITY OF ITEM(S) TO CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>See next page for details of changes to the VM-20 Reserves Supplement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing the reporting for the Life PBR Exemption, corresponding to changes in the Life PBR Exemption in the Valuation Manual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAIC STAFF COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment on Effective Reporting Date: ____________________</td>
</tr>
<tr>
<td>Other Comments: ____________________</td>
</tr>
</tbody>
</table>

** This section must be completed on all forms. Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

VM-20 Reserves Supplement Blank:
- Part 2: Add Question 3, a disclosure of the year that the Life PBR Exemption was actively filed and a confirmation of the eligibility criteria in the case of ongoing exemptions. Also, correct references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be “not rejected”).

VM-20 Reserves Supplement Instructions:
- Add instructions for the new disclosure item, Question 3. Also, correct references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be “not rejected”).

Supplemental Exhibits and Schedules Interrogatories (Quarterly Statement):
- For Question 8, add instructions for how to respond if the company is utilizing the ongoing exemption. The same instructions can also be found in the Valuation Manual, Section II, Subsection 1.G.1.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VM-20 RESERVES SUPPLEMENT – PART 2

Life PBR Exemption

This section of the Supplement should be completed by a company that was allowed a Life PBR Exemption by its state of domicile. Depending on state requirements, “allowed” may mean “granted”, “acknowledged”, “not rejected”, or similar language.

If a company was allowed a Life PBR Exemption by its state of domicile, the company must indicate the source of the Life PBR Exemption, which could be defined in a state statute, a state regulation or in the NAIC-adopted Valuation Manual. If the source of the Life PBR Exemption is not the NAIC-adopted Valuation Manual, the company must disclose the criteria of the state’s Life PBR Exemption that the company has met, and the company must disclose the minimum reserve requirements that are required by the state of domicile. If the minimum reserve requirements of the state of domicile are the same as those specified in the NAIC-adopted Valuation Manual, the company may indicate: “Same as NAIC VM”. If the criteria for the Life PBR Exemption is the same as or substantially similar to the NAIC-adopted Valuation Manual, the company must also disclose the calendar year that the Life PBR Exemption was filed with and not rejected by its state of domicile. If that calendar year is prior to the year of the annual statement, then the company must confirm that they meet the criteria for an ongoing exemption.

Companies whose individual ordinary life business is exempted from the requirements of VM-20 pursuant to a Life PBR Exemption are not required to complete Part 1 of this VM-20 Supplement.
### Life PBR Exemption

For The Year Ended December 31, 20__

(To Be Filed by March 1)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the company been allowed a Life PBR Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 NAIC Adopted VM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 State Statute (SVL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Is the criteria in the State Statute (SVL) different from the NAIC adopted VM?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
| b. If the answer to “a” above is “Yes”, provide the criteria the state has used (i.e., the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write “SAME AS NAIC VM”):
| 2.3 State Regulation |   |    |
| a. Is the criteria in the State Regulation different from the NAIC adopted VM? | Yes | No |
| b. If the answer to “a” above is “Yes”, provide the criteria of the state’s Life PBR Exemption that the company has met and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write “SAME AS NAIC VM”:

3. If the criteria for the “Life PBR Exemption” is the same as or substantially similar to the NAIC adopted VM (i.e., Question 2 is checked or Question 2.2.a is “No” or Question 2.3.a is “No”), then provide the most recent year that the company filed a statement of exemption that was not rejected. If such calendar year is not the current calendar year for this statement, also provide confirmation that the company meets the criteria for utilizing an ongoing statement of exemption, meaning that none of the following apply: 1) the company fails to meet either of the conditions in VM Section II, Subsection 1.G.2, 2) the policies exempted contain those in VM Section II, Subsection 1.G.3, or 3) the domiciliary commissioner contacted the company prior to Sept. 1 and notified them that the statement of exemption was rejected:
QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

Response

Detail Eliminated To Conserve Space

8. Will the Life PBR Statement of Exemption be filed with the state of domicile by July 1st and electronically with the NAIC with the second quarterly filing per the Valuation Manual (by August 15)? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter. In the case of an ongoing statement of exemption, enter “SEE EXPLANATION” and provide as an explanation that the company is utilizing an ongoing statement of exemption. .................................
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue: APF to fix language that is hard to follow.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Section 3.F.9.h.ii
January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

VM-31 Section 3.F.9.h.ii:
ii. Documentation that the implied volatility scenarios generated do not result in a lower TAR than that obtained by assuming that the implied volatility at all ITM levels at a given time step in a given scenario is equal to the realized volatility of the underlying asset scenario over the same time period as required by VM-21 Section 8.D.3.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NACR Staff Comments:

<table>
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<tr>
<th>Dates:</th>
<th>Received</th>
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<th>Distributed</th>
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</table>

Notes: APF 2022-02

© 2022 National Association of Insurance Commissioners
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:

General cleanup, including updating cross-references, better consistency between VM-20 and VM-21, where reasonable, and making clarifying edits:

1. **Update cross-references:** Add a reference to the newly added VM-21 Section 12 (general assumption setting) alongside the reference to Section 10 in the Guidance Note after Principle 3 in VM-21.

2. **Update cross-references:** Existing section references are too general to be useful for the asset spread assumptions discussed in VM-21 Section 4.D.4.a.iii and 4.D.4.a.iv.

3. **VM-20/VM-21 Consistency:** VM-21 Sections 4.D.5.a and 4.D.5.b should be made consistent with VM-20; new Sections 4.D.5.c and 4.D.5.d were also added to be consistent with VM-20 where appropriate.

4. **Clarifying Edits:** Avoid the SPA partial withdrawal assumptions from requiring modeling less than the RMD amount for tax qualified contracts with ages greater than or equal to the RMD age in VM-21 Section 6.C.4.

5. **Update cross-references:** Correct section reference errors in VM-21 Sections 6.C.4 and 6.C.5.

6. **Clarifying Edits:** Revenue sharing income assumption requirements need clarification, and language needs cleaning up in VM-20, VM-21, and VM-31.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

   Issue 1: VM-21 Section 1.B
   Issue 3: VM-21 Section 4.D.5
   Issue 4: VM-21 Section 6.C.4
   Issue 5: VM-21 Section 6.C.4 and 6.C.5

   January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

   See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
1. Add a reference to the newly added Section 12 (general assumption setting Section 12 added by APF 2021-11 for the 2023 Valuation Manual) alongside the reference to Section 10 in the Guidance Note after Principle 3.
4. The current SPA partial withdrawals assumption does not consider the RMD requirement for tax-qualified contracts with ages greater than or equal to the federal RMD age. Some companies assumed this was intended to be reflected, but it should be clarified in VM-21.
6. Both VM-20 and VM-21 need to clarify that the haircut prescribed for the non-contractually guaranteed revenue sharing is only a guardrail which is neither redundant to nor a substitution for the margin determination requirements of VM-20 Section 9.G.6 and VM-21 Section 4.F.5.c. Two guidance notes from VM-20 should be added to VM-21 for appropriate consistency. The reporting requirement language which is already in VM-31 should be removed from VM-20 and the reporting requirement in VM-31 is augmented and clarified.

VM-21 Section 1.B (Guidance Note after Principle 3)

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 4.D.4.a.iii and Section 4.D.4.a.iv

iii. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in VM-20 Section 9.F.8.a through Section 9.F.8.c. (For purposes of this subsection, “public” incorporates both registered and 144a securities.) The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F.8.d for interest rate swap spreads;

VM-21 Section 4.D.5

5. Cash Flows from Invested Assets

a. Cash flows from general account fixed income assets and derivative asset programs associated with these assets, including starting and reinvestment assets, shall be reflected in the projection as follows:
   i. Model gross investment income and principal repayments in accordance with the contractual provisions of each asset and in a manner consistent with each scenario. Grouping of assets is allowed if the company can demonstrate that grouping does not materially understate the modeled reserve that would have been obtained using a seriatim approach,
ii. Reflect asset default costs as prescribed in VM-20 Section 9.F and anticipated investment expenses through deductions to the gross investment income.

iii. Model the proceeds arising from modeled asset sales and determine the portion representing any realized capital gains and losses.

iv. Reflect any uncertainty in the timing and amounts of asset cash flows related to the paths of interest rates, equity returns or other economic values directly in the projection of asset cash flows. Asset defaults are not subject to this requirement, since asset default assumptions must be determined by the prescribed method in VM-20 Section 9.F.

b. Cash flows from general account equity assets—i.e., non-fixed income assets having substantial volatility of returns, such as common stocks and real estate—and derivative asset programs associated with these assets, including starting and reinvestment assets, shall be reflected in the projection as follows:

i. Determine the grouping for asset categories and the allocation of specific assets to each category in a manner that is consistent with that used for separate account assets, as discussed in Section 4.A.2.

ii. Project the gross investment return including realized and unrealized capital gains in a manner that is consistent with the stochastically generated scenarios.

iii. Model the timing of an asset sale in a manner that is consistent with the investment policy of the company for that type of asset. Reflect expenses through a deduction to the gross investment return using prudent estimate assumptions.

c. Determine cash flows for each projection interval for all other general account assets by modeling asset cash flows on other assets that are not described in Sections 4.D.5.a and 4.D.5.b using methods consistent with the methods described in Sections 4.D.5.a and 4.D.5.b. This includes assets that are a hybrid of fixed income and equity investments.

d. Determine cash flows or total investment returns as appropriate for each projection interval for all separate account assets as follows:

i. Determine the grouping for each variable fund and subaccount (e.g., bonds funds, large cap stocks, international stocks, owned real estate, etc.) as described in Section 4.A.2.

ii. Project the total investment return for each variable fund and subaccount in a manner that is consistent with the prescribed returns described in Section 4.A.2 and Section 8.C.3.

VM-21 Section 6.C.4 (Intro)

4. Partial Withdrawals

Partial withdrawals required contractually or previously elected (e.g., a contract operating under an automatic withdrawal provision, or that has voluntarily enrolled in an automatic withdrawal program, on the valuation date) are to be deducted from the Account Value in each projection interval consistent with the projection frequency used, as described in Section 4.F, and according to the terms of the contract. However, if a GMWB or hybrid GMIB contract’s automatic withdrawals results in partial withdrawal amounts in excess of the GMWB’s guaranteed maximum annual withdrawal amount or the maximum amount above which withdrawals reduce the GMIB basis by the same dollar amount as the withdrawal amount (the “dollar-for-dollar maximum withdrawal amount”), such automatic withdrawals shall be revised such that they equal the GMWB’s guaranteed maximum annual withdrawal amount or the GMIB’s dollar-for-dollar maximum withdrawal amount. However, for tax qualified contracts with ages greater than or equal to the federal RMD age, if the prescribed withdrawal amount is below the RMD amount, the withdrawal amount may be reset to the RMD amount.

Guidance Note: Companies are expected to model withdrawal amounts consistent with the RMD amount where applicable and where practically feasible; however, it is understood that this level of modeling sophistication may not be available for all companies.
For any contract not on an automatic withdrawal provision as described in the preceding paragraph, depending on the guaranteed benefit type, other partial withdrawals shall be projected as follows but shall not exceed the free partial withdrawal amount above which surrender charges are incurred and may be floored at the RMD amount for tax qualified contracts with ages greater than or equal to the federal RMD age:

**VM-21 Section 6.C.5**

5. Withdrawal Delay Cohort Method

To model the initial withdrawal for certain GMWBs and hybrid GMIBs as discussed in Sections 6.C.4.h and 6.C.4.j, the actuary shall adopt a modeling approach whereby a contract is split into several copies (referred to as “cohorts”), each of which is subsequently modeled as a separate contract with a different initial withdrawal period. The contract Account Value, bases for guaranteed benefits, and other applicable characteristics shall be allocated across the cohorts based on different weights that are determined using the method discussed below in this section.

**VM-21 Section 4.A.5.f**

1. The amount of net revenue-sharing income assumed in a given scenario shall be applied with a margin to reflect any uncertainty but shall not exceed the sum of (i) and (ii), where:
   
   i. Is the contractually guaranteed net revenue-sharing income projected under the scenario; and
   
   ii. Is the company’s estimate of non-contractually guaranteed net revenue-sharing income before reflecting any margins for uncertainty multiplied by the following factors:

   - 1.00 in the first projection year.
   - 0.95 in the second projection year.
   - 0.90 in the third projection year.
   - 0.85 in the fourth projection year.
   - 0.80 in the fifth and all subsequent projection years.

**Guidance Note:** Provisions such as one that gives the entity paying the revenue-sharing income the option to stop or change the level of income paid would prevent the income from being guaranteed. However, if such an option becomes available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed up to the time the option first becomes available.
The company is responsible for reviewing the revenue-sharing agreements that apply to that group of policies and verifying compliance with these requirements. The amount of net revenue-sharing income assumed in a given scenario shall be applied with a margin to reflect any uncertainty but shall not exceed the sum of (a) and (b), where:

a. Is the contractually guaranteed GRSI, net of applicable expenses, projected under the scenario.

b. Is the company’s estimate of non-contractually guaranteed net revenue-sharing income before reflecting any margins for uncertainty multiplied by the following factors:

 VM-31 Section 3.D.7.c

Revenue-Sharing Margins – The level of margin in the prudent estimate assumptions for revenue-sharing income and description of the rationale for the margin for uncertainty. Also, a demonstration that the amounts of net revenue-sharing income, after reflecting margins, do not exceed the limits set forth in VM-20 Section 9.G.8.

 VM-31 Section 3.F.7.c

c. Revenue-Sharing Margins – The level of margin in the prudent estimate assumptions for revenue-sharing income and a description of the rationale for the margin for uncertainty. Also, a demonstration that the amounts of net revenue-sharing income, after reflecting margins, do not exceed the limits set forth in VM-21 Section 4.A.5.f.
ECONOMIC SCENARIO GENERATOR WORK GROUP UPDATE ON MODEL OFFICE TESTING

March 3, 2022—2 p.m. EST

VM-21 ESG Model Office Testing

Variable Annuities with Guaranteed Lifetime Withdrawal Benefit (GLWB) and Guaranteed Minimum Death Benefit (GMDB)

Albert Zlogar, MAAA, FSA
Agenda

1. Product Specifications
2. Reserve Method
3. Liability Assumptions
4. Asset Assumptions
5. Caveats

Product Specifications

- Variable Annuity with a GLWB and GMDB (details on next slide)
- Seven-year surrender charge period
- Single model point issued to a male age 60 on the valuation date with single premium of $100,000
- Premium/fund allocation: all of the single premium is invested in separate account funds, allocated 80% U.S. large cap equity and 20% long term U.S. corporate bond funds
  - Monthly rebalancing to maintain 80/20 mix.
Product Specifications

### Variable Annuity Base contract

- **Issue age**: 60
- **Single premium at issue**: $100,000
- **Fund allocation**: 80% US large cap equity / 20% US LT Corp bond, rebalanced monthly
- **M&E risk charges (annul.)**: 1.30% (applied to fund value)
- **Inv mgmt fee (annul.)**: 0.75% (half of this fee comes back to company as guaranteed revenue sharing)
- **Surrender charge period**: 7 years
- **SC % of deposit**: 8, 7, 6, 5, 4, 3, 2%

#### Guaranteed Benefits

<table>
<thead>
<tr>
<th>GLWB</th>
<th>GMDB</th>
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<tbody>
<tr>
<td>Benefit Base Rollup %</td>
<td>5%</td>
</tr>
<tr>
<td>Rollup period</td>
<td>10 years</td>
</tr>
<tr>
<td>Ratchet or reset</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Guarantors

- **Pro-rata**
- **Pro-rata**

#### GLWB withdrawal rate %

| Attained Age 59-64 | 4.00% |
| Attained Age 65-69 | 5.00% |
| Attained Age 70-74 | 5.50% |
| Attained Age 75-79 | 6.00% |

#### GLWB withdrawal rate %

1. **Pro-rata reduction in guaranteed benefit base for any WDs taken in excess of (a) or (b), where (a) is the annual 10% free WD amount prior to income election, and (b) is the GLWB guaranteed annual withdrawal amount after income election.**
   - Upon income election, the fund value reduces dollar for dollar as WDs are taken until fund value exhausts to zero. Any excess WD’s taken above the lifetime WD amount cause a prorata reduction in the Benefit Base and effect the income amount.

#### Examples of potential GLWB lifetime income benefits at different income election ages and return scenarios

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<th>EoY attained age</th>
<th>EoY Guaranteed Benefit Base</th>
<th>annual BB return</th>
<th>cum annuld geom mean BB return</th>
<th>annual GLWB income %</th>
<th>annual GLWB $</th>
<th>approx life exp. years</th>
<th>approx life exp. at age</th>
<th>total income over life exp</th>
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<td>10</td>
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<td>5.00%</td>
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Reserve Method

- Reserve and C3P2 Risk-Based Capital (RBC) and Total Asset Requirement (TAR) calculated per VM-21:
  - Reserve = Stochastic Reserve + Additional Standard Projection Amount (ASPA), where
    - Stochastic Reserve = Conditional Tail Expectation (CTE) of 10,000 Scenario Reserves
    - Scenario Reserve for this model segment = Max (aggregate cash surrender value (CSV), Starting Assets + Greatest Present Value of Accumulated Deficiencies (GPVAD))
    - Starting assets = CSV, so scenario GPVAD is portion of reserve held in general account to ensure all liability cash flows are paid off to the end of the projection for the scenario
    - Discount rate = net earned rates on additional assets backing GPVAD
    - ASPA = add-on if base assumptions are less conservative than prescribed assumptions (not applicable for these tests, i.e., ASPA=0, since assumptions used are not less conservative than prescribed)
- C3P2 RBC uses macro tax adjustment (MTA) method:
  - C3 amount = max(0, 25% * ((CTE98 + ASPA - Statutory Reserve) x (1-Federal Income Tax (FIT) rate) - (Statutory Reserve - Tax Reserve) x FIT rate))

Liability Assumptions

- Used ASPA prescribed assumptions for lapse, mortality and expense (broadly reflects average industry experience)
  - Lapse rates decrease as guaranteed benefit is in the money
    - (In-the-money (ITM)(t) for GLWB defined as PV future income benefits(t) > current fund value(t))
  - Mortality 2012 IAM, improvement scale G2, VM-21 ASPA Fx factors
  - Expense
    - $100 per policy + 7bp on fund value annual maintenance & overhead
- Exception to ASPA assumptions used for GLWB income election:
  - Simplified from ASPA WD delay cohort method (many multiple election dates) to one or two dates (e.g., 100% elect at year 10, or a mix of election year 5, 10, 15 cohorts)
Asset Assumptions

- Starting asset amount = CSV, all in the separate account funds
  - General account investments occur gradually over first ~10-20 years (depending on scenarios) as fee revenues (net of expenses and any excess GMDB payments) are collected, to fund future guaranteed benefits
- General account investment/reinvestment strategy
  - Invest 50%/50% in AA/A non-callable corporate bonds
    - Use prescribed tables (from VM-20) for defaults/spreads
  - 9 basis points (bp) annual investment expense
  - Maturity mix 30/20/10/7/5/1-year bonds; starts longer and shortens over time to maintain reasonable match to liability cash flows (next slide shows sample liability cash flow profile)
  - If there is a shortfall, borrow at same strategy as reinvestment (“negative assets approach”); initial “CARVM allowance” borrowing at 7-year bond rate
- Initially no hedging or reinsurance modeled. Considering adding this but time may not permit.

Sample scenario liability cash flow profile

![Sample scenario annual general account liability cash flows](image)

Developed by the Academy Economic Scenario Generator Work Group
Caveats

- Intended as illustrative limited data points for assessing materiality and relative impact to reserve and C3 RBC levels from a change to the scenarios
- Not intended to:
  - Cover wide variety of annuity products available on the market
  - Reflect a full distribution of issue ages / genders within the given product
  - Thoroughly test all the underlying assumptions
Agenda

1. Reserve Methodology
2. Product Specifications
3. Liability Assumptions
4. Asset Assumptions
5. Caveats

Reserve Methodology

- VM-20 reserve = Max (SR, DR, NPR), where
  - SR = Stochastic Reserve
  - DR = Deterministic Reserve
  - NPR = Net Premium Reserve

- DR: Model office uses method “B,” which solves for minimum starting assets to ensure all liability cashflows are paid off to the end of projection
  - DR is omitted from the model office if a deterministic scenario (i.e., Stochastic Exclusion Test scenario #12) is not provided

- SR: CTE70 of Scenario Reserves (Starting assets + GPVAD)
  - 1,000 scenarios picked out of 10,000 with Academy methodology
  - Use starting assets solved from the DR run (if DR > SR), or solve for starting assets within 2% of the SR (if SR > DR)
Product Specifications

- Universal Life product with a Secondary Guarantee (ULSG)
- Crediting rate is based on General Account (GA) portfolio rates (see asset slide for GA reinvestment strategy)
- Guaranteed minimum crediting rate = 3.25%
- Guaranteed to not lapse until age 110 if minimum premiums are paid (even if policyholder fund value is exhausted)
- Cost of insurance risk charges based on 2015 Valuation Basic Table (VBT) Relative Risk (RR) 100 mortality table
- 2% premium tax
- $64 annual expense charges (with 2% inflation)
- Acquisition fees = $214 + $1.20 per 1,000 of face amount
- 20-year surrender charge period
- Single model point issued at valuation date to a female non-smoker age 45 with $1 million face amount

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Liability Assumptions

- **Mortality**
  - 2015 VBT RR 100 Gender / Smoker distinct Age Last Birthday
  - VM-20 2019 mortality improvement to valuation date
  - Prescribed industry mortality provisions for adverse deviations (PAD)

- **Lapse**
  - Canadian Institute of Actuaries (CIA) Term to 100 Gender distinct / Smoker distinct

- **Expense**
  - Consistent with 2020 Generally Recognized Expense Table (GRET) factors with 2% inflation and 5% expense margin

Asset Assumptions

- **Starting asset portfolio**
  - 50%/50% in AA/A 20-year corporate bonds
  - Amount scaled to the calculated VM-20 reserve at valuation date

- **General account reinvestment strategy**
  - Invest positive cashflows 50%/50% in AA/A 20-year corporate bonds
    - Use 2020 prescribed VM-20 tables for defaults/spreads

  - If there is a shortfall:
    - Sell from existing assets until exhausted
    - Otherwise, borrow at 3-month Treasury + 1%
Caveats

- Intended as an illustrative single data point for assessing materiality and relative impact to reserve levels and volatility from a change to the scenarios
- Selected ULSG product has exposure to interest rates only, no exposure to equity or bond fund returns
- Not intended to:
  - Cover wide variety of life products available on the market
  - Reflect a full distribution of issue ages / genders within the given product
  - Thoroughly test all the underlying assumptions
  - Be used as a basis for assessing appropriateness of an Economic Scenario Generator

Questions?

- Please contact lifeanalyst@actuary.org.
Life Actuarial (A) Task Force
Virtual Meeting
February 24, 2022

The Life Actuarial (A) Task Force met Feb. 24, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ted Chang, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Charles Santana (DE); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Exposed a Blanks Proposal for Changes to the VM-20 Reserves Supplement

Jennifer Frasier (NAIC) presented a proposal for modifying the VM-20, Requirements for Principle-Based Reserves for Life Products, Supplement in the Life, Accident and Health/Fraternal annual statement blank and instructions to reflect that the Life Principle-Based Reserving (PBR) Exemption is revised to allow an ongoing statement of exemption. The proposed changes will be effective for the 2022 annual statement blanks.

Mr. Leung made a motion, seconded by Mr. Chou, to expose the proposal (Attachment Four-A) for a seven-day public comment period ending March 2. The motion passed unanimously.

2. Discussed Comments on the IUL Exposure

Mr. Andersen said a survey of state insurance regulators reported that Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A) has effectively addressed the indexed universal life (IUL) product features, including multipliers and buy-up accounts that were previously concerning. He said state insurance regulators have discovered new IUL Illustration problems caused by combining volatility-controlled funds and fixed bonuses to produce illustrations more favorable than those produced using the traditional capped Standard & Poor’s 500 index (S&P 500). He said the IUL exposure (Attachment Four-B) is designed as a step to potentially address that issue. He asked Task Force members to consider three categories of options for how to address the issue: 1) changes that entail a small amount of work and might require a slight tweak to AG 49-A; 2) changes that restrict IUL illustrations such that they illustrate similar to traditional universal life (UL); and 3) changes requiring an extensive amount of work and that have a greater impact than the first category but still allow IUL illustrations that are more favorable than UL illustrations.

Seth Detert (Securian Life) said the Securian comment letter (Attachment Four-C) agrees that the multiplier and buy-up illustration issues have been largely resolved. He said Securian believes the current practice of illustrating volatility-controlled indices does not meet the intent of AG 49-A and should be quickly addressed. He said Securian specifically supports regulatory changes that would extend the 145-basis point (bp) limit, which AG 49-A applies to benchmark index accounts, to illustrations of option profits in excess of the 145-bp for non-benchmark index accounts.
Mr. Andersen said the Valmark comment letter (Attachment Four-D) expresses the need for a more robust solution for the IUL illustration problem. Valmark provided a paper (Attachment Four-E) on the complexity of IUL marketing materials and an example (Attachment Four-F) of the methodology for a particular product.

Alicia Carter (American Academy of Actuaries—Academy) said the Academy comment letter (Attachment Four-G) notes that AG 49-A has had the intended effect for products with multipliers and other index enhancements. She said if the Task Force decides to update AG 49-A, the Academy recommends that either an additional limit be applied to the illustrated option profit or the benchmark index account limit be aligned with the option spend by allowing multiple benchmark index accounts.

Brian Lessing (Equitable) said Equitable’s comment letter (Attachment Four-H) is a reminder of the proposal it submitted in 2020 and indicates how that proposal might be applicable to the volatility-controlled funds issue. He asked that the proposal be considered if the Task Force decides to revise AG 49-A.

Mr. Andersen said the Allianz comment letter (Attachment Four-I) provides the company’s perspective on the consumer value of volatility-controlled indices.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Four-J) provides commentary on the use of volatility-controlled funds with fixed bonuses. He said the ACLI is seeking clarity from the Task Force on how state insurance regulators would prefer to proceed. He said a potential path could be to require additional disclosures.

Mr. Andersen read the comment letter (Attachment Four-K) from an anonymous source. The commenter expressed agreement with the findings in the IUL exposure. The letter detailed the commenter’s list of existing AG 49-A issues.

Jerry Vanderzanden (Coalition of Concerned Insurance Professionals—Coalition) said the Coalition comment letter (Attachment Four-L) articulates their view of the current IUL illustration challenges. He highlighted some specific points they consider important: 1) the use of account specific fixed interest bonuses can produce illustrated gains as large as the multiplier strategies that led to the development of AG 49-A; 2) volatility-controlled indices used in conjunction with fixed bonuses to augment performance is the easiest way to work the strategy, but it is not the only way; and 3) the Task Force is encouraged to develop a holistic solution that addresses the lookback methodology.

Birny Birnbaum (Center for Economic Justice—CEJ) said if the purpose of the illustration is to help consumers understand the product, whether an IUL illustrates better than a UL is irrelevant. He said while the Task Force is focusing on addressing the current IUL practices that are inconsistent with the purpose of illustrations, the CEJ asks that the Life Insurance and Annuities (A) Committee take broader actions like reengineering illustrations to help consumers better understand how a product operates, addressing the conflict of interest with the index provider also providing the hedging product, and stopping the use of back testing as a basis for future performance.

Mr. Andersen said the IUL Illustration (A) Subgroup will consider the comments and appropriately revise the exposure.
3. **Disbanded the GI Life Valuation (A) Subgroup**

Reggie Mazyck (NAIC) announced that the Task Force agreed via e-vote to disband the Guaranteed Issue (GI) Life Valuation (A) Subgroup. The Subgroup charges have been absorbed by the Task Force.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/:w:/r/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/National Meeting/Spring National Meeting/1 LATF Minutes/Feb 24 Minutes (3).docx
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>EMAIL ADDRESS:</td>
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<tr>
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FOR NAIC USE ONLY

Agenda Item #
Year
Changes to Existing Reporting [ ]
New Reporting Requirement [ ]

REVIEVED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ ]
Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ X ] QUARTERLY STATEMENT
[ X ] INSTRUCTIONS
[ X ] CROSSCHECKS

[ ] Life, Accident & Health/Fraternity
[ ] Property/Casualty
[ ] Health

[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

See next page for details of changes to the VM-20 Reserves Supplement.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Changing the reporting for the Life PBR Exemption, corresponding to changes in the Life PBR Exemption in the Valuation Manual.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

VM-20 Reserves Supplement Blank:
- Part 2: Add Question 3, a disclosure of the year that the Life PBR Exemption was actively filed and a confirmation of the eligibility criteria in the case of ongoing exemptions. Also, correct references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be “not rejected”).

VM-20 Reserves Supplement Instructions:
- Add instructions for the new disclosure item, Question 3. Also, correct references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be “not rejected”).

Supplemental Exhibits and Schedules Interrogatories (Quarterly Statement):
- For Question 8, add instructions for how to respond if the company is utilizing the ongoing exemption. The same instructions can also be found in the Valuation Manual, Section II, Subsection 1.G.1.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

VM-20 RESERVES SUPPLEMENT – PART 2

Life PBR Exemption

This section of the Supplement should be completed by a company that was allowed a Life PBR Exemption by its state of domicile. Depending on state requirements, “allowed” may mean “granted”, “acknowledged”, “not rejected”, or similar language.

If a company was allowed a Life PBR Exemption by its state of domicile, the company must indicate the source of the Life PBR Exemption, which could be defined in a state statute, a state regulation or in the NAIC-adopted Valuation Manual. If the source of the Life PBR Exemption is not the NAIC-adopted Valuation Manual, the company must disclose the criteria of the state’s Life PBR Exemption that the company has met, and the company must disclose the minimum reserve requirements that are required by the state of domicile. If the minimum reserve requirements of the state of domicile are the same as those specified in the NAIC-adopted Valuation Manual, the company may indicate: “Same as NAIC VM”. If the criteria for the Life PBR Exemption is the same as or substantially similar to the NAIC-adopted Valuation Manual, the company must also disclose the calendar year that the Life PBR Exemption was filed with and not rejected by its state of domicile. If that calendar year is prior to the year of the annual statement, then the company must confirm that they meet the criteria for an ongoing exemption.

Companies whose individual ordinary life business is exempted from the requirements of VM-20 pursuant to a Life PBR Exemption are not required to complete Part 1 of this VM-20 Supplement.
VM-20 RESERVES SUPPLEMENT – PART 2
Life PBR Exemption
For The Year Ended December 31, 20__
(To BeFiled by March 1)

Life PBR Exemption as defined in the NAIC adopted Valuation Manual (VM):

1. Has the company been allowed a Life PBR Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile? Yes [   ] No [   ]

2. If the response to Question 1 is “Yes”, then check the source of the “Life PBR Exemption” definition (Check either 2.1, 2.2 or 2.3)

2.1 NAIC Adopted VM [   ]

2.2 State Statute (SVL) [   ]
   a. Is the criteria in the State Statute (SVL) different from the NAIC adopted VM? Yes [   ] No [   ]
   b. If the answer to “a” above is “Yes”, provide the criteria that the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria) and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):

2.3 State Regulation [   ]
   a. Is the criteria in the State Regulation different from the NAIC adopted VM? Yes [   ] No [   ]
   b. If the answer to “a” above is “Yes”, provide the criteria of the state’s Life PBR Exemption that the company has met and the minimum reserve requirements that are required by the state of domicile (if the minimum reserve requirements are the same as the Adopted VM, write SAME AS NAIC VM):

3. If the criteria for the “Life PBR Exemption” is the same as or substantially similar to the NAIC adopted VM (i.e., Question 2.1 is checked or Question 2.2.a is “No” or Question 2.3.a is “No”), then provide the most recent year that the company filed a statement of exemption that was not rejected. If such calendar year is not the current calendar year for this statement, also provide confirmation that the company meets the criteria for utilizing an ongoing statement of exemption, meaning that none of the following apply:

   a. the company fails to meet either of the conditions in VM Section II, Subsection 1.G.2,
   b. the policies exempted contain those in VM Section II, Subsection 1.G.3,
   c. the domiciliary commissioner contacted the company prior to Sept. 1 and notified them that the statement of exemption was rejected.

Deleted: filed and been granted

Deleted: granted

Deleted: the state has used to grant the Life PBR Exemption (e.g., Group/Legal Entity criteria and the...
QUARTERLY STATEMENT BLANK – LIFE/FRATERNAL

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

Response

Detail Eliminated To Conserve Space

8. Will the Life PBR Statement of Exemption be filed with the state of domicile by July 1st and electronically with the NAIC with the second quarterly filing per the Valuation Manual (by August 15)? (2nd Quarter Only) The response for 1st and 3rd quarters should be N/A. A NO response resulting with a bar code is only appropriate in the 2nd quarter. In the case of an ongoing statement of exemption, enter SEE EXPLANATION and provide an explanation that the company is utilizing an ongoing statement of exemption. 

............................................
IUL Illustration exposure as follow-up to 12/8/21 LATF session

Please send your comments to Reggie Mazyck (RMazyck@NAIC.Org)

By COB February 4
Request for comments:

In general, the indexed universal life illustrations post-AG 49-A have shown lower credited rates and related values than we saw prior to AG 49-A. However, those illustrated rates and values may not be lowered by as much as contemplated when the Guideline was adopted.

A key issue identified is an increased use of volatility-controlled funds. These funds rebalance between equities and fixed income as equity volatility fluctuates.

In certain subsets of history, the uncapped volatility-controlled funds performed better than capped S&P 500 funds. Our research found that some insurers are or are potentially planning on using this result to only use a portion of the hedge budget (the amount of assets left over after funding the zero-return floor) on providing the upside potential and using the remainder to fund a fixed bonus to the policyholders.

In some insurers’ minds, this allows them to illustrate volatility-controlled funds plus the fixed bonus more favorably than a traditional, capped S&P 500 index.

That is the main issue regulators have identified at this point. We would welcome comments, by February 4, 2022, on whether and how to address that issue in early 2022.

Background on IUL illustration issue:

NAIC model regulation 582 contains standards for life insurance illustrations. A key component of Model 582 is the illustrated scale, which constrains how non-guaranteed elements such as credited interest rates are presented to life insurance customers. Limits to what can be illustrated include that they should be no more favorable than current credited rates and past credited rates.

In 2015, because of range of practice regarding handling of exotic indices and how to look back at past credited rates, and because loan arbitrage, AG 49 was developed. The thought was that IUL had unique aspects that were not appropriately clarified in the model reg, and therefore an AG was needed.

AG 49 eliminated the favorability of illustrating exotic indices, defined the lookback method, constrained loan arbitrage, and required an alternate, more conservative scale to be illustrated side by side with the illustrated scale.

In 2020, IUL products which applied fees to purchase multipliers were identified as an issue – these led to higher illustrated performance than contemplated when AG 49 was developed.

This led to adoption of AG 49-A. It appears that IUL products no longer contain multipliers that illustrate more favorably than products without multipliers.

Background on volatility-controlled funds:

Volatility-controlled funds have been around for at least 10 years. With variable annuities, compared to pure equity funds, they can provide downside protection to the company and the policyholder.
The way they work is a volatility-controlled fund may be heavy in equities during low equity volatility environments and then when volatility goes up (usually following a stock market downturn), the fund will shift away from equities and towards fixed income securities. The thought process is that further market downturns are more likely during volatile times than during stable times. The market movement can go either way at any time; therefore, long-term comparisons between volatility-controlled funds and 100% equity funds may be mixed.

In IUL, with S&P equity funds, to be able to ensure a non-negative return floor when the stock market goes down but provide upside when the stock market goes up, the upside potential is typically capped. So, instead of your AV going down 30% when the market goes down 30% and up 30% when the market goes up 30%, the range of AV movement may be between 0% and 10%.

In IUL, with volatility-controlled funds, the downside protection is still there. However, these funds may be marketed as uncapped but not provide close to the upside potential as an uncapped S&P 500 fund.

Prices in the stock and derivatives market drive how high the cap is for capped S&P 500 funds and may drive the portion of a volatility-controlled fund that’s in equities. Part of the person’s account value, called a hedge budget, is invested in these derivatives to provide the upside potential.

There is one or more company that has had this fund strategy in place in the past and several others that have started to incorporate this fund strategy after AG 49-A was adopted.
Dear Fred,

Securian Financial respectfully presents these comments in response to the NAIC IUL Illustrations (A) Subcommittee request for comments on the findings from the Q3 Post AG49-A IUL survey.

Securian believes the Post AG49-A IUL survey demonstrates that AG49-A accomplished one of the main goals set forth by the Subcommittee:

- That products with charged for multipliers and/or buy-up accounts illustrate substantially similar to those products without the additional charges.

However, with new developments in the industry AG49-A appears to have fallen short of the second stated goal:

- That within an illustration there is consistent treatment of policy features such as multipliers, index bonuses, participating loan crediting, and non-benchmark indices across the industry.

Specifically, after AG49-A, as noted by the request for comment letter, we are seeing an increase in the utilization of volatility-controlled indices in conjunction with fixed bonuses. Carriers are utilizing this combination to drive meaningfully higher illustrated results.

In direct contrast to the intent of AG49-A, carriers are illustrating much more aggressively with these volatility-controlled indices relative to their own S&P 500 BIA accounts.

Securian does not believe there is anything inherently wrong with fixed account value based bonuses. Fixed account value bonuses are not specific to IUL and they have been part of the individual life products for decades. In addition, fixed bonuses were discussed rather extensively during the drafting of AG-49A and from those discussions LATF determined it was appropriate to illustrate them, in hopes of furthering consumer understanding on the differences between products.

Volatility-controlled indices have also been in the insurance industry for years. They have been prevalent in Fixed Index Annuities for a decade (or more) and there have been a small amount of them available for on IUL contracts for the last 5 to 10 years. We are seeing an increase in the availability and utilization of volatility-controlled index in the industry and Securian supports that direction. Volatility-controlled indexes provide options for our clients that can reasonably provide more stable index returns over a long period of time.

However, Securian does think that the current practice of how volatility-controlled indexes are being illustrated in the industry does not meet the intention of AG49 or AG49-A and should be addressed in...
the very near future. Specifically, the 145% limit should be applied to all accounts, not just the BIA account. Let me explain further.

Within AG-49 the determination of the maximum illustrated rate for the BIA account is limited to 145% of the Annual Net Investment Earnings Rate used to support the index. We think this guardrail should also be applied to non-BIA accounts. What we are seeing in the industry can be illustrated by a simple example:

- Let’s consider a carrier that has a 4% Annual Net Investment Earnings Rate and they spend that amount on the BIA account. This translates to a maximum illustrated rate of 4% * 1.45% = 5.8%.
- The carrier also has a volatility-controlled index that costs 3% to hedge which allows the carrier to offer a 1% fixed bonus on that indexed account to get a total 4% cost.
- The volatility-controlled index’s 30 year look back rate is at or above the maximum BIA rate of 5.8% in this example. Most carriers are then illustrating the volatility-controlled index at 5.8%.
- By illustrating the volatility-controlled index at 5.8% they are illustrating a hedge payoff of (5.8%/3%) = 1.93% which is excess of the 1.45% guardrail of the BIA.
- The increased illustrated hedging payoff in excess of the 145% BIA guardrail is what Securian believes is the main driver higher illustrated values for volatility-controlled indices.
- If volatility-controlled indices were limited in illustrating a maximum of 1.45% hedge payoff you would get a max illustrated rate in this example of 3%*1.45% = 4.35%.
- Using the example above with an adjustment to AG49-A to limit the hedge payoff to 145% of the volatility-controlled index you would get a total crediting rate of 4.35% plus the 1% fixed bonuses for a total crediting rate of 5.35% versus what is being currently being illustrated in the industry of 5.8% plus a 1% fixed bonus for a total crediting rate of 6.8%.

Securian believes there are several ways to change AG49-A to make it clearer/enforce that the 145% guardrail applies to all illustrated indexes. If desired by LATF we are ready to work with our industry peers to put forth draft language to address what we see is the crux of the concern presented by LATF from the findings of the post AG49-A survey.

Respectfully,

Seth Detert, Securian Financial

Securian Financial is the marketing name for Securian Financial Group, Inc. and its affiliates. Insurance products are issued by its affiliated insurance companies. Securities and investment advisory services offered through Securian Financial Services, Inc., registered investment advisor, member FINRA/SIPC.
January 31, 2022

Mr. Reggie Mazyck, Life Actuary
National Association Insurance Commissioners
IUL Illustration (A) Subgroup
11353 Liberty Street
Fulton, MD 20759

Via Email @ rmazyck@naic.org and VIA Overnight Delivery

Dear Mr. Mazyck and Members of the Committee:

Thank you for the opportunity to comment on what Index Universal Life ("IUL") promoters call "proprietary indexes" and what the committee refers to as volatility-controlled funds. I commend the NAIC for again turning to address continued abuses and misleading consumer information with IUL life illustrations. In our experience, the core issue with IUL continues to be the inappropriate marketing of IUL through overly aggressive, highly complex illustrations leading consumers to have unreasonable expectations of far higher credits to their policies than they have, or will ever, receive from these products. The consumer is left with a myriad of resulting issues including loss of protection, additional outlays, and even income tax exposure.

I am CEO and Chairman of the Valmark Financial Group. We believe in the importance of life insurance products in protecting families and businesses. We are proud of our role in helping advisors put in place over $60 billion of insurance protection for clients and have extensive experience with all kinds of life insurance issued through scores of carriers. Our group also weighed in with a comment letter in May 2020 as part of the NAIC’s and this Committee’s attempt to address IUL abuse through Actuarial Guideline XLIX-A ("AG 49-A"). Our company works with and though 126 independently owned financial services firms that offer a wide range of financial products including life insurance and annuity products.

The financial professionals in these firms have clients and prospects who come to them for second opinions on schemes that utilize proprietary indexes as a key element in selling IUL contracts. Because of my writings and social media posts on IUL sales abuses in the marketplace, consumers who either purchased one of these programs or who were close to committing millions of dollars in premiums (some on a leveraged basis) have also sought me out for a second opinion. Additionally, we have helped our financial professionals work through dozens of additional proposals and in-force plans sold by other agents.

In the last 2 years since AG 49-A was put in place, we have seen dozens of proposed and in-force IUL plans -- many featuring these proprietary indexes. A significant number of these policies are also leveraged though premium financing using external bank debt. In our opinion, AG 49-A and its narrow focus on certain types of bonuses did not stop IUL illustration abuse, AG49-A just moved the locus of the abuse to illustrations with proprietary indexes especially as cap rates have continued to fall. To put it bluntly, every time regulatory action is taken to rein in abuse,
the product promoters find new ways to circumvent both the spirit and language of the regulations.

It has become abundantly clear that proprietary indexes’ heavy reliance upon back-tested models further inflates consumer expectations of returns even to the point of where consumers believe the AG 49-A limited illustration are a “conservative baseline” for the returns they will likely see. They have little or no understanding that these back-tested returns for a hypothetical index that did not exist during the time measured, nor for the discretionary contractual elements that could negatively impact them. It is inherently misleading to apply today’s economic climate (portfolio yields, options pricing, market volatility) that determine cap rates, participation rates, thresholds to a past economic period which would have had different factors at play in every year of the back-tested models.

We believe that proprietary indexes just take the abuse of IUL to a new level and are purposefully designed to maximize IUL sales, by leading the consumer to believe that they will get higher returns than a capped S&P 500 index, while reducing financial risk and costs for the issuer. These indexes evade the purpose and spirit of previous attempts by the NAIC to restrain unethical marketing of IUL products in AG 49. Our concern with these indices’ centers on 3 key issues: First, these products are far too complex for consumers to understand and in fact even most of the agents who sell them do not know how they work. Second, the use of back tested returns is misleading to consumers and set unreasonable expectations of return. And third, the structure of these proprietary index options lets insurance companies indirectly do exactly what AG 49-A was meant to prohibit with bonuses and multipliers.

**The complexity of index calculations is not understood by consumers buying these products and most people selling them**

Our first exposure to these proprietary indexes was in Index annuity products, before these indexes were featured in IUL products. (See enclosed whitepaper, All That Glitters Is Not Gold, that Valmark produced to help our advisors better understand how one of these indexes functioned in an annuity.) In that paper, we document the wide divergence between what the contract language provided, and the marketing materials inferred the customer would receive. Presumably, after the client had paid their premium, they could read the 26-page contract and the 156-page index description and have all of 10 days to determine if their purchase was in their best interest. If the policyholder had a Ph.D. in finance, they could, theoretically, make an informed decision on the many variables that would impact their policy’s performance, including various policy charges and the myriad of ways the insurance company could change the cap or spreads as well as fund allocations to low-yielding buckets in the index and ultimately discontinue and substitute indexes at their unilateral discretion. The whitepaper took a team of experienced professionals several days to dissect these documents and outline our understanding of this one investment option in a single contract. We have yet to meet a single policyholder who we believe understands these complexities to make an informed decision.
Back-tested returns used in marketing materials and illustration lead consumers to believe that they will earn substantially more than they are likely to earn

Previous regulatory attempts to reign the “overpromise risk” has primarily focused on aggressive IUL illustrations. Proprietary indexes usually magnify this problem. One illustration we reviewed from a leading IUL carrier showed a “30-year historical index performance” with multiplier credits averaging 10.73% with various range of returns over 10, 15, 20, and 25 years all earning no less than 9.46% in the illustration materials. The clear implication of the entire presentation was that the 6.33% AG 49-A limited rate was a baseline that was certain to be exceeded and very conservative. Under these conditions, of course it made sense to borrow millions of dollars to buy this policy.

We’ve subsequently examined the actual returns of the proprietary index annuity we focused on in our 2019 whitepaper. The results are telling. The average return was far less than standard equity returns and in a 5-year period (where equity markets were up substantially, averaging between 16% and 18% per year depending upon whether you included dividends), the proprietary index averaged a return of less than 4% a year. See the following table for actual returns:

<table>
<thead>
<tr>
<th>Year</th>
<th>S&amp;P 500 Price Index</th>
<th>JP Morgan Mosaic II</th>
<th>JP Morgan Mosaic II /w Floor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>19.42%</td>
<td>6.68%</td>
<td>6.68%</td>
</tr>
<tr>
<td>2018</td>
<td>-6.24%</td>
<td>-0.32%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2019</td>
<td>28.88%</td>
<td>6.84%</td>
<td>6.84%</td>
</tr>
<tr>
<td>2020</td>
<td>16.26%</td>
<td>-2.11%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2021</td>
<td>26.02%</td>
<td>4.91%</td>
<td>4.91%</td>
</tr>
<tr>
<td>Total</td>
<td>84.34%</td>
<td>16.00%</td>
<td>18.43%</td>
</tr>
<tr>
<td>5-year avg</td>
<td>16.86%</td>
<td>3.20%</td>
<td>3.70%</td>
</tr>
</tbody>
</table>

Not unsurprisingly, back-tested returns often assume that all the unfavorable contractual levers that can be pulled by companies, at the expense of the consumer, will not be pulled. Again, not unsurprisingly, these back-tested returns often assume initial caps, participation rates, spreads and multipliers are maintained during their entire lookback period. This practice in based upon the erroneous assumption that today’s underlying economic climate remained the same for the entirety of the back testing period -- including portfolio yield, options pricing, options budget, volatility, and options demand. The hindsight of knowing which markets, at which times, performed well leads to what amounts to “time machine investing.” Historically a switch to

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1,2 For the sake of demonstrating relative expected past performance of an index compared to the expected past performance of the Nationwide New Heights fixed indexed annuity using the JP Morgan Mosaic II index allocation, the hypothetical calculations used the following methodology. Actual annual Mosaic II index performance for calendar years beginning January 2017 through November 2021 was taken and reduced each calendar year by the 1.50% spread currently applied to the Mosaic indexed annuity allocation Strategy A as of February 1, 2022. These new annual returns were then used to calculate the total return of an investment in 2-year term increments to reflect the 2-year term on the indexed annuity strategy, with 0% being the lowest possible return over a 2-year term. These returns do not reflect any actual performance or client experience. Actual client performance in the Nationwide New Heights indexed annuity is based on index allocation, declared rate allocation, declared rate, strategy spreads, and index performance during the 2-year term from contract anniversary to contract anniversary. Clients should reference their account with Nationwide to see their actual performance.
fixed income, when rates were falling, produced positive results, but it would not if bond yields increased from our current historical lows. If we could go back in time and build an index, why not build a FAANG index which invests in the five most popular, best-performing, American technology companies: Meta (formerly known as Facebook), Amazon, Apple, Netflix, and Alphabet (formerly known as Google)?

In fact, the original AG 49 was instituted, in part, to address exotic indexes projecting significant returns through their cherry-picking of esoteric indexes, like the Hang Seng, in years of outsized returns.

We have consistently argued that even the basic assumption underlying AG 49, allowing companies to assume a 45% options profit to support their cap rates, is unsustainable and unrealistic. Time has borne this belief out. Instead of avoiding the decline in interest rates, IUL policies have magnified these declines as drops in cap rates have produced dramatically lower illustrated rates.

**The complexity of IUL is well beyond the ability of most consumers to understand**

IUL policies are the most complex form of life insurance sold today. It takes an immense technical knowledge of life insurance to fully comprehend the mechanics of IUL especially when coupled with the use of a proprietary index. Meticulous reading by well-informed and experienced professionals still may not spot the deception by omission or inference rampant in many IUL illustrations. We’ve included with this letter an example of the methodology of one such index – the S&P Prism Index. Does the average consumer understand “trend signals,” “a binary position indicator,” “90-day volatility of excess returns,” “the 200-day excess return of each sub-index,” “scaled volatilities,” and “inverse weights with regard to target volatility?” Will these consumers actually “refer to the Risk Control indices section of the index mathematics document for equations 55, 56, 59, and 60, where the underlying index is the reference index calculated above and: \( K_{n} = \text{Min} (100\% \times 0.5, \text{Realized Volatility}_{n}) \)” It’s doubtful they will. In fact, it’s simply preposterous to believe a consumer (or their agent) is equipped to comprehend these complexities.

**Proprietary indexes exploit a loophole in AG 49-A**

Proprietary indexes were designed to hide the drop in standard capped indexes like the S&P 500 that IUL products have historically had and lock in lower options prices. These proprietary indexes, the creation of very smart investment bankers, are designed to be good for the profitability of life insurance companies because they are predictable. At times when options prices are high, these proprietary indices reduce exposure to indexes and options costs. These theoretical excess options profits can be used to support multipliers and bonuses.

Others that have followed this debate will opine more clearly how these proprietary indexes allow the very loopholes in AG49-A to continue. Theoretical excess options budgets are being used to support the very bonuses that NAIC sought to address with AG-49 A magnifying illustrated values.
Conclusion
Unfortunately, the disappointment IUL policyholders are experiencing today is not new to the life business. As bond and crediting rates have dropped over the last 30 years, general account products have seen declines in credited rates, unachieved projections, and disappointed policyholders. Life insurance ended up costing more and paying less in benefits than expected. A new and quite disturbing trend is the tremendous amount of leverage consumers are being encouraged to take on through IUL premium financed bank loans. Consumers of various economic means are unknowingly betting significant parts of their liquid net worth on the arbitrage between bank loans and what they believe will be credited to IUL policies. This is an uninformed bet against loaded dice with little or perhaps no prospect of winning for the policyholder.

We continue to see overly aggressive IUL premium financed proposals and transactions harming consumers in very significant ways. This activity emanates primarily from insurance-only licensed producers who operate with no oversight of their sales materials or advice and without the supervision of a FINRA-registered broker-dealer or the Securities & Exchange Commission. These proposals and transactions often involve millions of dollars in a complex product that neither they nor consumers fully understand. Their advice to consumers to leverage the purchase of these complex products and pledge an illiquid investment against loans, sometimes which exceed the client’s entire liquid net worth, to pay for the purchase of IUL policy boarders on criminal. There is no real financial arbitrage in these transactions, just regulatory arbitrage.

The NAIC needs to investigate these practices and create a much more robust solution for dealing with this problem rather than attempting superficial changes to how IUL is illustrated. I would welcome the opportunity to share with the committee numerous actual examples of this abuse should the NAIC decide to address this ongoing problem. Again, thank you for the opportunity to be part of your effort to protect consumers.

Sincerely,

Lawrence J. Rybka, JD, CFP®
Chairman, CEO

Enclosures
ALL THAT GLITTERS IS NOT GOLD
A REVIEW OF NATIONWIDE’S NEW HEIGHTS® 8 FIXED INDEXED® ANNUITY
J.P. MORGAN MOZAIC IISM INDEX

BY: LAWRENCE J. RYBKA, JD, CFP® AND JESSICA RORAR, CFP®

Who wouldn’t want an investment that provided market-like returns? Even better, an investment that provided year-to-year consistency of returns and “no downside risk,” especially in today’s volatile market? On the surface, that is what the Nationwide New Heights® Fixed Indexed Annuity with an equity indexed strategy developed and sponsored by J.P. Morgan claims to offer to clients. The marketing pitch contained within the sales brochure, the website, and accompanying video (referred to in this article as “the large print”) includes claims regarding:

- Tax deferral;
- Earnings that are “protected against downside market risk,” translated by non-fiduciaries during the sales process as “no downside market risk;”
- An Index designed to provide consistent positive returns in both good and bad market environments;
- Broad diversification across 15 global asset classes from several countries;
- An index with hypothetical, back-tested average annual return from 12/1996 that is within 21 basis points of the S&P 500 annual return for that time period;
- A hypothetical return with “72% less volatility” and none of the dramatic dips during turbulent market events like 1999’s dot-com bubble or 2008’s financial crisis with its ensuing Great Recession;
- A momentum investment strategy which capitalizes on focusing upon investment areas with superior performance in the preceding six months;
- No caps on the client’s upside unlike most fixed indexed annuities; and finally,
- An optional life time income rider that promises increasing guaranteed lifetime income that you cannot outlive and where “your income can only go up and will never go down.”

The job of a good financial advisor is to really know his or her client and be able to know if a given product is suitable to meet a specific client’s goals. The difference between a great salesperson and true financial advisor acting in a client’s best interest, also referred to as a fiduciary, involves much more than just watching a 4-minute video and passing on a wholesaler’s marketing points and graphs to a client. It requires the advisor to be an advocate for the client, to really test the product’s claims and to read both the large and the fine print of the contract. Only with this level of diligence and scrutiny, including truly understanding how the product works and the possible downsides of that product, should any advisor make a recommendation to a client, and then only to clients whose circumstances warrant it. The ultimate test, after really understanding these elements, is to apply the Golden Rule and ask, on behalf of the client, “Is this something into which I would put a large portion of my own money?”

The Nationwide New Heights® Fixed Indexed Annuity is an equity indexed annuity, issued by an insurance company and regulated by state insurance regulations. Neither the advisor, nor the policyholder, are given the pre-purchase benefit of a Securities & Exchange Commission reviewed prospectus, as they would with a variable annuity. Instead, the contract is filed with the department of insurance and can then be sold by insurance agents appointed with the company. What the client will actually get in terms of financial results from this type of product is not driven so much by equity markets, but by contractual provisions.
including: charges, riders and other important provisions. The Nationwide New Heights® Fixed Indexed Annuity has several index options the client can choose from including those that track: the S&P 500® Index, the MSCI EAFE® Index, the NYSE® Zebra Edge® Index and finally, the J.P. Morgan Mozaic IISM Index which includes several indexes that rotate in a manner that will be described later. This product has several optional riders including a lifetime income and an enhanced death benefit rider both available at an additional, ongoing charge.

“The Large Print Giveth and the Small Print Taketh Away”

The most important things a client would want to know about Nationwide’s New Heights® 8 Fixed Indexed Annuity, or any indexed annuity or life insurance product, is usually found in the “fine print” of the written contract and not the marketing materials. Under most state insurance laws, the client has 10 days from receipt of the contract (ordinarily delivered at the time of purchase) to decide whether they want to return the policy and receive their money back (referred to as a “free look”) or keep the policy. Interestingly, while the brochures and video highlighting the attractive features of Nationwide’s New Heights® 8 Fixed Indexed Annuity are available through a product-specific marketing website hosted by Nationwide, the actual contract is not and can only be obtained from the carrier upon request.

If a client had a PhD in Finance, or perhaps was an experienced securities lawyer, and read the 83-page New Heights® 8 Fixed Indexed Annuity contract or the 156-page J.P. Morgan Mozaic IISM Index Supplement, here are some of the things they would find within “the small print:"

- **Tax deferral** – This claim is true - as it is of all annuities, with a caveat that applies to clients who make withdrawals from any annuity prior to age 59½ where gains on the contract would be subject to a 10% early withdrawal federal tax penalty. Additionally, all withdrawals may be subject to ordinary income tax as well.

- **“No downside risk”** – This is mostly true with Nationwide New Heights® 8 Fixed Indexed Annuity as it is with most indexed annuities. The money deposited into the contract is primarily invested by the insurance carrier in bonds. These funds allow the company to bring the client’s account value back to the invested principal year-to-year if negative performance occurs in the client’s selected investment strategy. The “upside” is produced by the carrier’s investment in derivatives, mostly futures contracts on the respective indexes available within the product, either the S&P 500® Index, the MSCI EAFE® Index, the NYSE® Zebra Edge® Index, or the J.P. Morgan Mozaic IISM. However, if there is an optional rider added to the policy, there is no longer a “0% downside” due to the rider fees that are deducted annually from the policy. The living benefit rider costs between 95-115bps and the death benefit rider costs between 50-80bps. These riders cannot be added in conjunction with each other.

Additionally, there is an initial risk of loss of principal with the surrender charge of 8% in the first policy year. See Figure 1 for the decreasing Contingent Deferred Sales Charge schedule for the New Heights® 8 Fixed Indexed Annuity. Also note that in the first year of the policy, no free withdrawals are allowed.
Figure 1–Contingent Deferred Sales Charge (CDSC) and Free Withdrawal Percentage

<table>
<thead>
<tr>
<th>Number of Completed Contract Years</th>
<th>CDSC Percentage</th>
<th>Free Withdrawal Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>1</td>
<td>7.00%</td>
<td>7.00%</td>
</tr>
<tr>
<td>2</td>
<td>6.00%</td>
<td>7.00%</td>
</tr>
<tr>
<td>3</td>
<td>5.00%</td>
<td>7.00%</td>
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</tr>
<tr>
<td>7</td>
<td>1.00%</td>
<td>7.00%</td>
</tr>
<tr>
<td>8+</td>
<td>0.00%</td>
<td>10.00%</td>
</tr>
</tbody>
</table>

Source: Page 30: Appendix A, New Heights® Sample Contract (Run Date 03.16.17)

- **Broad diversification across 15 global asset classes in several countries** – In addition to the S&P 500® Index, the MSCI EAFE® Index and the NYSE® Zebra Edge® Index, the New Heights® 8 Fixed Indexed Annuity offers policy holders the ability to link or allocate their policies to the J.P. Morgan Mozaic IISM Index. This relatively complex index, requiring 156-pages to fully describe its strategy, contains 15 “Basket Constituents” comprised of various “Equity Constituents,” “Bond Constituents,” as well as “Commodity Constituents.” The insurance carrier does not directly invest in the underlying index to which the account is allocated to, but rather in derivatives (mainly futures contracts). It is important to note that since there is no direct investment in the securities upon which the index returns are based, there are no dividends earned as would be the case when securities are directly owned. Nor is the cash value of the annuity invested in a fund managed by J.P. Morgan, rather J.P. Morgan has licensed use of its Mozaic IISM Index to Nationwide. Also, J.P. Morgan may unilaterally terminate the Mozaic IISM Index on short notice as J.P. Morgan is “under no obligation to continue compiling, calculating, maintaining or sponsoring the Index.” One would presume this must mean that if the Mozaic IISM Index was terminated, the client would have an option to allocate their funds to one of the remaining index strategies. A critical fact that every client must understand is that this contract gives the insurance carrier the authority to unilaterally and “at its sole discretion” revise the crediting factors within the client’s chosen index allocation. Additionally, the carrier could allocate as much as 95% of the client’s funds into a “declared rate” bucket also known as a fixed account that has a minimum crediting rate of 0%, significantly decreasing the potential for returns shown in Figure 2.
Figure 2–Crediting Factor Guarantees for the Balanced Allocation Strategy Options (Strategy Options)

<table>
<thead>
<tr>
<th>Strategy Option and Index</th>
<th>Minimum Strategy Term</th>
<th>Minimum Equity Indexed Allocation</th>
<th>Minimum Declared Rate Allocation</th>
<th>Minimum Declared Rate</th>
<th>Maximum Strategy Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P 500 STRAT A</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.85%</td>
</tr>
<tr>
<td>S&amp;P 500 STRAT B</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>MSCI EAFE STRAT A</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.95%</td>
</tr>
<tr>
<td>MSCI EAFE STRAT B</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>JPMORGAN MOZAIC II STRAT A</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td>JPMORGAN MOZAIC II STRAT B</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>NYSE ZEBRA EDGE STRAT A</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>6.25%</td>
</tr>
<tr>
<td>NYSE ZEBRA EDGE STRAT B</td>
<td>1 Year</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.00%</td>
</tr>
</tbody>
</table>

The length of each Strategy Term will be no longer than the Initial Strategy Term.

Source: Page 33: Appendix A, New Heights 8® Sample Contract (Run Date 03.16.17)

Figure 3–J.P. Morgan Mozaic II™ Index & S&P 500 Price Index

The J.P. Morgan Mozaic II™ Index would have provided positive calendar year returns every year for more than 20 years.

From 11/1/96 to 12/31/17. Note: The J.P. Morgan Mozaic II™ Index was established on 12/28/16. Performance shown is back-tested by applying the index strategy to historical financial data when all components are available and was designed with the benefit of hindsight. Back-tested performance is hypothetical and has been provided for informational purposes only. The S&P 500 Price Index results are actual performance for the full period. Past performance is not indicative of nor does it guarantee future performance. The hypothetical data above does not take index fees or transaction costs into account.

Source: J.P. Morgan Mozaic II SM Index Marketing Brochure
The claim in Figure 3 bears much scrutiny. It shows returns from December 1996 through December 2017 for J.P. Morgan’s Mozaic IISM Index compared to the S&P 500 Index (excluding dividends). The J.P. Morgan’s Mozaic IISM Index has only actually been in existence for 2 years, established on 12/28/2016. In 2017, the index returned 6.68% vs. S&P 500’s 19.42%. In 2018, J.P. Morgan’s Mozaic IISM Index returned -0.50% vs. S&P 500’s -6.24%. The rest of the results and the accompanying graph come from what is commonly referred to as “hypothetical back testing.” Said another way, this means that if the J.P. Morgan Mozaic IISM index existed in 1996 and investors could go back in a time machine to invest directly in the index, then and only then would the investor have experienced these hypothetical returns. On another hand, if one could go back in that same time machine to 1996 and, with the benefit of hindsight, buy stock in Apple, Google or Microsoft, and then switch to bonds in both 2000 and 2007, then their returns would definitely beat the S&P 500, the J.P. Morgan Mozaic IISM Index and every investor in the world - including Warren Buffet. Note these types of hypothetical back-tested models are not permitted within sales material when offering SEC-registered securities and their use to predict future performance is deemed inappropriate by FINRA, yet are permitted in the sales materials associated with products that are only regulated by state insurance regulators.

- **Volatility smoothing to less than half the volatility of the S&P 500** – Again, the hypothetical, back-tested results demonstrate that, with the benefit of hindsight, volatility can be significantly reduced. However, there are three important “values” to which advisors and their clients must pay close attention:

  - **Contract Value** – The contract value has a 0% floor for index returns, meaning that if the index has a return of -5%, the client holding the policy will have a 0% return for the term. Fees associated with optional living benefit or death benefit riders can be deducted from the contract value however.

  - **Minimum Guaranteed Contract Value (MGCV)** – MGCV is the minimum amount defined in the policy that the contract owner is guaranteed to receive upon surrender of the annuity after the application of any surrender charges and/or market value adjustments. This value is equal to 87.5% of the premium deposited into the contract and will grow at a guaranteed 1% each year, shown in Figure 4. This is conveniently left out of illustrations and can only be found in the contract specimen received after purchase.

  - **Surrender Value** – The Nationwide New Heights Fixed Indexed Annuity offers 4 different surrender schedules from which to choose: 8, 9, 10 or 12 years. The surrender value is the amount of cash you can walk away with at any given point in time. It is the greater of the MGCV or your contract value minus any surrender penalties and built-up rider fees.
- **No caps on the client’s upside unlike most Equity Index Annuities** – It is true that this contract does not, like most indexed annuities, have the typical cap of 5 or 5.5% on the upside of the indexes referenced. In fact, there is one choice that offers the client 117% of the return on the J.P. Morgan Mozaic Index II™ described previously with no cap as shown in Figure 5 below.

Figure 5—Initial Crediting Factors for the Balanced Allocation Strategy Options (Strategy Options)

<table>
<thead>
<tr>
<th>Strategy Option and Index</th>
<th>Initial Strategy Term</th>
<th>Initial Equity Indexed Allocation</th>
<th>Initial Declared Allocation</th>
<th>Initial Declared Rate</th>
<th>Initial Strategy Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P 500 STRAT A</td>
<td>2 Years</td>
<td>55.00%</td>
<td>45.00%</td>
<td>0.00%</td>
<td>1.85%</td>
</tr>
<tr>
<td>S&amp;P 500 STRAT B</td>
<td>2 Years</td>
<td>30.00%</td>
<td>70.00%</td>
<td>0.50%</td>
<td>0.00%</td>
</tr>
<tr>
<td>MSCI EAFE STRAT A</td>
<td>2 Years</td>
<td>60.00%</td>
<td>40.00%</td>
<td>0.00%</td>
<td>1.95%</td>
</tr>
<tr>
<td>MSCI EAFE STRAT B</td>
<td>2 Years</td>
<td>35.00%</td>
<td>65.00%</td>
<td>0.50%</td>
<td>0.00%</td>
</tr>
<tr>
<td>JPMORGAN MOZAIC II STRAT A</td>
<td>2 Years</td>
<td>117.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>JPMORGAN MOZAIC II STRAT B</td>
<td>2 Years</td>
<td>90.00%</td>
<td>10.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NYSE ZEBRA EDGE STRAT A</td>
<td>2 Years</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.25%</td>
</tr>
<tr>
<td>NYSE ZEBRA EDGE STRAT B</td>
<td>2 Years</td>
<td>73.00%</td>
<td>27.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Again, one must read the fine print in the contract to understand how this crediting method works and how it can be changed. Not only can the investor be reallocated 95% to a fixed account, but the company can and does charge a spread on the index strategy. By contract, the insurance carrier can increase the annual spread it charges on this index. The contract gives the carrier the right to increase this spread to as much as the original spread plus 5% per index strategy. This bears repeating for emphasis. *The contract allows the insurance company to increase the charge against earnings to 500 to 600 basis points on the J.P. Morgan Mozaic II™ Index and up to 685 basis points on the S&P 500 and up to 695 basis points EAFE Index.* Thus, if the “uncapped” J.P. Morgan Mozaic II™ Index strategy produced a 6% return and the client elected the 117% participation option in Figure 5, the crediting would be 7.02% (6% X 117%). The insurance company could reduce these earnings back to 1.02% by applying the maximum spread of 6% (7.02%-6%), shown in Figure 2. The hypothetical back-tested performance chart in Figure 3 shows only the J.P. Morgan Mozaic II™ Index performance, not what is credited to client’s accounts via participation rates and/or spreads.

- **There is an optional lifetime income rider that promises increasing guaranteed lifetime income that you cannot outlive.** – The rider is called The Nationwide High Point 365® Lifetime Income Benefit rider. For the New Heights® 8 Fixed Indexed Annuity, the rider cost is 95 basis points. The income base increases at 1% compound for the first 10 years of the policy and the living benefit rider cannot be turned on until the 5th policy anniversary. This is a very important point that is unique to the New Heights product. Most riders can be turned on at any time after policy issuance. The New Heights® High Point 365® rider offers inflexibility by mandating that withdrawals under the rider can’t occur until the 5th anniversary. If the client wants to pay 115bps for the rider, they can have a 3% bonus added to their rider value, contract value and death benefit. The 3% bonus is based upon the purchase payment of the policy. As if this wasn’t complex enough, the withdrawal bands are different for each client based on the age the client purchased the policy, the age they decide to turn on income (must wait at least 5 years) and whether it is a single or joint lifetime income stream. Therefore, a 60-year old client who purchases the New Heights® 8 Fixed Indexed Annuity policy with the non-bonus version of the High Point 365® Lifetime Income Benefit rider with $100K deposit, is guaranteed to have a $6,295.55 annual income stream for life if income is turned on at the 5th anniversary. Withdrawal bands are shown below in Figure 6.
Conclusion

Even though Nationwide’s New Heights 8® Fixed Indexed Annuity is only a state regulated annuity contract, FINRA’s Notice to members 05-50 and 12-03 on complex products requires broker dealers to monitor and train on products while imposing heightened supervision upon them. FINRA Notice 12-03 requires that “the registered representative also should discuss the scenarios in which the product may perform poorly.”

Although this product offers little risk of loss of principal, outside being subject to steep surrender charges, financial advisors must use caution to temper what could lead to inflated client expectations created by the marketing materials. Advisors must thoroughly understand the entire annuity contract and its limitations on the crediting methodology. This may be an appropriate product for fixed income clients who are willing to trade illiquidity for the potential of a higher tax-differed return. This product offers safety of principal for a portion of their savings and provides the potential for lifetime income. An informed purchaser must take into account that the entire value and safety of principal is completely predicated on the claims-paying ability of the issuing company - Nationwide Life and Annuity Insurance Company, a subsidiary of Nationwide Insurance Company. As such, it would be prudent to diversify a client’s investments and have only a portion of any client’s investment in this product or any other product supported by the general account assets of an insurance carrier.

The J.P. Morgan Mozaic IISM Index methodology may have the potential of exceeding index returns of other equity indexed annuities, by a slight margin, as it did in 2017. A recent study by Cannex which looked at the entire index annuity market concluded the average return for all equity index annuity products using the S&P 500 Index with the traditional caps would be 3.18%. The highest observed cap in the study was a 6.1% cap with 100% participation rate giving this product a predicted average return of 3.58% over a longer-term using Monte Carlo simulation. Thus, in its first year, this product using the J.P. Morgan Mozaic IISM Index methodology exceeded other index methodologies. It must also be noted however, that it substantially trailed the S&P 500. Looking forward, it would be best to set the client expectation well below the marketing materials featuring back-tested J.P. Morgan Mozaic IISM Index return of 6.30%. A more pragmatic outlook would have returns slightly higher than the industry average of 3.18% from the Cannex study on all equity index annuities. Various disclosures and cautions within the “fine print” of the contract with Nationwide and J.P. Morgan’s Index documentation make this point abundantly clear.
The contract provisions give very wide latitude to Nationwide to change the index, the index allocations from equities to bonds and, most importantly, the spread on charges against these credits for the index. We can think of no securities product registered with the SEC that would provide this degree of latitude in potential charges. Any prospect for returns higher than a typical indexed annuity is highly dependent on these factors. If an insurance carrier exercised the options available to it and increased spreads or allocated assets mostly to the fixed account, it is likely the product would produce returns only slightly higher than 1% a year.

If the client is looking for guaranteed income in future years, there are many other annuity options that offer greater upside potential with the added safety of separate account protection.

“The Valmark Fit”
With Valmark’s Comprehensive Annuity Review and Evaluation Service™ (CARES™), we have the ability to analyze new annuity policies being recommended to clients or existing policies already owned, by comparing them to a benchmark annuity that fits the client’s objective. We have four different outputs based on the following objectives: Income, Death Benefit with Income, Death Benefit or Accumulation. The CARES™ Process clearly articulates to clients the large and small print that might be murky in insurance carrier marketing material. At Valmark we understand that annuities can be complex, whether they are fixed, indexed or variable. The CARES™ Process is designed to help provide clarity on these products that your clients desire and deserve.

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Although this product is technically a “fixed annuity” and, therefore, not a security, it offers contract holders no true “fixed interest” return, unless invested in the fixed account. Rather, all returns are dependent upon, or “linked to,” an external equity reference or an equity index. See: Page 7 of Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17). For illustration purposes here, the author has chosen to discuss a product linked to J.P. Morgan Mozaic IISM Index.


https://www.nationwidenuhights.com/

https://www.nationwidenuhights.com/jp-morgan-mozaic/

See page 3: https://nationwidefinancial.com/media/pdf/FAM-0678AO.pdf

Source: Page 33: New Heights 8th Sample Contract (Run Date 03/16/17)

https://www.nationwidenuhights.com/lifetime-income/

EAFE Index is a stock market index that is designed to measure the equity market performance of 21 developed markets outside of the U.S. & Canada the EAFE acronym stands for Europe, Australasia and Far East

See: https://www.nyse.com/publicdocs/nyse/indices/NYSE_Zebra_Edge_Index_Brochure.pdf for a further explanation regarding this index.

American Singer/Songwriter, Tom Waits, “Step Right Up”

https://www.nationwidenuhights.com

See Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17)

See Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17)

https://www.jpmorgan.com/jpmpdf/1320720120416.pdf


Id.

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https://www.jpmorgan.com/jpmpdf/1320720120416.pdf


Id.

See page 47: Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17)

Id.

FINRA Rule 2210(d)(1)(F)(i)


Page 30 of Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17).
https://www.nationwidenewheights.com/nationwide-new-heights/

Page 27 of Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17).
Source: Page 33: New Heights 8th Sample Contract (Run Date 03/16/17)
Source: Page 32: New Heights 8th Sample Contract (Run Date 03/16/17)

See Page 33: Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17)

Id.

See page 6: https://nationwidefinancial.com/media/pdf/FAM-0678AO.pdf


Id.


$100K X 1.01^5 = $105,101.01 Income Base on 5th Anniversary. $105,101.01 X 5.99% withdrawal band at 65 = $6,295.55. Withdrawal Bands are for Single Life payouts in chart above.


See: Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17).

https://www.jpmorgan.com/jpmpdf/1320720120416.pdf

Page 33: Appendix A, New Heights 8th Sample Contract (Run Date 03/16/17)
S&P PRISM Index

Methodology

March 2019
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Introduction

Index Objective and Highlights

The S&P PRISM Index is an index of indices designed to measure the performance of an inverse risk weighted basket of three component indices after accounting for technical and fundamental indicators. The three underlying component indices each represent a different asset class, as defined below:

<table>
<thead>
<tr>
<th>Underlying Component Index</th>
<th>Asset Class Represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P 500 ER (3M Libor) Index</td>
<td>Equities</td>
</tr>
<tr>
<td>S&amp;P GSCI Excess Return Index</td>
<td>Commodities</td>
</tr>
<tr>
<td>S&amp;P 10-Year U.S. Treasury Note Futures Excess Return Index</td>
<td>Fixed Income</td>
</tr>
</tbody>
</table>

Please refer to Index Construction for details on each index’s allocation to equities, commodities, and fixed income.

Supporting Documents

This methodology is meant to be read in conjunction with supporting documents providing greater detail with respect to the policies, procedures and calculations described herein. References throughout the methodology direct the reader to the relevant supporting document for further information on a specific topic. The list of the main supplemental documents for this methodology, and the hyperlinks to those documents, is as follows:

<table>
<thead>
<tr>
<th>Supporting Document</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P Dow Jones Indices’ Index Mathematics Methodology</td>
<td>Index Mathematics Methodology</td>
</tr>
<tr>
<td>S&amp;P Dow Jones Indices’ Float Adjustment Methodology</td>
<td>Float Adjustment Methodology</td>
</tr>
<tr>
<td>S&amp;P Dow Jones Indices’ Fixed Income Index Mathematics Methodology</td>
<td>Index Mathematics Methodology</td>
</tr>
</tbody>
</table>

This methodology was created by S&P Dow Jones Indices to achieve the aforementioned objective of measuring the underlying interest of each index governed by this methodology document. Any changes to or deviations from this methodology are made in the sole judgment and discretion of S&P Dow Jones Indices so that the index continues to achieve its objective.
Index Construction

Approach

The index allocates among three sub-indices based on their respective realized volatilities and a multiplier that is applied to its volatility. The resulting index of indices forms the underlying non-risk controlled index.

The underlying Commodity and Treasury futures sub-indices are calculated and published by S&P DJI on a daily basis as excess return indices.

The third underlying sub-index, the S&P 500 ER (3M Libor) Index, is calculated as follows and is based on the S&P 500 TR Index using the 3-month LIBOR for the interest rate:

**S&P 500 ER (3M Libor) Index (SP500 ER3ML)**

\[
SP500\ ER3ML_t = SP500\ ER3ML_{t-1} \times (1 + SP500\ 3ML_t\ Excess\ Return)
\]

\[
SP500\ 3ML_t\ Excess\ Return = \left( \frac{SP500\ TR\ Index_t}{SP500\ TR\ Index_{t-1}} \right) - \left( InterestRate_{t-1} \times \frac{NumDays_t}{360} \right) - 1
\]

**Step 1: Trend Signals and Volatilities**

Before calculating the weights in the non-risk controlled index, three trend signals are calculated. For each sub-index, the following process is used to calculate a binary “position indicator” series of 1 or 0:

A. Calculate the 200 day simple moving average of the underlying sub-indices.
B. Calculate a trend signal based on the following rule:

$$\text{Trend Signal}_{asset,t} = \begin{cases} 1, & \text{if } \text{Index}_{asset,t} > 200\text{DMA}_{asset,t} \\ 0, & \text{otherwise} \end{cases}$$

C. Create two series, $UpCount_t$ and $DownCount_t$, that serve as counting indices. These indices will start at 0 on the 200th day, and increment each day thereafter.

$$UpCount_{asset,200} = DownCount_{asset,200} = 0$$

$$UpCount_{asset,t} = \begin{cases} UpCount_{asset,t-1} + 1, & \text{if Trend Signal}_{asset,t-1} = 1 \\ 0, & \text{otherwise} \end{cases}$$

$$DownCount_{asset,t} = \begin{cases} DownCount_{asset,t-1} + 1, & \text{if Trend Signal}_{asset,t-1} = 0 \\ 0, & \text{otherwise} \end{cases}$$

D. Finally, calculate the binary “position indicator” as follows:

$$\text{Position Indicator}_{asset,t} = \begin{cases} 1, & \text{if } UpCount_{asset,t} > 4 \\ 0, & \text{otherwise} \end{cases}$$

E. For each sub-index, compute the 90 day volatility of excess returns

$$\text{Volatility}_{asset,t} = \sqrt{\frac{\sum_{i=0}^{89} (\text{DailyReturn}_{asset,i} - \text{AvgDailyReturn}_{asset})^2}{89}} \times \sqrt{252}$$

Where,

$$\text{DailyReturn}_{asset,t} = \frac{\text{Index}_{asset,t}}{\text{Index}_{asset,t-1}} - 1$$

$$\text{AvgDailyReturn}_{asset} = \frac{\sum_{i=0}^{89} \text{Index}_{asset,t-i} - 1}{90}$$

Step 2: Rank Long Sub-Index Returns

A. For each sub-index, compute the 200 day excess return

$$200 \text{ Day Return}_{asset,t} = \frac{\text{Index}_{asset,t}}{\text{Index}_{asset,t-200}} - 1$$

B. For each sub-index on an excess return basis, plus cash (which has a daily excess return of 0), rank the 200 day excess returns on day t across sub-index, with 1 being the highest return, and 4 being the lowest return.

C. Compute the trailing 5 day average rank for equities and fixed income.
Step 3: Volatility Scalars

A. Calculate a yield curve multiplier that is based on a lagged 120 day 60 day average of the spread between the 10-year U.S. Treasury rate and the 3-month U.S. Treasury rate as follows:

\[
Yield\ Curve\ Multiplier_t = \begin{cases} 
1, & \text{if } \frac{\sum_{i=1}^{60} 10\ Year\ Rate_{t-119-i} - 3\ Month\ Tbill\ Rate_{t-119-i}}{60} > 0 \\
5, & \text{Otherwise}
\end{cases}
\]

B. Calculate a bond trend indicator:

\[
Bond\ Trend\ Position_t = \begin{cases} 
1, & \text{if } Position\ Indicator_{bond,t} = 1 \\
10, & \text{if } Position\ Indicator_{bond,t} = 0 \text{ AND } (10\ Year\ Rate_t - 3\ Month\ Tbill\ Rate_t) < 0 \\
1, & \text{Otherwise}
\end{cases}
\]

C. Calculate the earnings yield and reference 10-year yield as:

\[
EY_t = Earnings\ Yield = \frac{1}{1\ yr\ forward\ PE_{t,s&p500}} \\
10Y_t = 10 - Year\ Yield\ at\ time\ t
\]

D. Calculate equity and bond volatility multipliers.

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>Scenario 4</th>
<th>Scenario 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yield Curve Multiplier (3A)</td>
<td>Average Equity Rank (2B)</td>
<td>10Y vs EY (3C)</td>
<td>Position Indicator_t (1D)</td>
<td>Equity Mult_t (Result)</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>&lt;&gt; 4</td>
<td>10Y &gt; EY</td>
<td>10Y &lt;= EY</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>&lt;&gt; 4</td>
<td>10Y &lt;= EY</td>
<td>&lt;&gt; 1</td>
<td></td>
</tr>
<tr>
<td>&lt;&gt; 1</td>
<td></td>
<td></td>
<td></td>
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<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>Scenario 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Fixed Income Rank (2B)</td>
<td>Bond Trend Position_t (3B)</td>
<td>Fixed Income Mult_t (Result)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>&lt;&gt; 4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>&lt;&gt; 4</td>
<td>&lt; 2%</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>&lt;&gt; 4</td>
<td>&gt;= 2%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>&lt;&gt; 4</td>
<td>&gt;= 2%</td>
<td>&lt;&gt; 1</td>
<td></td>
</tr>
</tbody>
</table>

Step 4: Inverse Volatility Weighting

A. Calculate the scaled volatilities for both equities and fixed income as:

\[
Equity\ Vol_t = Volatility_{Equity,t} \times Equity\ Mult_t \\
Fixed\ Income\ Vol_t = Volatility_{Fixed\ Income,t} \times Fixed\ Income\ Mult_t
\]

B. Determine the inverse weights with regard to the target volatility:

\[
Inverse_{Equity,t} = \frac{5.5\%}{Equity\ Vol_t} \\
Inverse_{Fixed,t} = \frac{5.5\%}{Fixed\ Income\ Vol_t}
\]
C. Calculate the final weights for each sub-index:

\[
Final \ Weight_{asset,t} = \frac{Inverse_{asset,t}}{\sum_{asset} Inverse_{asset,t}}
\]

Step 5: Reference Index Calculation

A. Calculate the index return:

\[
Weighted \ Avg \ Return_t = \sum Final \ Weight_{asset,t-2} \times Excess \ Daily \ Return_{asset,t}
\]

\[
Ref \ Index \ Return_t = \begin{cases} 
0.75 \times Weighted \ Avg \ Return_t, \text{if } Equity \ Mult_{t-2} + Fixed \ Income \ Mult_{t-2} = 15 \\
Weighted \ Avg \ Return_t, \text{Otherwise}
\end{cases}
\]

B. Final step is to calculate the reference index level

\[
Ref \ Index \ Level_t = Ref \ Index \ Level_{t-1} \times (1 + Ref \ Index \ Return_t)
\]

Step 6: Final Index Level

In order to calculate the final index levels, a risk control methodology is applied. Please refer to the Risk Control Indices section of the index mathematics document for equations 55, 56, 59 and 60, where the underlying index is the reference index calculated above and:

\[
K_{rb} = \min(100\%, \frac{5.5\%}{Realized \ Volatility_{t-2}})
\]
Index Maintenance

Rebalancing

The index is rebalanced on US business days after the market close. If a component of the index is not published on the rebalancing date, the prior value of that component is used. As part of the rebalancing process, the weights of the various asset class components are determined based on the sub-indices weights in the benchmarks as described in Index Construction.

Corporate Actions

For information on Corporate actions, please refer to S&P Dow Jones Indices’ Equity Indices Policies & Practices.

Currency of Calculation and Additional Index Return Series

In addition to the indices detailed in this methodology, additional return series versions of the indices may be available, including, but not limited to: currency, currency hedged, decrement, fair value, inverse, leveraged, and risk control versions. For a list of available indices, please refer to S&P DJI’s All Indices by Methodology Report.

For information on the calculation of different types of indices, please refer to S&P Dow Jones Indices’ Index Mathematics Methodology.

Base Date and History Availability

Index history availability, base date and base value are shown in the table below.

<table>
<thead>
<tr>
<th>Index</th>
<th>Launch Date</th>
<th>First Value Date</th>
<th>Base Date</th>
<th>Base Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P PRISM Index (USD)</td>
<td>02/12/2018</td>
<td>08/16/1990</td>
<td>08/16/1990</td>
<td>1000</td>
</tr>
</tbody>
</table>
Index Governance

Index Committee

S&P Dow Jones Indices’ Factor Indices Index Committee maintains the index. The Committee meets regularly. At each meeting, the Committee reviews matters that may affect index constituents, statistics comparing the composition of the index to the market, and any significant market events. In addition, the Index Committee may revise index policy covering rules for selecting constituents, treatment of dividends, share counts or other matters.

S&P Dow Jones Indices’ considers information about changes to its indices and related matters to be potentially market moving and material. Therefore, all Index Committee discussions are confidential.

S&P Dow Jones Indices’ Index Committees reserve the right to make exceptions when applying the methodology if the need arises. In any scenario where the treatment differs from the general rules stated in this document or supplemental documents, clients will receive sufficient notice, whenever possible.

In addition to the daily governance of indices and maintenance of index methodologies, at least once within any 12-month period, the Index Committee reviews the methodology to ensure the indices continue to achieve the stated objectives, and that the data and methodology remain effective. In certain instances, S&P Dow Jones Indices may publish a consultation inviting comments from external parties.

For information on Quality Assurance and Internal Reviews of Methodology, please refer to S&P Dow Jones Indices’ Equity Indices Policies & Practices Methodology.
Index Policy

Holiday Schedule

The index is calculated on all U.S. equity market business days.

A complete holiday schedule for the year is available at www.spdji.com.

Rebalancing

The index committee may change the date of a given rebalancing for reasons including market holidays occurring on or around the scheduled rebalancing date. Any such change will be announced with proper advance notice where possible.

Unexpected Exchange Closures

For information on Unexpected Exchange Closures, please refer to S&P Dow Jones Indices’ Equity Indices Policies & Practices Methodology.

Recalculation Policy

For information on the recalculation policy, please refer to S&P Dow Jones Indices’ Equity Indices Policies & Practices Methodology.

For information on Calculations and Pricing Disruptions, Expert Judgment and Data Hierarchy, please refer to S&P Dow Jones Indices’ Equity Indices Policies & Practices Methodology.

Contact Information

For questions regarding an index, please contact: index_services@spglobal.com.
Index Dissemination

Index levels are available through S&P Dow Jones Indices’ Web site at www.spdji.com, major quote vendors (see codes below), numerous investment-oriented Web sites, and various print and electronic media.

**Tickers**

The table below lists headline indices covered by this document. All versions of the below indices that may exist are also covered by this document. Please refer to S&P DJI’s All Indices by Methodology Report for a complete list of indices covered by this document.

<table>
<thead>
<tr>
<th>Index</th>
<th>Return Type</th>
<th>Bloomberg</th>
<th>Reuters</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P PRISM Index (USD)</td>
<td>Excess Return</td>
<td>SPPRISME</td>
<td>.SPPRISME</td>
</tr>
</tbody>
</table>

**Index Data**

Daily constituent and index level data are available via subscription.

*For product information, please contact S&P Dow Jones Indices, [www.spdji.com/contact-us](http://www.spdji.com/contact-us).*

**Web site**

*For further information, please refer to S&P Dow Jones Indices’ Web site at [www.spdji.com](http://www.spdji.com).*
liable to any party for any direct, indirect, incidental, exemplary, compensatory, punitive, special or consequential damages, costs, expenses, legal fees, or losses (including, without limitation, lost income or lost profits and opportunity costs) in connection with any use of the Content even if advised of the possibility of such damages.

S&P Global keeps certain activities of its various divisions and business units separate from each other in order to preserve the independence and objectivity of their respective activities. As a result, certain divisions and business units of S&P Global may have information that is not available to other business units. S&P Global has established policies and procedures to maintain the confidentiality of certain non-public information received in connection with each analytical process.

In addition, S&P Dow Jones Indices provides a wide range of services to, or relating to, many organizations, including issuers of securities, investment advisers, broker-dealers, investment banks, other financial institutions and financial intermediaries, and accordingly may receive fees or other economic benefits from those organizations, including organizations whose securities or services they may recommend, rate, include in model portfolios, evaluate or otherwise address.
February 3, 2022

Mr. Mike Boerner  
Chair, Life Actuarial Task Force (LATF)  
National Association of Insurance Commissioners (NAIC)  

Re: IUL Exposure from the December 8, 2021 LATF Session  

Dear Mr. Boerner,  

The American Academy of Actuaries\(^1\) Life Illustrations Work Group (the “Work Group”) is pleased to provide comments to the LATF on the Indexed Universal Life (IUL) Exposure from the December 8, 2021, session.

As described in the IUL Exposure, some volatility control index accounts have a lower hedge budget than a capped S&P 500 index account but illustrate at the same lookback rate as the Benchmark Index Account (“BIA”). These accounts illustrate at the same lookback rate as the BIA because their option profits (hedge returns relative to hedge costs) are assumed to be higher than the option profits for the BIA. The remaining net investment earnings that are not put toward purchasing options may then be used to offer a fixed bonus, which results in higher illustrated values than those under the BIA.

Although the illustrated values for these accounts can be higher, as noted in the IUL Exposure, the differences may be smaller in magnitude than the illustrations of multipliers or other index enhancements that were addressed by AG 49-A. Indeed, the Work Group notes that AG 49-A has largely had the intended effect that products with multipliers and other index enhancements should not illustrate any better than products without these features.

However, if LATF decides an update to AG 49-A is needed, the Work Group suggests consideration of either of the following approaches that could be used to address current practices:

(A) **Apply an additional limit to the illustrated option profit (e.g., 45%)**  
This approach would apply a fixed predetermined limit to the illustrated option profit, similar, in concept, to the current limit of 145% of the net investment earned rate. However, it differs from the net investment earned rate as it would place a limit on the illustrated option profit for each account. LATF could apply a limit to the illustrated

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
option profit by requiring an amendment to AG 49-A that would bring the illustrated option profits of volatility control indices more in line with the illustrated option profits of other indices. However, this approach could still result in some index accounts illustrating somewhat higher policy values than what the BIA would produce (although more limited than today). An appropriate factor, such as 45% or something else, would have to be determined.

(B) Align BIA limit with option spend through multiple BIAs
Under this approach, the illustrated index rate for each index account would be limited to the lookback rate for a BIA with the same amount spent on hedging. BIAs with lower hedge budgets would have lower caps, and therefore lower lookback rate limits would be applied to the index accounts that use lower hedge budgets. The Work Group notes that multiple BIAs were allowed under AG 49 for cap buy-up accounts but were eliminated under AG 49-A, so we suggest language could be borrowed from AG 49 and applied to indices with lower hedge budgets without reversing decisions that have already been made for multipliers and buy-ups. In contrast to approach (A), approach (B) would not result in some index accounts illustrating higher policy values than the BIA and would not require an agreed-upon appropriate factor. While drafting language for approach (B) may be more difficult and therefore may take more time than for approach (A), the Work Group notes that approach (B) may be a more comprehensive solution.

Changes to AG 49-A that make index accounts illustrate more similarly may result in reduced customer understanding because the differences are not shown in the illustrated values. The Work Group also notes that the approaches described in (A) and (B) do not place limits on the illustration of fixed bonuses, because fixed bonuses do not appear to be the core issue.

In addition, the Work Group notes that there were some questions during the December 8, 2021, LATF session about how volatility control index accounts work and how they may perform relative to other index accounts, such as those based on the S&P 500. The Work Group notes that these questions could be addressed via disclosures.

The Work Group appreciates the efforts of the LATF and IUL Illustration Subgroup to review AG 49 and AG 49-A. If you have any questions or would like further input on the above topics, please contact Khloe Greenwood, life policy analyst, at greenwood@actuary.org.

Sincerely,

Alicia Carter, MAAA, FSA
Chairperson, Life Illustrations Work Group
American Academy of Actuaries
Dear Mr. Andersen,

Equitable provides the following comments in response to the December 9, 2021 IUL Exposure, both as a reminder of Equitable’s 2020 proposal (attached), and also to indicate how the proposal would relate to illustrations of Volatility Controlled Funds (VCFs). More specifically, Equitable believes that reconsideration of its 2020 proposal is appropriate if it is decided that substantive changes to AG 49-A are necessary in order to address regulators’ concerns.

In essence, Equitable’s 2020 proposal would uniformly guardrail illustrations (1) by tying illustrated index credits to the option budget, and (2) by imposing a guardrail on assumed excess returns irrespective of the mechanics of the strategy. We think such an approach would be sensible under a “no free lunch” assumption.

One reason for adoption of AG 49-A was regulators’ concern that additional fees charged by insurers to fund multipliers and other indexed enhancements exposed policy owners to the risk that such relatively expensive policies would underperform policies without such fees and enhancements, if illustrated index performance did not materialize. While VCFs as described in the exposure document wouldn’t present the same concern (since the illustrated performance wouldn’t be reliant on charging additional fees), such VCFs could nevertheless expose policyholders to additional risk that loaned policies will collapse due to insufficient net policy value, if illustrated loan arbitrage (including the fixed bonus) doesn’t actually materialize.

It should be noted that any problem posed by relatively high values illustrated for VCFs isn’t primarily related to fixed bonuses. Any unused hedge budget for a VCF could be used in many other ways to increase illustrated values, such as to reduce COI charges or expense charges. In fact, fixed bonuses are a relatively transparent way of providing higher illustrated values, as compared to COI or other charge reductions which may be much less visible to policyholders.

The philosophy behind AG 49 was to use a traditional capped S&P 500 indexed account (the BIA) as a guardrail against overly optimistic illustrations. In order to achieve the subsequent goal that products with indexed enhancements should not illustrate better than products without such enhancements, AG 49-A in effect limited each company’s illustrated hedge budget to not exceed such company’s annual net investment earnings rate (ANIER).

While the limitation of the illustrated hedge budget to each company’s ANIER achieved the immediate objective of regulators, it does not comport well with the expected decline of current portfolio ANIERs given today’s far lower prevailing investment yields. In contrast, Equitable’s proposal limited the amount of each indexed account’s hedge budget that can be used to support illustrated indexed credits to the greater of the ANIER and 5%. This higher limit was based on the belief that (1) policyholders may reasonably seek contracts with greater market exposure than what can be created by a hedge budget supported only by prevailing yields on high quality assets, and (2) better governance of illustrated rates of return under Equitable’s proposal would allow for more latitude in the illustration of hedge budgets that rely in part on moderate supplemental charges and not exclusively on investment returns.

However, please note that Equitable’s proposed limit on the amount of the hedge budget that could be used to support the illustrated scale to max (ANIER, 5%) would limit the use of higher charges to support illustration of higher multipliers or other indexed enhancements, similar to the existing AG 49-A. It would also have the effect of limiting illustrated loan leverage.
One important element of Equitable’s proposal for AG 49-A was (1) the continuation from AG 49 of the allowance for more than one BIA and (2) the corresponding requirement that the assumptions for account charges and additional amounts credited (i.e., fixed bonuses) must be consistent between each BIA and the indexed accounts for which it acts as a guardrail. This protective feature of AG 49 was not included in the ACLI proposal for AG 49-A that was ultimately adopted.

Under Equitable’s proposal, for a VCF as described in the exposure document, the corresponding BIA would need to provide a fixed bonus that was at least as high as that provided by the VCF, and charges for the BIA could not be increased beyond the charges for the VCF, ensuring consistency between the hedge cost assumptions of the VCF and the BIA guardrail. More importantly, this aspect of Equitable’s proposal would ensure consistency of charge and credit assumptions between BIAs and all future indexed accounts they govern (not just VCFs), ensuring continued future efficacy of the BIA guardrails.

Equitable’s proposal integrated the best elements of the Independent Proposal and the ACLI proposal that was ultimately adopted – this integration is explained in detail in the table on page 3 of the proposal. Equitable’s proposal to this extent represented a compromise between the two approaches.

By replacing the look back approach to computing the BIA guardrail with the Black Scholes formula for option valuation plus a reasonable risk premium (we suggested 20% rather than 45%), Equitable’s proposal would have the added benefit of encouraging insurers to move away from dependence on “certain subsets of history” in evaluating past performance, and toward a more standardized and uniform method based on modern financial theory and practice. Under Equitable’s proposal, total illustrated index credits (including any indexed enhancements) would be limited to at most 6% (computed as 120% of 5%) per annum, except for insurers who have ANIERs of greater than 5% per annum.

Equitable’s attached 2020 proposal was written during the period of development leading up to adoption of the final version of AG 49-A, and hence the redline of the ACLI’s proposal that was submitted at that time (attached) would need to be updated. Equitable would welcome the chance to participate in any such effort, should regulators decide that substantive changes to AG 49-A are needed.

Thanks very much for the opportunity to share our thoughts with you and the other members of the IUL Illustration (A) Subgroup on these important matters.
Equitable 5-27-2020 Comments on AG 49 Integrated Proposal
Mr. Fred Andersen  
Chair, NAIC Indexed Universal Life (IUL) Illustration (A) Subgroup  

Re: IUL Exposure  

Mr. Andersen,  

Allianz appreciates the opportunity to provide comments on the matters discussed in the LATF IUL Exposure from December, 2021. Allianz offers a variety of allocations with various crediting methods and indexes to consumers. When the cost of hedging any given allocation changes, it is possible to have better historical performance than the S&P500 at a lower cost. In these cases, a company can decide what they would like to do with this excess hedge budget and what the consumer may find most valuable, whether it be higher caps/rates, fixed bonuses, lower charges, or other unique features. The decision on where to provide additional value occurs across all allocations, whether or not they are a Volatility Control Index (VCI). When there are situations where hedging costs are lower and the allocation provides historical outperformance compared to the S&P500, we think it is valuable to the consumer to reflect the additional affordable benefits that are offered within the current restrictions of AG 49-A. Because VCIs are specifically highlighted in the LATF letter and Allianz has offered VCIs for over 8 years, we wanted to provide our perspective on the consumer value of VCIs.  

Allianz History  
Allianz began offering allocations tied to VCIs on its Fixed Index Annuity (FIA) and IUL products in 2013 and 2014 respectively. The benefits of offering an index with a volatility control mechanism include diversification, stability in rate renewal, stability in and strong credit performance, and unique benefits only available with VCIs. Because of these benefits, allocations tied to VCIs offer and have delivered unique value to our policyholders and they are an important part of our index line-up.  

VCIs are indexes that have some type of mechanism to control volatility. This mechanism can range from a defined formulaic approach, to active management, to something in between. The VCIs that Allianz offers on our IUL products use a defined formula that rebalances between an equity component and fixed income/cash components on a daily basis. The purpose of this daily rebalancing is to hit a specific volatility target, thus controlling the volatility of the index. Generally speaking, equities are more volatile than fixed income, so the indexes will allocate more heavily to equity in times of low volatility and more heavily to fixed income in times of high volatility.  

Benefits of Volatility Controlled Indexes  

Diversification  
The combination of equity and fixed income can provide a diversification benefit and the VCIs we offer have both equity and fixed income components, leading to more diversification than a standard equity only index. VCI performance can benefit when either equity or fixed income does well, or if one of the components does not perform well, the other component can offset that low performance and allow the policyholder to still get a credit. This allows the policyholder to experience positive results in many different market environments, not only when the equity market is strong.
Diversification through fixed income can bring risks, and a common question raised about VCIs is will their high allocation to fixed income lead to underperformance in rising interest rate environments and is their good historical performance due to decreasing interest rates over the last 20 years. It is true that fixed income allocations will likely underperform when interest rates rise, but because of the diversification VCIs offer, the overall impact on long term performance of the VCI will vary based on all components of the index, including the equity component. The chart below compares the relationship of interest rates with the performance of the first VCI we offered, the Bloomberg US Dynamic Balance Index over the last 20 years.

**Note:** The Bloomberg US Dynamic Balance Index has been active since 2013, index performance before that is based on the underlying components of the index and the prescribed formula used to balance between the components.

While the general trend in rates has been down over the last 20 years, there have been several periods of sustained rate increases or rate spikes, like 2003-2006, 2009, 2017-2018, or 2021. The performance of the Bloomberg US Dynamic Balance Index during those periods is mixed, some really good, some moderate, and some flat. This is because market volatility and the performance of the equity component are material considerations of the VCI performance. In fact, over the last 10 years, interest rates have risen slightly and the performance of the index has been strong, mainly due to lower volatility and strong equity performance.

Because of the diversification offered by VCIs, the performance of the index is also able to weather equity market downturns, like the ones in 2002, 2008/2009, 2018, and 2020. The graph above shows that the VCI did not suffer large losses during those periods. This was due to the volatility control mechanism allocating away from equities when volatility spiked during the market downturns, further enhancing the benefits of diversification of the VCI.

**Stable Rate Renewal**
Volatility is a key driver of hedging costs and market volatility can fluctuate greatly from year-to-year. For a capped S&P500 allocation, changes in market volatility will lead to changes in hedging costs and therefore changes in the offered cap. This can lead to large changes in caps on a year-to-year basis and large changes in the historical lookback used for setting maximum illustrated rates in AG49. By contrast, VCIs target a stable volatility, leading to more stable option costs and therefore more stable affordable participation rates. On a year-to-year basis, the policyholder is less likely to experience large changes in participation rates and large changes in the AG49 lookback. This provides the policyholder a more stable and predictable experience over the life of their contract and creates historical lookbacks that rely less on current market conditions and are more representative of what would have actually been experienced over the historical period.
Stable and Strong Credit Performance

The VCIs we offer target a low and controlled volatility, so the index will increase and decrease more slowly than a higher volatility index, like an equity index. More stable index values lead to more stable credits, which is a benefit for IUL policyholders where product fees are present and timing of high or low credits can impact long term policy performance. Stable credits also better align with IUL illustrations, which do not show the variability of index performance.

The higher stability in credits a VCI can achieve is illustrated below by comparing the distribution of historical performance over the last 20 years between the Bloomberg US Dynamic Balance Index allocation and our capped S&P500 allocation. The analysis uses currently offered caps and participation rates and it can be seen that the distribution of the Bloomberg US Dynamic Balance Index credits are more evenly distributed than the S&P500 credits, which are more barbell shaped and have more instances where the policyholder does not receive a credit.

![Distribution of Credits - 2001-2021](image)

Note: The Bloomberg US Dynamic Balance Index has been active since 2013, index performance before that is based on the underlying components of the index and the prescribed formula used to balance between the components.

What can also be seen in the analysis above is that Bloomberg US Dynamic Balance Index allocation offers more potential upside than the capped S&P500 allocation. This strong historical performance is seen in the differences in historical lookbacks between the VCI allocations we offer and the capped S&P500, with the VCI allocations outperforming the S&P500 allocation by 2-3% on average.

Allianz started offering allocations tied to the Bloomberg US Dynamic Balance Index on our IUL policies in 2014, so in addition to strong historical lookback performance, we have 7 full years of credits that have been realized by our policyholders. Over that time, our allocation to this VCI has averaged 1.25% higher credits per year than the S&P500 allocation and both of the allocations have performed above the AG49 maximum allowed illustrated credit.

<table>
<thead>
<tr>
<th>Average Realized Credits 2015-2022</th>
<th>AG49 Maximum Illustration Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capped S&amp;P500</td>
<td>6.77%</td>
</tr>
<tr>
<td>Bloomberg US Dynamic Balance with Par Rate</td>
<td>8.02%</td>
</tr>
<tr>
<td><strong>Average Limit 2015-2022</strong></td>
<td>6.18%</td>
</tr>
<tr>
<td><strong>Current Limit</strong></td>
<td>5.50%</td>
</tr>
</tbody>
</table>

Note: The analysis above assumes a 1/1/2015 contract issue date, with the version of our IUL product available at that time.
Unique Benefits Available to VCIs

The composition of the VCIs we offer allow us to offer unique benefits to our policyholders. Hedging for the VCIs we offer currently cost less than options for S&P500. We are able to take the hedging savings and offer a variety of benefits for the policyholder to choose from, including higher participation rates, a multiplier bonus, or a fixed bonus, all with a unique lock feature on top of these other benefits.

Our lock feature allows a policyholder to “lock-in” their index performance at any point during their crediting period instead of waiting until their policy anniversary, giving the policyholder a level of control over their policy that they cannot get with any other index. We have seen tremendous interest in this benefit since we introduced it in 2019 and we are only able to offer it because of the stable option costs for VCIs.

Summary

Allianz has offered allocations tied to VCIs since 2013. Our policyholders that have allocated to these indexes have benefited from diversification, stability in renewal rates, stability in and strong credit performance, and features like Index Lock. These policyholders have realized credits that exceed our S&P500 allocations and have been the recipients of additional benefits because of the lower and more stable option costs associated with the VCIs. The VCIs we offer and the additional benefits tied to them make up an important part of our product offering and give our policyholders valuable choice in their allocations. In order to have a fully informed and educated consumer when selecting their allocation choice, we feel that the additional benefits and value VCIs provide should be reflected while still adhering to the current AG 49-A illustration restrictions.

Thank you for the opportunity to provide these comments.

Regards,

Austin Bichler, FSA, MAAA
AVP Actuary & Illustration Actuary
Allianz Life Insurance Company of North America
Brian Bayerle  
Senior Actuary  

February 4, 2022  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Mr. Fred Andersen  
Chair, NAIC Indexed Universal Life (IUL) Illustration (A) Subgroup (IUL Subgroup)  

Re: IUL Exposure  

Dear Messrs. Boerner and Andersen:  

The American Council of Life Insurers (ACLJ) appreciates the opportunity to submit the following comments on the exposed document pertaining to IUL illustrations.  

ACLJ appreciates the hard work of LATF and the IUL Subgroup in the development of AG 49-A and the continued monitoring of IUL illustrations. The primary goal of AG 49-A was to reduce the illustrated values on multiplier accounts, which per the exposure appears to have been successful. Our understanding is that some regulators believe that the overall level of illustrated values did not decrease as much as regulators may have envisioned. ACLJ is committed to working with regulators to develop appropriate requirements that allow consumers to understand the value and risks of the policies they purchase.  

ACLJ would like to provide some commentary on the use of volatility-controlled funds with a fixed bonus. Volatility-controlled indexes have relatively low hedge costs associated with the options supporting the indexes, which enables companies to also provide a fixed bonus. These fixed bonuses are not linked to the performance of the indexes; such bonuses are just one way to provide product enhancements and do so in a transparent way. We have provided an appendix with several examples that demonstrate the mechanics of these index strategies and show how these products may have similar illustrated values as similarly situated products without volatility-controlled indexes.  

ACLJ seeks clarity on how regulators prefer to proceed. AG 49-A was designed to target multipliers and similar products and appears to have been successful in doing so. The question appears to be what additional refinements are needed. If the level of illustrated values resulting from current practices for volatility-controlled funds and similar features is deemed reasonable, a disclosure-only approach that could apply to all new inforce illustrations issued since the effective date of AG 49-A...
may provide better education to consumers about the risks associated with these features. If regulators believe the level of the illustrated values is unreasonable, we would ask regulators to provide clear objectives for a revised guideline so industry can work with regulators to address their concerns.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

cc: Reggie Mazyck, NAIC
Appendix - Examples

The following examples are approximate values showing how the credited rates might behave between different simplified products. All examples assume the NIER is 4%.

Baseline – BIA: S&P one-year point-to-point with a 100% participation rate, solved for cap, zero floor, no multiplier, no bonus

For the BIA, the hedge budget is 4%. Based on the average option cost over the last 10 years, that would provide an 8.5% cap, which would translate to a 5.45% credited rate using the AG 49-A prescribed lookback methodology.

Scenario 1: S&P one-year point-to-point with a 100% participation rate, solved for cap, zero floor, no multiplier, 50 bp fixed bonus

For this index strategy, the hedge budget is 3.5%. This results in a 7.25% cap, which would translate to a 4.76% illustrated indexed rate before the fixed bonus, and a 5.26% illustrated rate after the fixed bonus. This example illustrates that AG 49-A allows for a lower hedge budget even independent of volatility-controlled funds. When an S&P account provides a fixed bonus for the same total cost as an S&P account without the bonus, it results in a lower illustrated rate.

Scenario 2: Volatility-Controlled index strategy with a 150% participation rate, no cap, zero floor, no multiplier, solved for fixed bonus.

For this index strategy, assume that the hedge cost for a 100% participation rate is 2.333%. Also assume that at a 150% participation rate, the prescribed lookback methodology produced returns greater than or equal to the 5.45% BIA rate. Set the participation rate to 150%. The hedge budget now needs to be 150% of 2.333%, or 3.5%. This difference leaves 50 bps for the fixed bonus. The resulting indexed credits plus fixed bonus is 5.45% + 0.50% = 5.95%. We note that different participation rates or hedge budgets could be used to achieve different fixed bonus percentages.

Scenario 3: S&P one-year point-to-point with a 100% participation rate, solved for cap, zero floor, no multiplier, 50 bp fixed bonus

This index strategy would be similar to the BIA but with an additional 50 bp bonus, so the resulting indexed credits plus fixed bonus is 5.45% + 0.50% = 5.95%. Such a strategy would require the bonus to be paid for elsewhere in the product design, such as higher COIs or other charges, resulting in a net result on illustrated values that is similar to the BIA account.

The following chart shows how the hedge budget for each scenario above is reflected in the determination of the maximum illustrated index credits for the account as well as the limit on the assumed earned interest rate underlying the disciplined current scale for the account, as prescribed in sections 4 and 5 of AG 49-A.
<table>
<thead>
<tr>
<th>AG 49.A Section</th>
<th>Baseline/BIA* HB = NIER</th>
<th>Scenario 1: S&amp;P Fund, 50bp fixed bonus</th>
<th>Scenario 2: vol-controlled fund, 150% participation + 50bp fixed bonus</th>
<th>Scenario 3: S&amp;P Fund, full hedge budget, 50bp fixed bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>3(B) Annual Net Investment Earnings Rate</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Cap</td>
<td>8.50%</td>
<td>7.25%</td>
<td>n/a</td>
<td>8.50%</td>
</tr>
<tr>
<td>Index Bonus (Multiplier)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Participation Rate</td>
<td>100.00%</td>
<td>100.00%</td>
<td>150.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>3(F) Hedge Budget</td>
<td>4.00%</td>
<td>3.50%</td>
<td>3.50%</td>
<td>4.00%</td>
</tr>
<tr>
<td>3(U) Supplemental Hedge Budget</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>4(B) Historical Credit Rate for Benchmark Index Account (A) Comment; BIA Lookback for Base Case</td>
<td>5.45%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>4(C)(I) Total Indexed Credits using actuarial judgment method consistent with 4A/4B if applicable</td>
<td>5.45%</td>
<td>4.76%</td>
<td>8.25%</td>
<td>5.45%</td>
</tr>
<tr>
<td>4(C)(II) for BIA</td>
<td>5.45%</td>
<td>4.76%</td>
<td>5.45%</td>
<td>5.45%</td>
</tr>
<tr>
<td>4(C)(II) for non-BIA Benchmark Index Account: 4(B) Non-BIA: mnh + 4(C)(II), 4(C)(II))</td>
<td>5.45%</td>
<td>4.76%</td>
<td>5.45%</td>
<td>5.45%</td>
</tr>
<tr>
<td>Annual Indexed Bonus</td>
<td>n/a</td>
<td>0.50%</td>
<td>0.50%</td>
<td>0.50%</td>
</tr>
<tr>
<td>Total Indexed Credits plus fixed bonus</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Maximum Indexed Credits</td>
<td>5.45%</td>
<td>4.76%</td>
<td>5.45%</td>
<td>5.45%</td>
</tr>
<tr>
<td>Minimum Indexed Credits less Supplemental Hedge Budget</td>
<td>5.45% - 0.00%</td>
<td>4.76% - 0.00%</td>
<td>5.45% - 0.00%</td>
<td>5.45% - 0.00%</td>
</tr>
<tr>
<td>5A Limit on earned rate underlying DCS as prescribed in 5(A/II) (based on ANIER, Hedge Budget for the account)</td>
<td>5.80%</td>
<td>5.58%</td>
<td>5.58%</td>
<td>5.80%</td>
</tr>
<tr>
<td>5A Lesser of 5(A/II) or limit described under 5(A/II) (based on the maximum illustrated indexed credits, the ANIER, and the Hedge Budget for the account)</td>
<td>5.45%</td>
<td>5.26%</td>
<td>5.58%</td>
<td>5.45%</td>
</tr>
</tbody>
</table>

* BIA = Best Interest Account

The American Council of Life Insurers (ACL) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACL’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACL’s 200 member companies represent 94 percent of industry assets in the United States.

acl.com
Dear Mr. Boerner and Mr. Andersen,

Thank you for the opportunity to comment on AG 49-A.

I concur with the findings noted in the exposure:

- Some carriers allow illustrations of certain index accounts to reflect account credits that exceed the maximum provided by the Benchmark Index Account (BIA) under AG 49-A
- These illustrations are for accounts based on proprietary volatility-controlled indexes that:
  - Backcast at least as well as the BIA has performed historically,
  - Have lower hedging costs than the BIA, and
  - Are paired with a fixed bonus that is not offered with the BIA
- For these accounts, some carriers allow account credits to include index credits as high as the BIA plus a fixed bonus (supported by the hedging cost savings) resulting in total account credits higher than the BIA.

I believe these illustrations are an issue under AG 49-A:

- **These illustrations violate the spirit of the regulation** – AG 49-A placed a limit on illustrated performance so that no index account could show account credits exceeding those of the BIA, thereby ensuring no illustration was overly aggressive. While the regulation at the time was aimed at accounts with multipliers, it was clear that the intention was for the maximum limit to apply to all types of accounts. Volatility-controlled index account illustrations directly circumvent these guardrails by allowing higher illustrated rates.
- **These illustrations are supported by imprudent assumptions:**
  - **Reliance on backcasting** – Carriers justify the illustrated performance of volatility-controlled index accounts with hypothetical backcast performance, not real historical performance. Hypothetical backcasting is subject to survivorship bias, can be a poor indicator of future performance, and should be treated with a high degree of skepticism. Afterall, it is very easy to create winning index strategies in retrospect.
  - **Reliance on excessive hedging profits** – In order for volatility-controlled index accounts to offer index credits as large as the BIA but with lower hedging costs, the illustrations must implicitly assume hedging profits greater than the profits assumed from hedging programs supporting the BIA and, in the case of some carriers, greater than the 45% hedging profit limit in AG 49-A (a limit that is already generous). These are very large levels of profit to assume from a new and untested asset.

Put simply, these illustrations present consumers with a rosy view of the future supported by scant evidence. These aggressive practices should be addressed swiftly. In the near-term regulators should:

- Clarify that no index account illustration may exceed the illustrated performance of the BIA (something that was clear in the intention of AG 49-A, despite current practices to the contrary)
- Amend AG 49-A to ensure the 45% options profit maximum applies to all hedging programs

In the longer-term regulators should consider ensuring better consumer understanding of novel index accounts through additional disclosure requirements.
These actions will allow carriers to continue to offer volatility-controlled index accounts and other new and innovative features, while immediately curtailing aggressive illustration practices. To be clear, there is nothing inherently wrong with volatility-controlled indexes, fixed bonuses, or other innovative features. Carriers should continue to innovate, but action is needed when such innovation results in overly optimistic illustrations.

As you know, the life insurance industry plays a vital role in providing financial security for families. Aggressive illustrations like those being shown today risk the opposite effect, transferring risk to consumers by setting unrealistic expectations about policy performance. AG 49-A and its predecessor have protected consumers by ensuring a realistic connection between index account credits and the hedging programs that back them. LATF and the IUL Illustration Subgroup must act to assure that AG 49-A can continue to provide this protection to consumers in the future.

Thanks again for the opportunity to comment.

Sincerely,

Anonymous
Fred,

We commend the IUL Illustrations Subgroup for once again addressing the issue of potential abuses in Indexed UL illustrations and appreciate the opportunity to comment. While AG 49-A was extremely effective at limiting the specific illustrated impacts of buy-up caps and multipliers, it left open other strategies to augment illustrated performance beyond what was intended by the Subgroup. We are disappointed – but not surprised – that many life insurers have pursued the particular strategy that was described during the Fall LATF meeting of combining “volatility-controlled funds” with a fixed interest bonus to augment illustrated performance.

**Overview of the Strategy to Increase Illustrated Performance**

One of the core tenants of AG 49-A is that the illustrated crediting rate for any indexed account should be limited to the illustrated crediting rate for the Benchmark Index Account (BIA). However, AG 49-A allows for the addition of fixed interest bonuses to the illustrated crediting rate and to illustrated loan arbitrage. It also prescribes that the illustrated rate for any non-BIA account be determined by the same methodology as the BIA – which is the hypothetical historical lookback methodology described in Section 4.

However, using the hypothetical historical lookback methodology, some indexed strategies generate higher illustrated rates than others while having the same hedge costs. In other words, the illustrated “option profits” for these strategies are higher than the BIA. Therefore, life insurers can reduce the hedge cost of a non-BIA account so that the illustrated rate matches the BIA and then redeploy the savings into a fixed interest bonus. The fixed interest bonus is then added to total illustrated crediting rate for the account. A step-by-step diagram of the strategy is shown in the graph below using hypothetical figures:

The net result is that this strategy is a fully AG 49-A compliant, zero-cost way to augment the illustrated performance of a non-BIA account (or a subset of accounts) beyond the maximum BIA illustrated rate. However, it is not the only way to augment illustrated performance of non-BIA accounts under AG 49-A, as we detailed in our 2020 letter (below) to the Subgroup. We are concerned that if the Subgroup addresses only this particular strategy, life insurers will simply move on to other, more nuanced but no less effective strategies.
It is also important to note that this strategy is the *opposite* of the multiplier strategies defended by some life insurers during the last inquiry in that it reduces option exposure – rather than increases, as with a multiplier – in order to augment illustrated performance. Under the assumption of perpetual, sustainable and structural “option profits” that has long been propagated by some life insurers, reducing exposure to options is actually a detriment to policyholder performance – despite the fact that, under AG 49-A, it produces *better* illustrated performance.

### The Current State of Indexed UL Illustrations

To demonstrate the current state of the market and the impact of this strategy on illustrated performance, the benchmark below shows illustrated income figures for the life insurers who combine fixed interest bonuses with specific indexed crediting strategies. The benchmark figures are based on a 45-year-old Preferred Male with $1 million in premium being paid over 7 years and income (using indexed loans) being taken from years 21 to 40. The S&P 500 account is the BIA, if offered, or the account that most closely resembles the BIA if the BIA is hypothetical and not available for allocation.

<table>
<thead>
<tr>
<th>Carrier</th>
<th>S&amp;P 500 Illustrated Rate</th>
<th>Non-BIA Illustrated Rate</th>
<th>Non-BIA Illustrated Bonus</th>
<th>Non-BIA Combined Rate</th>
<th>S&amp;P 500 Illustrated Income</th>
<th>Non-BIA Illustrated Income</th>
<th>Non-BIA Income Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5.95%</td>
<td>6.24%</td>
<td>2.65%</td>
<td>8.89%</td>
<td>156,548</td>
<td>251,083</td>
<td>60.4%</td>
</tr>
<tr>
<td>B</td>
<td>5.51%</td>
<td>5.70%</td>
<td>1.00%</td>
<td>6.70%</td>
<td>150,934</td>
<td>222,040</td>
<td>47.1%</td>
</tr>
<tr>
<td>C</td>
<td>5.05%</td>
<td>5.05%</td>
<td>1.50%</td>
<td>6.55%</td>
<td>109,585</td>
<td>158,126</td>
<td>44.3%</td>
</tr>
<tr>
<td>D</td>
<td>5.44%</td>
<td>6.15%</td>
<td>0.65%</td>
<td>6.80%</td>
<td>170,488</td>
<td>229,307</td>
<td>34.5%</td>
</tr>
<tr>
<td>E</td>
<td>7.47%</td>
<td>7.16%</td>
<td>1.00%</td>
<td>8.16%</td>
<td>251,241</td>
<td>330,898</td>
<td>31.7%</td>
</tr>
<tr>
<td>F</td>
<td>6.15%</td>
<td>6.00%</td>
<td>0.90%</td>
<td>6.90%</td>
<td>173,657</td>
<td>228,166</td>
<td>31.4%</td>
</tr>
<tr>
<td>G</td>
<td>5.18%</td>
<td>5.71%</td>
<td>0.35%</td>
<td>6.06%</td>
<td>173,714</td>
<td>208,934</td>
<td>20.3%</td>
</tr>
<tr>
<td>H</td>
<td>6.20%</td>
<td>6.20%</td>
<td>0.65%</td>
<td>6.85%</td>
<td>198,779</td>
<td>236,268</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

It is readily apparent from the last column in the preceding table that combining a non-BIA account with a fixed interest bonus is a powerful tool for augmenting illustrated performance under AG 49-A. The percentage increases in income are broadly equivalent to what was seen in the market using buy-up caps and multipliers prior to AG 49-A, the subject of the last round of inquiry and action by the Subgroup. This is not a matter of a “minor” tweak or the need for disclosure.

### The Role of “Volatility-Controlled Funds”

Any index or payoff structure with higher illustrated “option profits” than the BIA, including “volatility-controlled funds,” will allow the life insurer to execute a strategy using a fixed interest bonus that increases the illustrated performance of a non-BIA account beyond what is illustrated in the BIA. While there may be merits (or demerits) to the particulars of “volatility-controlled funds,” the fact is that these funds/indices are not a necessary ingredient to executing the strategy and augmenting illustrated performance. They are simply the easiest, most consistent and likely most profitable way.

Further, there are several life insurers in market who offer “volatility-controlled funds” without fixed interest bonuses. These life insurers illustrate the “volatility-controlled funds” at the same overall performance as the BIA, which is consistent with the intent of AG 49-A. Therefore, in our view, the nature of “volatility-controlled funds” should be outside the scope of this discussion. Instead, our view is that the Subgroup would be best served by focusing on the particular strategy by which some life insurers are using non-BIA account specific bonuses to augment illustrated performance in ways that were not intended by AG 49-A.
Potential Solutions
We strongly recommend that the Subgroup consider following through on its previously stated commitment to explore a holistic and permanent solution in the event that the Subgroup is reconvened to address yet another issue facing Indexed UL illustrations.

We continue to believe, as we detailed in our 2020 letter appended below, that an illustration methodology for Indexed UL rooted in standard fair-market option valuation – a methodology used the world over by option practitioners – will produce a framework that cannot be meaningfully gamed and will produce more consistent, consumer-friendly and economically indicative results than the current AG 49 / AG 49-A framework.

Again, thank you for the opportunity to comment and we look forward to working with the Subgroup to implement a lasting solution for Indexed UL illustrations.

Coalition of Concerned Insurance Professionals

Signed (alphabetically):
  Barry Flagg, President, Veralytic
  Ben Baldwin Jr
  Bill Boersma, President, OC Consulting Group
  Bobby Samuelson, Executive Editor, The Life Product Review
  Chris Hause, FSA, President, Hause Actuarial Solutions
  Jerry Vanderzanden, Insurance Fiduciary
  Larry Rybka, President & CEO, Valmark Financial Group
  Richard M. Weber, President, The Ethical Edge, Inc
  Scott Witt, FSA, President, Witt Actuarial Services
  Steven Roth, President, Wealth Management International, Inc, Licensed Life & Disability Insurance Analyst
  Tom Love, VP, Insurance Analytics, Valmark Financial Group
Letter submitted to IUL Illustration Subgroup on 2/21/2020

Fred,

Thank you for the opportunity to comment on potential revisions to AG49. While we see merits in the Supplemental Option Budget approach, we believe that it is unable to address the full spectrum of designs that could lead to effective illustrated rates well in excess of the AG49 maximum illustrated rate for the Benchmark Index Account (BIA). For example, it is not effective for dealing with the implications of alternative crediting strategies and hybrid indices that have higher imputed option profits based on the hypothetical historical lookback methodology in AG49 Section 4(A), which already provide for means of illustrating returns well in excess of the BIA maximum illustrated rate in products available for sale today. It is also not clear how the concept of a Supplemental Option Budget would interact with persistency funded multipliers, bonuses or cash infusions, as are commonly found on Indexed UL products currently in market.

As a result, we believe that alternatives to the Supplemental Option Budget approach should be considered that will better align Indexed UL illustrations to Fixed Indexed Annuity illustrations and address the full spectrum of potential indexed crediting and product designs. This letter outlines an alternative methodology with specific AG49 language recommendations. We believe that the changes we are proposing to AG49 will accomplish the goals set forth by the regulators while maintaining the ability for life insurers to clearly differentiate crediting strategies and products on the basis of risk and return characteristics using historical index return data.

Our recommendation is for two primary modifications to AG49. The first is to move the hypothetical historical lookback methodology currently used in 4(A) to the crediting rate reports described in Section 7. We also recommend that Section 7 be augmented to encompass best case, worst case and most recent case historical returns over 10 years, aligning Indexed UL illustrations with Fixed Indexed Annuity illustrations. Finally, we recommend that Section 7 be clarified to allow any additional credits or charges contractually related to providing indexed interest which, again, is in accordance with Fixed Indexed Annuity illustrations. Taken together, these changes will augment the insurer’s ability to show how variability of returns can impact crediting performance in a variety of scenarios for each indexed crediting option, thereby increasing consumer understanding of the crediting mechanics and potential risks and returns of the strategies.

Second, we recommend using an option valuation methodology for Section 4(A) with pricing inputs being drawn from the previous calendar year. We recommend using the Black-Scholes formula, a universally accepted valuation methodology for derivatives, including call options, and is commonly applied to the valuation of financial products containing derivatives-based payoffs, such as warrants and retail structured products. Replacing 4(A) with an option valuation formula aligns the maximum illustrated rate with the denominator for all indexed-linked credits in the contract, regardless of whether they are funded through the insurer’s portfolio yield, additional policy charges or persistency. This modification to 4(A) will eliminate the illustrated benefits of multipliers and buy-up caps.

It would also align the illustrated benefits of alternative crediting strategies and hybrid indices with the Benchmark Index Account. There would be differences in the illustrated rates for the various accounts based solely on the fair market value of the options, which is a true and reasonable indicator to consumers of the current intrinsic value of the indexed crediting option. However, consumers would still be able to see the potential risks and rewards of these strategies in the hypothetical historical crediting reports described in Section 7 based on historical index returns. By combining these two approaches, consumers will be able to make an informed decision about choosing an indexed crediting strategy based on both the current fair-market valuation.
of the replicating options for the strategy (Section 4(A)) and its potential to deliver performance in a variety of historical return scenarios (Section 7).

The changes to the AG49 language proposed herein would accomplish the following goals stated by regulators:

1. Standardizing illustrated rates across Benchmark Index Account options, in accordance with the stated goals of the original Indexed UL Illustration Subgroup in 2013.
2. Limiting the ability for alternative crediting strategies and indices to illustrate more advantageously than traditional indices and crediting strategies, in accordance with the stated goals of the original subgroup.
3. Ensuring that products with multipliers illustrate similarly to products without multipliers, in accordance with the recent vote taken by the IUL Illustration Subgroup.
4. Ensuring that products with buy-up caps illustrate similarly to products without buy-up caps, in accordance with the vote taken at the most recent NAIC meeting in Austin.
5. Bringing Indexed UL illustrations into alignment with Fixed Indexed Annuity illustrations.
6. Maintaining of the majority of the current AG49 language, including the 145% factor for illustration actuary testing, thereby avoiding a time-intensive rework of the guideline.

The language proposed herein would also satisfy the following concerns raised by life insurers:

1. Continuing to provide for the ability of life insurers to differentiate their products and crediting methodologies by demonstrating the potential for different indexed crediting options to offer different risk/return profiles, including multipliers, buy-up caps and proprietary/hybrid indices.
2. Providing for illustrated loan arbitrage to a similar degree as Whole Life, thereby ensuring that Indexed UL is not at a competitive disadvantage to Whole Life in terms of illustrated loan treatment.
3. Providing for the continued illustration of persistency-based, embedded multipliers and bonuses, thereby ensuring that Indexed UL is not at a competitive disadvantage to other types of Universal Life products.

Specific AG49 language changes, with accompanying comments, are appended. We appreciate the opportunity to comment and respectfully submit our proposal.

Signed,

Bobby Samuelson, Executive Editor, The Life Product Review
Larry Rybka, President & CEO, Valmark Financial Group
Joseph M. Belth, professor emeritus at Indiana University
Chris Hause, FSA, President, Hause Actuarial Solutions
Richard M. Weber, President, The Ethical Edge, Inc
Barry Flagg, President, Veralytic
Stephen R. Leimberg, Publisher, Leimberg Information Services, Inc
Bill Boersma, President, OC Consulting Group
Tom Love, VP, Insurance Analytics, Valmark Financial Group
Mike Brohawn, President, Your Life Insurance Solution
Steven Roth, President, Wealth Management International, Inc., Licensed Life & Disability Insurance Analyst
Ben Baldwin Jr
Suggested AG49 Language Modifications

1. Replace 4(A) with:

A. Calculate the value of the replicating option trades for the Benchmark Index Account over the preceding calendar year, based on the Black-Scholes formula using the following inputs calculated on each trading day:
   i. Average closing implied volatility for 12-month, at-the-money S&P 500 call options
   ii. Average closing implied volatility for out-of-the-money 12-month S&P 500 call options with a normalized strike price equal to the currently declared cap
   iii. Average dividend yield on the S&P 500
   iv. Average 12-month LIBOR

This section is designed to replicate the reasonable price of replicatively hedging the current index parameters in the Benchmark Index Account. An alternative approach may be for the NAIC to publish standard tables of the estimated price for hedging index participation parameters at defined intervals (0.25%, for example) with allowance for insurers to interpolate between the datapoints. This would limit the degree to which insurers with identical index participation parameters would have different illustrated performance. LIBOR may also be exchanged for another measure of Risk Free Rates.

2. Replace 4(B) with:

B. The value calculated in 4(A) shall be the maximum credited rate(s) for the illustrated scale.

3. Remove 3(A) – The Alternate Scale

4. Replace 4(C) with:

C. For other Index Accounts using other equity, bond, and/or commodity indexes, and/or using other crediting methods, the illustration actuary shall use actuarial judgement to determine the maximum credited rate for the illustrated scale. The determination shall reflect the fundamental characteristics of the Index Account as relates to the inputs for the Black-Scholes valuation formula, including realized volatility, implied volatility, volatility targets (if applicable), embedded fees (if applicable), deduction of an interest rate component (if applicable), dividend participation (if applicable) and other factors that may apply.

This section is designed to ensure that products using different crediting methodologies, indices or combinations of the two illustrate in the same methodology as the Benchmark Index Account in accordance with their fundamental, underlying characteristics

5. Replace 7 with the following:
A. A table showing the minimum and maximum of a geometric average for any available Benchmark Index Account using the following methodology:
   i. Calculate the geometric average annual credited rate for each applicable Benchmark Index Account for the 25-year period starting on 12/31 of the calendar year that is 66 years prior to the current calendar year (e.g., 12/31/1949 for 2015 illustrations) and for each 25-year period starting on each subsequent trading day thereafter, ending with the 25-year period that ends on 12/31 of the prior calendar year.
   ii. Calculate the arithmetic average of the geometric average annual returns in all 25-year periods

B. For each Index Account illustrated, a table showing actual annual historical index changes and corresponding hypothetical interest rates using current index parameters, including any applicable asset-based charges and asset-based interest bonuses or index credit multipliers paid within the first 10 years of the policy:
   i. The 10-year period with the lowest calculated returns within the period referenced in 7(A)(i)
   ii. The 10-year period with the highest calculated returns within the period referenced in 7(A)(i)
   iii. The most recent 10-year historical period as calculated on the final trading day of the preceding calendar year

C. If an index has not been in existence for 10 years, the table shall replace the figures with the maximum available back-tested performance.

This section is designed to bring Indexed UL illustrations into alignment with Fixed Index Annuity illustrations. These demonstrations will also provide latitude for insurers to demonstrate the potential risk and return profiles of various crediting strategies, indices and policy mechanisms.

The following sections of AG49 were not altered for the following reasons:

5. There is no need to change the 145% provision in 5(A) as it will provide a cushion for the inevitable mismatches between the standardized illustrated price of the replicating options calculated in 4(A) and the insurer’s own pricing for options, expectations of prices or cap-setting process. Retaining the 145% will allow insurers who have economies of scale in hedging, are supporting higher caps with higher policy charges or other designs to illustrate benefits and costs accordingly. However, it may be advisable to adopt some of the clarifications to this language previously proposed in other comment letters.

6. There is no need to change the 100 basis points allowance for illustrated loan arbitrage. As with Section 5, there are inevitable mismatches between what an insurer is willing to charge on a loan and the value of what it may credit by providing current index participation parameters. This section preserves the ability for insurers to reflect those changes. However, it may be prudent to add clarifying language about the inclusion of illustrated bonuses and multipliers for the 100bps allowance.
The Life Actuarial (A) Task Force met Feb. 17, 2022, in joint session with the Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ted Chang, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Jessica K. Altman represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT). The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed the ESG

Scott O’Neal (NAIC) provided an update (Attachment Five-A) on the economic scenario generator (ESG). He said the ESG Drafting Group is considering two candidates for the Treasury Model. The candidates are the Conning calibration with a generalized fractional floor and an alternative calibration with a shadow rate floor, which introduces a floor rate believed to preserve the arbitrage-free property of the scenarios. He said the field test will help determine which floor to use for the ESG. He noted that the Conning calibration met all the acceptance criteria prioritized by the drafting group for use in the field test.

Mr. O’Neal said the drafting group discussed key recommendations for the setup of the equity and corporate models. The recommendations include: 1) retaining the ESG equity-treasury linkage (supported primarily by the state insurance regulators on the drafting group); 2) using a Sharpe ratio approach with a 5% corridor to represent international equities; 3) capturing initial market conditions by allowing the recent market volatility to affect equity scenarios; and 4) including both the simplified and the complex Conning GEMS corporate model in the field testing. Mr. O’Neal said the drafting group is working to address questions on the structure of the field test and scope of business to include. He said the field test will begin in June and run to September. Results are expected to be presented to the public by November. Pat Allison (NAIC) said the response to the initial request for field test participation resulted in companies offering to test a broad range of products. She said a follow-up request, with more details on the field test, is forthcoming.

Brian Bayerle (American Council of Life Insurers—ACLI) discussed the ACLI comments (Attachment Five-B). The comments indicated general concerns, as well as concerns specific to the treasury and equity models. Mr. Bayerle said the ACLI does not believe the Conning GEMS model meets the need for determining life insurance and annuity reserves. He said the limited documentation available for the Conning GEMS model is an issue of concern. He said ACLI experts have just offered an alternative model that is understandable and transparent. He stated the ACLI preference for using that model instead of the Conning GEMS model. Jason Kehrberg (American Academy of
Actuaries—Academy) said the Academy also questions the suitability of the Conning GEMs model for life insurance reserving. He said the Academy has offered proposals for changes to the modeling of interest rates, equity returns, and fixed income returns. He said the Academy is working to provide model office results for the current candidates for the field test for discussion on a future call.

Having no further business, the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group adjourned.

https://naiconline.sharepoint.com/:w:/r/sites/NAICSsupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/LATF Calls/02 17/Feb 17 Minutes.docx
ESG Update to the Life Actuarial (A) Task Force and the Life RBC (E) Working Group

2/17/22

Agenda

1. ESG Project Status
2. Information on Treasury scenario set candidates for field testing
   a) Conning Calibration and Generalized Fractional Floor (“Non-shadow”)
   b) Alternative Calibration and Shadow Floor (“Shadow”)
3. Key Decisions for Equity and Corporate Models
4. Field Test Considerations
5. Questions and Comments
ESG Project Status

• Over the past year the ESG Drafting Group, which is composed of regulators, subject-matter experts, Conning staff and NAIC Staff, has been working to develop a calibration that will work for use in the upcoming ESG Field Test.
• While public status updates were delivered periodically over this time, more frequent touchpoints will be needed as we move towards the June target for a field test to:
  • receive input from all stakeholders, and to
  • position regulators to be able to make the final recommendation for scenarios to be used in the field test.
• The ESG Drafting Group is currently considering two Treasury model calibration candidates for field testing, as described on the slide 7.
• Additionally, the ESG Drafting Group is also considering key properties of the Equity and Corporate models as outlined in slide 12.
ESG Project Status – Next Steps

- The ESG Field Test is expected to be conducted from June through August 2022.
- Once results are compiled by the NAIC, aggregated results of the field test are expected to be presented starting in September 2022.
- After regulators review the field test results, changes may be desired to the calibration of the ESG used in field testing. In that case Conning would begin work in the 4th quarter of 2022 to modify the ESG calibration as appropriate. A follow-up to the field test could be conducted for companies to test this new set of scenarios in the first quarter of 2023.
- After field testing, regulators may approve the ESG for use in determining statutory reserves and capital. For implementation in 2024, amendments to the valuation manual would have to be approved by the Life Actuarial (A) Task Force by June of 2023 according to the normal process. The Life RBC (E) Working Group changes to C3 Phase I and C3 Phase II instructions need to be adopted by June of 2024 for use in 2024 RBC calculations.

Information on Treasury Scenario Set Candidates for Field Testing
Treasury Model Candidates

The ESG Drafting Group is currently considering two Treasury model candidates for field testing.

<table>
<thead>
<tr>
<th>Conning Calibration and Generalized Fractional Floor</th>
<th>Alternative Calibration and Shadow Floor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Conning calibration, paired with a floor, was designed to meet the acceptance criteria that were chosen by regulators for the Treasury scenarios.</td>
<td>• There were several motivations behind the Alternative Calibration including:</td>
</tr>
<tr>
<td>• A generalized fractional floor has been applied to the scenarios resulting from the Conning calibration to reduce the frequency and severity of negative interest rates. More details on the generalized fractional floor are shown on slide 8.</td>
<td>• producing realistic term premiums and yield curve behavior over time, and</td>
</tr>
<tr>
<td>• Additional analysis of the scenarios from the Conning calibration and generalized fractional floor will be discussed in the next section.</td>
<td>• fitting a wide variety of historical yield curves.</td>
</tr>
</tbody>
</table>

Generalized Fractional Floor Formula:

If Unfloored Rate < Adjustment Threshold,

Floored Rate = Adjustment Threshold + Factor * (Unfloored Rate - Adjustment Threshold)

Otherwise,

Floored Rate = Unfloored Rate

Example:

Unfloored Rate = -1%  Threshold = 40BPs  Factor = 20%
Floored Rate = 0.4% + 20%*(-1% - 0.4%) = 0.12%

• The Conning GEMS Treasury model has the capability of producing negative interest rates, which have been a feature prevalent in other countries currently and in recent history.
• While the basic formula for the generalized fractional floor (see below) is relatively simple, the implementation of the floor in the Conning Calibration is more complex. In this particular implementation, the Treasury model is fit to an implicit yield curve that is chosen such that the actual yield curve is matched at time zero after the floor has been applied.
• Applying a generalized fractional floor methodology to the scenarios from the Conning Treasury calibration allows for increased control of the frequency and severity of negative interest rates.
• After testing, Conning has chosen a threshold value of 40 BPs and a factor of 20% to reduce the frequency and severity of negative interest rates while ensuring that other regulator objectives, such as low for long, are met.
## Prioritized Acceptance Criteria: Conning Calibration Results

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Acceptance Criteria</th>
<th>Criteria Met?</th>
</tr>
</thead>
</table>
| 1.   | Low For Long | a) At least 10% of scenarios should have a 10-year geometric average of the 20-year UST that is below 1.45%*  
       |          | b) At least 5% of scenarios should have a 30-year geometric average of the 20-year UST that is below 1.45%* | a) 10-year threshold: 19.5% - PASS  
       |          |                     | b) 30-year threshold: 5.2% - PASS |
| 2.   | Prevalence of High Rates, Upper Bound on Treasury Rates | a) The scenario set should reasonably reflect history, with some allowance for more extreme high and low interest rate environments  
       |          | b) Upper Bound:  
       |          | i. 20% is >= 99th percentile on the 3M yield fan chart, and no more than 5% of scenarios have 3M yields that go above 20% in the first 30 years  
       |          | ii. 20% is >= 99th percentile on the 10Y yield fan chart, and no more than 5% of scenarios have 10Y yields that go above 20% in the first 30 years | a) PASS  
       |          |                     | b) PASS |

*1.45% was the current level of the 20-year UST at 12/31/20.

## Prioritized Acceptance Criteria: Conning Calibration Results (cont.)

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Acceptance Criteria</th>
<th>Criteria Met?</th>
</tr>
</thead>
</table>
| 3.   | Lower Bound on Negative Interest Rates, Arbitrage Free Considerations | Apply the following guidance for negative rates:  
       |          | a) All maturities could experience negative interest rates  
       |          | b) Interest rates may remain negative for multi-year time periods  
       |          | c) Rates should generally not be lower than -1.5% | PASS |
| 4.   | Initial Yield Curve Fit, Yield Curve Shapes in Projection, and Steady State Yield Curve Shape | a) Review initial actual vs. fitted spot curve differences for a sampling of 5 dates representing different shapes and rate levels for the entire curve and review fitted curves qualitatively to confirm they stylistically mimic the different actual yield curve shapes  
       |          | b) The frequency of different yield curve shapes in early durations should be reasonable considering the shape of the starting yield curve (e.g. a flatter yield curve leads to more inversions).  
       |          | c) The steady state curve has normal shape (not inverted for short maturities, longer vs shorter maturities, or between long maturities) | a) Pending Review  
       |          |                     | b) PASS  
       |          |                     | c) PASS |
### Key Decisions for Equity and Corporate Models

#### Equity Model Key Decisions

<table>
<thead>
<tr>
<th>Decision</th>
<th>Current Direction for Field Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should Existing GEMS ESG Equity-Treasury Linkage be Utilized?</td>
<td>Yes</td>
</tr>
<tr>
<td>How should the returns for the international indices be set?</td>
<td>Utilize a Sharpe-ratio approach with a 5% corridor</td>
</tr>
<tr>
<td>How should equity returns respond to initial market conditions?</td>
<td>Use existing functionality to allow recent market volatility to impact the equity scenarios.</td>
</tr>
</tbody>
</table>

#### Corporate Model Key Decisions

<table>
<thead>
<tr>
<th>Decision</th>
<th>Current Direction for Field Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should the “Complex” GEMS Corporate model be used or a simplified model?</td>
<td>Include Simplified and “Complex” GEMS Corporate models in field testing</td>
</tr>
</tbody>
</table>
Field Test Considerations

Field Test Considerations - Background

- Regulators, NAIC staff, American Academy of Actuaries volunteers, and representatives of the American Council of Life Insurers that form a ESG Field Test Planning Group are collaborating to develop specifications for the ESG field test, a set of instructions for field test participants, and a results template for participating companies to record results.
- The ESG Field Test Planning Group is currently working to address the following questions, among others:
  - Do multiple scenario sets, representing additional valuation dates or sensitivities, need to be included in the field test?
  - Should some portion of the field test be made optional to increase participation?
  - What survey questions can be added to the field test to better understand participant results?
  - Does model office testing need to be performed alongside the field test?
  - Should an attribution analysis be performed by participants to understand the drivers of results?
### Field Test Considerations - Scope

**VM-20**
- All individual life insurance policies issued on or after the operative date of VM-20, or issued during the transition period, if elected by the company. Smaller insurance companies may obtain an exemption.
- Stochastic reserves, Deterministic reserves, and stochastic exclusion ratio test (SERT) values will need to be field tested.

**VM-21/C3 Phase II**
- Variable deferred or immediate annuity contracts whether or not they have GMDBs or VAGLBs, group annuity contracts containing GMDBs or VAGLBs, and policies or contracts with guarantees similar in nature to GMDBs or VAGLBs where there is no other explicit reserve requirement.
- Stochastic Reserves and CTE with Prescribed Assumptions will need to be field tested. The CTE 70 metric will need to be tested for reserves and the CTE 98 metric will be tested for TAR.

**VM-22/C3 Phase I**
- Include certain annuities (with the exception of indexed annuities) and single premium life insurance for C3 Phase I testing.
- VM-22 methodology changes will be deferred to the VM-22 field test, and therefore VM-22 calculations are out of scope for this field test.

### Timeline

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</tr>
</thead>
<tbody>
<tr>
<td>A. ESG and Tool Customization, Exposure, and Refinement</td>
<td>B. Field Test Design</td>
<td>C. Company Selection and Notification</td>
<td>D. Field Test Exposure</td>
<td>E. Field Test</td>
<td>F. NAIC Compile Results</td>
<td>G. Results Presented</td>
<td></td>
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</tbody>
</table>

For Item A, the ESG Drafting group is working to specify the Treasury, Corporate, and Equity models for use in the field test. The ESG would then be exposed for public comment. Any tweaks to the ESG and associated tools following comment are also included in this step.
Questions & Comments
Comments on Economic Scenario Generator Progress

February 17, 2022

ACLl Principles of ESG Effort

- NAIC prescribed scenario generator should be “fit for purpose” and produce a reasonable baseline set of economic scenarios.

- There should be a balance between complexity, transparency, ease of use, and stability of scenario generator parameters.

- Scenarios should reflect “history plus”: a reflection of economic dynamics from relevant history as well as an appropriate distribution of worse-than-history tail events, particularly around low-for-long interest rate conditions.
Concerns Surrounding the Models

1) General concerns
   - “Fit for Purpose”
   - Potential volatility

2) Treasury Model
   - Negative Interest Rates
   - Curve Shapes

3) Equity Model
   - Linkage to Interest Rates
   - Incomplete Recalibration of Equity Model Parameters

4) Corporate Model
   - Conning Simplified Model Limitations
   - Transparency

Treasury Model
Treasury Model – Negative Interest Rates

- GEMS-type models are known for producing excessively frequent and severe negative interest rates, particularly in low-rate environments.
- GEMS is producing an unreasonable number of negative interest rates.
  - Before including a floor, more than half the rates were negative in the near-term and up to 30% of rates were negative in the steady-state as of 12/31/20.
- Further, the model (without a floor) is producing rates near -9%.
- Floors are generally used to address outliers. ACLI has serious reservations about a floor that overrides rates at some point in nearly every scenario and will have significant implications elsewhere.

Treasury Model – Negative Interest Rates (Unfloored)

- Direct flooring approaches are likely to affect all scenarios and override up to half of the rates in a given month.
- Approaches that start with a "shadow" rate curve would generate even more negative scenarios to floor.
- The choice of floor is likely to be a key driver of rate levels used to calculate reserves and capital.
**Treasury Model – Negative Interest Rates**

- In the unfloored scenarios, about 50% of rates are negative in the initial months and 30% of rates are negative in the steady state.

- In the subset of available Conning floored scenarios, up to 60% of rates are negative in the initial months, 30% of rates are negative in the early years, and 20% of rates are negative in the steady state.

**Treasury Model – Yield Curve Shapes**

- Curve shapes, including frequency and severity of inversions, are inconsistent with historical dynamics and economics.

- This is problematic as it could:
  - Create significant non-economic costs to companies whose investment and hedging strategies are sound in real world applications but might generate significant reserves due to the differences.
  - Incent ALM mismatches.
Treasury Model – Yield Curve Shapes

- The frequency of yield curve inversions generally varies by rate levels. Controlling for rate level differences, inversions may be roughly twice as frequent in the 10/2021 scenarios as in historical data.
- Conning floored results show similar inversion frequencies.

<table>
<thead>
<tr>
<th>% Inverted</th>
<th>&lt; -1%</th>
<th>[-1%, 0%)</th>
<th>[0%, 1%)</th>
<th>[1%, 2%)</th>
<th>[2%, 3%)</th>
<th>[3%, 4%)</th>
<th>[4%, 5%)</th>
<th>[5%, 6%)</th>
<th>[6%, 7%)</th>
<th>[7%, 8%)</th>
<th>[8%, 9%)</th>
<th>[9%, 10%)</th>
<th>&gt; 10%</th>
<th>All Yields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years 1-5</td>
<td>0%</td>
<td>0%</td>
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<td>Years 6-10</td>
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<tr>
<td>Years 11-15</td>
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<td>Years 16-20</td>
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<td>Years 21-25</td>
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<tr>
<td>Years 26-30</td>
<td>0%</td>
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<tr>
<td>Years 31-35</td>
<td>0%</td>
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<td>100%</td>
</tr>
</tbody>
</table>

Hist %

- The magnitude of yield curve inversions also appears to be significantly higher than history when reflecting rate levels.
- Conning floored results show similar magnitudes of inversions.

<table>
<thead>
<tr>
<th>10Y vs. 2Y - Inverted Spread Distribution (Years 1-30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Inverted</td>
</tr>
<tr>
<td>Min</td>
</tr>
<tr>
<td>1%</td>
</tr>
<tr>
<td>5%</td>
</tr>
<tr>
<td>10%</td>
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<tr>
<td>25%</td>
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<tr>
<td>50%</td>
</tr>
<tr>
<td>75%</td>
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<tr>
<td>90%</td>
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<tr>
<td>95%</td>
</tr>
<tr>
<td>99%</td>
</tr>
<tr>
<td>Max</td>
</tr>
<tr>
<td>Avg</td>
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</tbody>
</table>

Hist Min       0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  100%
Hist Median    1.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  100%
Hist Average  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  0.0%  100%
Equity Model

Equity Model – Concerns with the Linkage to Interest Rates

- Conning assumes a constant mean relationship between equities and interest rates in each individual month (i.e., Expected equity return = Expected short-term interest rate + a random component).
  - This simplification is not supported by historical data or economic research.

- This simplification results in counterintuitive results and creates:
  1. “Mark to Model” relationships that can result in artificial volatility
  2. Procyclical results
  3. Scenario distributions that vary in their level of conservatism/aggressiveness from reporting period to period
Equity Model – Concerns with the Incomplete Recalibration of Equity Model Parameters

- Interest rates are a key input in Conning’s equity model.
  - Current interest rate models under consideration have significant differences vs. Conning’s standard calibration.

- Defaulting to Conning’s calibration for other parameters (after changing the underpinnings of the model) has led to an unsupported ~45% decrease in median 30-year cumulative equity returns (and more extreme decreases in lower percentiles) based on 12/31/20 conditions.

- Conning’s incomplete recalibration also includes scenarios where broad equity indices become worthless.

Equity Model – Concerns with the Incomplete Recalibration of Equity Model Parameters

- While theoretically possible, projecting that equity indices become essentially worthless in some scenarios is extreme for reserve and capital projections and may cause operational issues (e.g., scenario selection).
Equity Model – Concerns with the Incomplete Recalibration of Equity Model Parameters

- The S&P 500 (price index) has negative returns over 30 years in ~18% scenarios even though this has never been observed in history, even using data since 1928.

<table>
<thead>
<tr>
<th>Index</th>
<th>Duration (Years)</th>
<th>Duration (Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S&amp;P 500</td>
<td>164</td>
<td>13.67</td>
</tr>
<tr>
<td>Russell</td>
<td>140</td>
<td>11.67</td>
</tr>
<tr>
<td>Mid</td>
<td>108</td>
<td>9.00</td>
</tr>
<tr>
<td>Nasdaq</td>
<td>193</td>
<td>16.08</td>
</tr>
<tr>
<td>EAFE</td>
<td>149</td>
<td>12.42</td>
</tr>
</tbody>
</table>

% of Scenarios with Cumulative Price Index Losses

Corporate Model
Corporate Model – Concerns

- Limited substantive documentation is currently available for the GEMS corporate model, and there are structural issues with the Conning proposed simplified model (including contradictions with prescribed VM credit assumptions and credit market dynamics and excessive cumulative credit related returns).

- Experts have offered a transparent and understandable alternative that appears to track closely with the GEMS corporate model.

- Since we are unaware of a meaningful implementation limitation on such a model, we would favor the transparent approach.

Recommendations

- Develop appropriate acceptance criteria (including contemplation of reference models) to facilitate an industry field study for maximal return on effort. Current criteria are not sufficient to assess economic scenarios, including potential non-economic behavior.

- Engage in a substantive discussion of model limitations and consider structural modifications (interest rates, corporate) and calibration refinements (equity) in the existing model form once more robust criteria are established.

- If continued analysis suggests untenable characteristics of the model remain, we believe it is critical that LATF begin contemplating alternatives.
### Appendix: Equity Result Comparison YE2019 to YE2020

- 141 bp decrease in initial overnight rates
  - ~10% lower price index levels though 30 years (= -0.4% annualized)
    - Patterns are similar for total return accumulation factors and for other indices.
    - Differences in the extreme tails may be from differences in the # of scenarios with multiple large jumps (e.g., ±20% or 25%).

#### S&P 500 Price Accumulation Factors

<table>
<thead>
<tr>
<th></th>
<th>YE2020</th>
<th>YE2019</th>
<th>YE2020 - YE2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Yr</td>
<td>5 Yr</td>
<td>10 Yr</td>
</tr>
<tr>
<td>Min</td>
<td>0.36%</td>
<td>0.29%</td>
<td>0.21%</td>
</tr>
<tr>
<td>Max</td>
<td>1.67%</td>
<td>1.72%</td>
<td>1.82%</td>
</tr>
</tbody>
</table>

#### S&P 500 Annualized Cumulative Returns

<table>
<thead>
<tr>
<th></th>
<th>YE2020</th>
<th>YE2019</th>
<th>YE2020 - YE2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Yr</td>
<td>5 Yr</td>
<td>10 Yr</td>
</tr>
<tr>
<td>Min</td>
<td>-54.3%</td>
<td>-54.6%</td>
<td>-54.8%</td>
</tr>
<tr>
<td>Max</td>
<td>66.8%</td>
<td>68.4%</td>
<td>70.6%</td>
</tr>
</tbody>
</table>

• 141 bp decrease in initial overnight rates
  - ~10% lower price index levels though 30 years (= -0.4% annualized)
  - Patterns are similar for total return accumulation factors and for other indices.
  - Differences in the extreme tails may be from differences in the # of scenarios with multiple large jumps (e.g., ±20% or 25%).
1. Exposed a Proposed Actuarial Guideline for Asset Adequacy Testing

Mr. Andersen said the proposed actuarial guideline addresses the increased use of complex assets in asset adequacy testing (AAT) modeling to support reserves. He said the guideline provides background for activities and findings leading to its development. He said while many complex assets tend to be associated with private equity firms, complex assets are also used by insurance companies with traditional ownership. He noted that the development of the guideline is associated with a broad NAIC effort, including coordination by the Macroprudential (E) Working Group, to establish regulatory practices related to private equity-owned insurers. He said the role of the Task Force is to ensure reserves are adequate even when complex assets do not perform as predicted. He said the focus of the guideline is on projected high net yield assets. The proposed effective date of the guideline is Dec. 31.

Mr. Andersen said the scope of the guideline covers life insurers with: 1) over $5 billion in actuarial reserves; or 2) over $500 million of actuarial reserves and over 5% of the assets supporting those reserves considered high yield. He said approximately 86 companies fall under the first criterion, and approximately 100 companies fall under the second criterion.

Mr. Carmello suggested that using the current U.S. Treasury rate to determine the investment grade net yield benchmark is better than using the U.S. Treasury rate on the asset purchase date. Mr. Chang said the Scope section should be adjusted for reinsurance agreements where a portion of the supporting assets are held by the reinsurer. Mr. Carmello said he is in favor of having the scope of the guideline apply to all life insurers. Mr. Leung said perhaps there are general principles that would apply to all companies; companies with high yielding assets would be subjected to additional requirements. Mr. Wallman stated his preference for continuing with sensitivity testing for year-end 2023 instead of moving to the proposed investment constraints.

Mr. Andersen made a motion, seconded by Mr. Leung, to expose the AAT actuarial guideline (Attachment Six-A) for a 35-day public comment period ending March 18. The motion passed unanimously.
2. **Exposed Amendment Proposal 2022-01**

Ms. Hemphill said amendment proposal 2022-01 clarifies the language in Section 8C(18) of VM-20, Requirements for Principle-Based Reserves for Life Products, that is applicable to retrocessions of yearly renewable term (YRT) business. Mr. Slutsker said the proposal clarifies that the same treatment that applies to the reinsurer also applies to the retrocessionaire.

Mr. Slutsker made a motion, seconded by Mr. Chupp, to expose amendment proposal 2022-01 (Attachment Six-B) for a 21-day public comment period ending March 3. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/MemberMeetings/Spring2022NationalMeeting/TaskForces/LifeActuarial/LATF Calls/02 10/LATF Fall 2021 Minutes.docx
Actuarial Guideline AAT – DRAFT FOR LATF CONSIDERATION

APPLICATION OF THE VALUATION MANUAL FOR TESTING THE ADEQUACY OF LIFE INSURER RESERVES

Background

The NAIC Valuation Manual (VM-30) contains actuarial opinion and supporting actuarial memorandum requirements, including requirements for asset adequacy testing. Regulators have observed a lack of uniform practice in the implementation of asset adequacy testing. The variety of practice in incorporating the risk of complex assets into testing does not provide regulators comfort as to reserve adequacy. Examples of complex assets are structured securities, including asset-backed securities and collateralized loan obligations, as well as assets originated by the company or affiliated or contracted entity. An initial increase of this activity has been noted in support of general account annuity blocks; however, recent activity was noted in other life insurer blocks.

This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy testing performed by life insurers. In particular, this Guideline:

1. Helps ensure reserve adequacy and claims-paying ability in moderately adverse conditions, including conditions negatively impacting cash flows from complex assets;

2. Clarifies how margins for uncertainty are established such that the greater the uncertainty the larger the margin and resulting reserve;

3. Ensures recognition that higher expected gross returns from assets are, to some extent, associated with higher risk, and that assumptions fit reasonably within the risk-return spectrum;

4. Requires sensitivity testing regarding complex assets currently supporting or assumed to provide future support for life insurer business;

5. Identifies expectations in practice regarding the valuation of complex assets;

6. Establishes a process for researching and monitoring the risks associated with complex assets;

7. Reflects that while complex assets tend to have higher uncertainty regarding timing and amount of cash flows than in more traditional investments, because complex assets are difficult to classify, and the regulatory concern is regarding the projected net yields and cash flows from those assets, the focus of the Guideline will be on assets deemed to be high-yield assets; and

8. Requires additional documentation of investment fee income relationships with affiliated entities or entities close to the company.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date, effective for a future valuation year. This Guideline will cease to apply to annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported in the December 31, 2022 and subsequent annual statutory financial statements.
statements.

2. Scope

This Guideline shall apply to all life insurers with:

A. Over $5 billion of actuarial reserves or

B. Over $500 million of actuarial reserves and over 5% of supporting assets in the category of Projected High Net Yield Assets, as defined in Section 3.B.

Actuarial reserve amounts are included in the amounts in A and B whether directly written or assumed through reinsurance and are determined before any reinsurance ceded credit.

3. Definitions

A. Investment Grade Net Yield Benchmark. A net yield calculated as i + ii – iii:

   i. For current assets, the Treasury rate at the asset purchase date for the time to maturity associated with the asset; for reinvestment assets, the Treasury rate related to the projected interest rate scenario at the projected asset purchase date for the time to maturity associated with the asset.

   ii. The spread found in Table F for existing assets and Table H for reinvestment assets, found in the VM-20 / VM-21 / VM-22 Tables tab on the principle-based reserve page of the NAIC website (NAIC website), using PBR Credit Rating 9 and the weighted average life of the associated asset.

   iii. The default cost found in Table A on the NAIC website, using PBR Credit Rating 9 and the weighted average life of the associated asset.

   iv. For assets such as equities or equity-like instruments without a clear weighted average life, apply judgment in establishing an appropriate weighted average life for this exercise and disclose the approach applied. If judgment is difficult to apply due to the circumstances, apply a weighted average life of 20 years.

B. Projected High Net Yield Assets. Assets where assumed, future net yields (net of default risk and other risk impacting timing and amount of cash flows) are higher than the Investment Grade Net Yield Benchmark. Included are currently held assets and reinvestment assets, including equities and equity-like instruments.

   i. Aggregation considerations

      (a) The comparison between assumed net yields from each asset and the Investment Grade Net Yield Benchmark shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy testing model.

      (b) For companies that model assets for each Committee on Uniform Securities Identification Procedures (CUSIP) number, this exercise is intended to be performed for each individual CUSIP.

      (c) For companies that group similar assets for asset adequacy testing modeling purposes, the companies may provide results at such level, or alternatively, for each individual asset.

   ii. For assets that do not have an explicit weighted average life or term to maturity (such as equities or equity-like instruments), the company shall disclose the method used to determine the appropriate weighted
average life used for comparing to the Investment Grade Net Yield Benchmark.

iii. For purposes of the comparison between assumed net yields from each asset and the Investment Grade Net Yield Benchmark, investment expenses shall be excluded.

4. Asset Adequacy Considerations for Analysis of Business Supported by Any Projected High Net Yield Assets

A. The actuarial memorandum should provide documentation on net return assumptions, including gross asset spreads, default costs, recovery rate assumptions. The memorandum should also identify and explain the types of risks present in the projected high net yield assets.

B. The actuarial memorandum shall detail the process to determine the assumed net yields on currently held assets and assets projected to be obtained in the future (reinvestments).

   i. This includes specifically identifying the assumed gross asset yield and all key components deducted to arrive at the assumed net asset yield, including but not limited to credit risk, liquidity risk, and investment expenses.

   ii. Include considerations of the underlying assets (e.g., debt instruments, securitization structure) and timing of expected payments when modeling.

   iii. An explanation shall also be provided for any future reinvestment strategy assumptions that differ from current practices and experience.

C. For projected high net yield assets, a detailed explanation shall be provided in the actuarial memorandum describing the extent to which higher expected gross returns from these assets are associated with higher risk. It shall also include, for the aspect of any higher expected gross returns not assumed to be associated with higher risk, an explanation of how overperforming assets with expected returns lying outside the risk-return spectrum can be assumed to persist and be available for reinvestments throughout the projection period.

Provide commentary on factors that could impact whether the conditions that may have contributed to past high net yields for certain asset classes would continue or not continue into the future in a moderately adverse environment including the potential of increased demand for such assets leading to declining available yield.

D. The actuarial memorandum should provide commentary on how, related to projected high net yield assets, there is consistency with the standard valuation law concept that margins for uncertainty should be established such that the greater the uncertainty the larger the margin and resulting reserve. Asset-related factors identified as being volatile and impactful through sensitivity testing or other means should contain an appropriate margin to reflect this volatility and impact.

E. Where significant risks associated with a complex asset are not adequately captured with traditional modeling techniques associated with simple assets like corporate bonds, more rigorous modeling of those risks should occur.

   i. Where necessary to adequately reflect the risk, multi-scenario testing of those risks specific to complex assets should be performed.

      (a) For example, investments that may provide a higher expected return in part due to limited information, niche skill sets, or other factors may require unique scenarios (for instance to adequately capture credit or liquidity risk) to fully encompass potential sources of loss.

      (b) Asset cash flows should be appropriately projected to reflect anticipated liquidity in a stressed market. If current models do not support analysis of this type of risk, then new model aspects should be developed; otherwise, if such model aspects are not developed, sufficient additional conservatism to reflect this risk shall be applied.
(c) To the extent that the process for modeling or otherwise evaluating the risks is complex, and the potential for disconnect between reality and modeling increases, an additional margin to assumption(s) should be applied. Any such margin shall be applied in the direction of asset adequacy testing results being less favorable.

ii. Note that a robust conditional tail expectation calculation considering all key risks specific to complex assets would likely show tail losses (from low probability, high impact events) affect asset adequacy results.

iii. A company may use simplifications, approximations, and modeling efficiency techniques if the company can demonstrate that the use of such techniques does not make asset adequacy testing results more favorable. These techniques may be less appropriate if the amount of complex, high-yielding assets becomes a higher percentage of total assets.

iv. Actuarial Standards of Practice (ASOPs), including ASOP No. 7 and No. 56 contain additional guidance on the use of models in the analysis of cash flows.

F. In asset adequacy testing, when an asset is projected to be available for sale, a fair value of that asset is established. Per fair value methodology, fair value should represent the price at which the security could be sold, based on market information. Fair value should only be determined internally (by the insurance or investment management company) when the market-based value cannot be obtained. When the fair value of complex assets is determined internally, the company shall provide a step-by-step description of the approach used to calculate the fair value of such assets.

In addition, when the fair value of complex assets is determined internally, two sensitivity tests should be performed (and the impact on asset adequacy testing results presented):

i. Assume a haircut to the internally derived fair values of 5%;

ii. Assume a haircut to internally derived fair values that the company deems reasonable given the commensurate level of anticipated uncertainty.

G. With respect to privately-originated assets, such as assets originated by the company, within the company’s group, or within an entity closely tied to a company’s group (inclusive of the company’s investment manager), practices to help ensure accurate valuation of those assets should be documented in the actuarial memorandum. Also, assumed net cash flows from assets should be net of all explicit or implicit fees or expenses, such as origination fees, as well as reflective of other asset-related risks including credit risk, illiquidity risk, and other market risks.

In particular, please disclose and detail how the following are appropriately reflected in the net cash flows:

i. Contractual agreements in place between such entities.

ii. Any measures related to the valuation of such privately-originated assets resulting from practices to ensure that the valuation is appropriate and accurate.

iii. Revenue sharing, e.g., performance fees, between the entity responsible for providing investment or other types of services and the insurer, if applicable.

H. Investment expenses, whether paid to an external asset manager or to internal investment management staff, as well as additional expenses that are directly attributable to the specific investments, should be commensurate with the complexity of the assets and reflected in the net yield assumed in asset adequacy testing.

I. In cases where fees are expected to be paid by the insurer, an appropriate amount of future expected fees should be modeled as part of the asset adequacy testing.
J. The actuarial memorandum should contain a detailed description of research and monitoring conducted related to trends impacting risks associated with the insurer's complex assets or industry-wide or market-wide assets of similar type.

K. In cases where material amounts of reserves are ceded to an entity that does not submit a VM-30 actuarial memorandum or where reinsurance counterparty risk is material, the company shall perform asset adequacy testing on the business that includes the ceded reserves. Depending on the circumstances including risk exposure, simplified asset adequacy testing techniques may be appropriate, as noted in ASOP No. 22. Relevant aspects of ASOP No. 11 not in conflict with this section should be considered in the asset adequacy testing.

L. Please identify if any borrowing is modeled beyond to address very short-term liquidity needs. Also, please verify borrowing and reinvestment rates to ensure that projections are not materially benefiting from arbitrage advantages.

{Drafting note: comments would be appreciated on the inclusion of board of director and senior management responsibilities on the quality of complex asset-related assumptions similar to those stated in VM-G}

5. Constraints, Sensitivity Tests, and Attribution Analysis related to Assumptions on Projected High Net Yield Assets

A. Constraint for year-end 2023 with early testing for year-end 2022

   i. For the year-end 2022 VM-30 actuarial memorandum, perform and disclose the asset adequacy testing results from the following sensitivity test. For the sensitivity test, assume individual asset (or asset group when there is asset compression) net yields for both current assets and projected reinvestment assets do not exceed net yields on public non-callable corporate bonds with gross asset spreads and asset default costs by projection year that are consistent with PBR Credit Rating 10, i.e., by using PBR Credit Rating 10 rather than PBR Credit Rating 9 and otherwise following the spread and default calculations for the Investment Grade Net Yield Benchmark.

   ii. For reserves reported in the December 31, 2023 and subsequent annual statutory financial statements, assumed individual asset (or asset group when there is asset compression) net yields for both current assets and projected reinvestment assets shall not exceed net yields on public non-callable corporate bonds with gross asset spreads and asset default costs by projection year that are consistent with PBR Credit Rating 10.

   {Drafting note: comments would be appreciated on the pros and cons of an individual asset-specific versus aggregate (VM-20-type) constraint and/or sensitivity test}

   iii. For the constraint and the early testing, any favorable impact to asset adequacy testing results due to borrowing at a rate lower than the rate at which positive cash flows are reinvested in the same time period, should be removed.

B. Perform an attribution analysis for any current assets or projected reinvestment assets assumed to produce net returns in excess of the Investment Grade Net Yield Benchmark, as follows:

   i. Please quantify the assumed excess net returns attributable to the following factors:

      (a) Credit risk (in excess of credit risk on corporate bonds with PBR Credit Rating 9, if not already reflected in the default assumption)

      (b) Illiquidity risk

      (c) Volatility and other risks (please identify and describe these risks in detail)
ii. For each of the factors contributing to assumed net returns in excess of the Investment Grade Net Yield Benchmark, please explain why the factor is not assumed to contribute to additional losses (tail or otherwise) related to the risks.

iii. Where appropriate, apply judgment and provide commentary on the supporting rationale of how the expected excess return is estimated across the various risk components.

iv. Examples of Attribution Analysis:

Example 1:
Current collateralized loan obligation (CLO), attained in the year 2018
Assumed annual net return: 5.7%
Investment Grade Net Yield Benchmark (similar issue date and weighted average life): 4.5%
Assumed excess net return: 1.2%

Attribution:
(a) Excess credit risk (if not already reflected in default cost) 0.2%
(b) Illiquidity risk 0.4%
(c) Volatility and other risks [provide detailed description] 0.6%

Explanation of why each factor is not assumed to contribute to additional losses related to the risks:
[provide explanations]

Example 2:
Assumed reinvestment in an asset-backed security
Assumed annual net return: 5.2%
Investment Grade Net Yield Benchmark (similar issue date and weighted average life): 3.3%
Assumed excess net return: 1.9%

Attribution:
(a) Excess credit risk (if not already reflected in default cost) 0.4%
(b) Illiquidity risk 0.5%
(c) Volatility and other risks [provide detailed description] 1.0%

Explanation of why each factor is not assumed to contribute to additional losses related to the risks:
[provide explanations]
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

**Identification:**
Rachel Hemphill, Texas Department of Insurance
Ben Slutsker, Minnesota Department of Commerce

**Title of the Issue:**
Clarify retrocessions of YRT business.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20 Section 8.C.18
January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

In reviewing companies filing PBR in 2020 for retrocessions of YRT business, companies appropriately treated the pre-reinsurance reserve as 1/2cx and the reserve credit as 1/2cx following VM-20 Section 8.C.18’s instruction for handling non-guaranteed YRT or similar business. However, reviewing these filings raised that the Valuation Manual should be made more clear for such retrocessions. Note that if a company had instead been required to model these retrocessions that are dependent on the YRT, then following the requirements that they “project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements”, the company would have had to model cashflows consistent with the 1/2cx treatment for the underlying reinsurance (i.e., a partial year’s cashflows) and then modeled the retrocession terms applied to those partial year cashflows. This would have been unnecessary effort for materially the same result. The inefficiency of the alternative further supports clarifying that this is not the required treatment.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

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When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. This includes retrocession arrangements covering non-guaranteed YRT reinsurance and similar agreements. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar arrangements, actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.
The Life Actuarial (A) Task Force met Feb. 3, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. **Adopted its 2021 Fall National Meeting Minutes**

   Mr. Chupp made a motion, seconded by Mr. Tsang, to adopt the Task Force’s Dec. 8, 2021, minutes (see NAIC Proceedings – Fall 2021, Life Actuarial (A) Task Force). The motion passed unanimously.

2. **Adopted Amendment Proposal 2021-11**

   Ms. Hemphill said amendment proposal 2021-11 (Attachment Seven-A) was re-exposed after several small changes. She said the amendment proposal augments VM-21, Requirements for Principle-Based Reserves for Variable Annuities, with sections providing guidance on general assumptions, assumption margins, and expenses. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI is generally supportive of the changes, but it has concerns about the regulatory value of the sensitivity testing the proposal adds to VM-21, as discussed in its comment letter (Attachment Seven-B). He suggested that clarification of why the additional sensitivity tests are needed would be helpful. Ms. Hemphill responded that the sensitivity tests are necessary for companies and state insurance regulators to understand the material risks. She suggested that the proposal be adopted as exposed.

   Mr. Leung made a motion, seconded by Mr. Chupp, to adopt amendment proposal 2021-11. The motion passed unanimously.

3. **Re-Exposed Amendment Proposal 2020-12**

   Ms. Hemphill said a drafting group of state insurance regulators and NAIC staff revised the previous draft of amendment proposal 2020-12 to create the current version. She said the concept of a seasoned hedging strategy that appeared in earlier drafts of the proposal is replaced with the concept of a future hedging strategy. She discussed the proposed changes to VM-01, Definitions for Terms in Requirements; VM-20, Requirements for Principle-Based Reserves for Life Insurance; VM-21; and VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation. She noted that a core change to VM-20 requires that where documentation of future hedging strategies is incomplete, the stochastic reserve must be increased to reflect that future hedging strategies are not clearly defined. She said VM-21 has a similar change that requires an increase in the error factor (E) if the hedging program is not clearly defined.
Mr. Bayerle asked if adoption of the amendment proposal will necessitate changes to accounting requirements. Ms. Hemphill said to the extent that changes are made to the definition of clearly defined hedging strategy (CDHS), coordination with *Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees* may be required.

Mr. Chupp made a motion, seconded by Mr. Leung, to re-expose amendment proposal 2020-12 (Attachment Seven-C) for a 47-day public comment period ending March 21. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/:w:/r/sites/NAICSsupportStaffHub/MemberMeetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/LATF Calls/02 03/Feb 3 Minutes.docx
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-21 Section 1.C.2.b, VM-21 Section 12, VM-21 Section 13, VM-21 Section 1.B, VM-21 Section 10.A, VM-31 Section 3.F.3.d, VM-31 Section 3.F.13.d

January 1, 2021 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

A new section is needed in VM-21 to provide general guidance and requirements for assumptions, similar to VM-20, to address assumption reporting issues identified in VM-21 PBR report reviews, e.g., some companies don’t discuss regular assumption reviews for any necessary updates. In addition, this section provides the specific requirements for assumptions that have not been covered in previous sections of VM-21, i.e., the expense assumptions. VM-21 is not very explicit about expenses (e.g., whether they are fully allocated or include one-time expenses). For VM-20, we have had some material impacts from how companies treat one-time expenses that may be multi-year but temporary. Companies could understate expenses if there is no adjustment for periodic or other recurrent expenses in expense study years where they do not occur. This APF is to make the VM-21 expense assumption requirement explicit and consistent with what is specified in VM-20 Section 9.E. The new section can also be used to cover any other assumptions requirements that need to be addressed in the future. The reporting requirement of the sensitivity testing and the impact of margin analysis is added to VM-31 to help regulators better understand how companies comply with the newly added assumption guidance and requirements.
VM-21 Section 1.C.2.b

a) Liability risks

i. Reinsurer default, impairment or rating downgrade known to have occurred before or on the valuation date.

ii. Mortality/longevity, persistency/lapse, partial withdrawal and premium payment risks.

iii. Utilization risk associated with guaranteed living benefits.

iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.

v. Annuitization risks.

vi. Additional premium dump-ins (high interest rate guarantees in low interest rate environments).

vii. Applicable expense risks, including fluctuation in maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

VM-21 Section 12 (new)

Section 12: Other Guidance and Requirements for Assumptions

A. Overview

This section provides guidance and requirements in general for setting prudent estimate assumptions when determining either the stochastic reserve or the reserve for any contracts determined using the Alternative Methodology. It also provides specific guidance and requirements for expense assumptions.

B. General Assumption Requirements

1. The company shall use prudent estimate assumptions for risk factors that are not stochastically modeled by applying margins to the anticipated experience assumptions if such risk factors have been categorized as material risks by following Section 1.B Principle 3 and requirements in Section 12.C.

2. The company shall establish the prudent estimate assumptions for risk factors in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

3. The company shall model the following risk factors stochastically unless the company elects the Alternative Methodology defined in Section 7.
a. Interest rate movements (i.e., Treasury interest rate curves).

b. Equity performance (e.g., Standard & Poor’s 500 index [S&P 500] returns and returns of other equity investments).

4. If the company elects to stochastically model risk factors in addition to the economic scenarios, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as contract holder behavior or mortality, until VM-21 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

5. The company shall use its own experience, if relevant and credible, to establish an anticipated experience assumption for any risk factor. To the extent that company experience is not available or credible, the company may use industry experience or other data to establish the anticipated experience assumption, making modifications as needed to reflect the circumstances of the company.

a. For risk factors (such as mortality) to which statistical credibility theory may be appropriately applied, the company shall establish anticipated experience assumptions for the risk factor by combining relevant company experience with industry experience data, tables or other applicable data in a manner that is consistent with credibility theory and accepted actuarial practice.

b. For risk factors (such as utilization of guaranteed living benefits) that do not lend themselves to the use of statistical credibility theory, and for risk factors (such as some of the lapse assumptions) to which statistical credibility theory can be appropriately applied but cannot currently be applied due to lack of industry data, the company shall establish anticipated experience assumptions in a manner that is consistent with accepted actuarial practice and that reflects any available relevant company experience, any available relevant industry experience, or any other experience data that are available and relevant. Such techniques include:

i. Adopting standard assumptions published by professional, industry or regulatory organizations to the extent they reflect any available relevant company experience or reasonable expectations.

ii. Applying factors to relevant industry experience tables or other relevant data to reflect any available relevant company experience and differences in expected experience from that underlying the base tables or data.
due to differences between the risk characteristics of the company experience and the risk characteristics of the experience underlying the base tables or data.

iii. Blending any available relevant company experience with any available relevant industry experience and/or other applicable data using weightings established in a manner that is consistent with accepted actuarial practice and that reflects the risk characteristics of the underlying contracts and/or company practices.

c. For risk factors that have limited or no experience or other applicable data to draw upon, the assumptions shall be established using sound actuarial judgment and the most relevant data available, if such data exists.

d. For any assumption that is set in accordance with the requirements of Section 12.B.5.c, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing and disclose the analysis performed to ensure that the assumption is set at the conservative end of the plausible range.

e. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

6. The company shall sensitivity test material risk factors that are not stochastically modeled and examine the impact on the stochastic reserve. The company shall update the sensitivity tests periodically as appropriate. The company may update the tests less frequently, but no less than every 3 years, when the tests show less sensitivity of the stochastic reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

   a. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

   b. Using data from prior periods.

Guidance Note: Sensitivity testing every risk factor on an annual basis is not required. For some risk factors, it may be reasonable, in lieu of sensitivity testing, to employ statistical measures for margins, such as adding one or more standard deviations to the anticipated experience assumption.

Commented [RH2]: Regarding ACLI comment (unrelated EDIT): Having an understanding both of uncertainty and the impacts of different types of variation are necessary in margin development (and reviewing the appropriateness of margin development). See, just for example, VM-21 Section 10.C. No change is needed for ACLI comment.

However, while reviewing we saw that adding “material” before “risk factors” would be a good clarifying edit in the first sentence.
The company shall vary the prudent estimate assumptions from scenario to scenario within the stochastic reserve calculation in an appropriate manner to reflect the scenario-dependent risks.

C. Assumption Margins

The company shall include margins to provide for adverse deviations and estimation error in the prudent estimate assumptions for all risk factors that are not stochastically modeled or prescribed, subject to the following:

1. The level of margin applied to the anticipated experience assumptions may be determined in aggregate or independently as discussed in Section 1.B Principle 3. It is not permissible to set a margin less toward the conservative end of the spectrum to recognize, in whole or in part, implicit or prescribed margins that are present, or are believed to be present, in other risk factors.

Risks that are stochastically modeled (e.g., interest rates, equity returns) or have prescribed margins or guardrails (e.g., assets, revenue sharing) shall be considered material risks. Other risks generally considered to be material include, but are not limited to, mortality, contract holder behavior, maintenance and overhead expenses, inflation and implied volatility. In some cases, the list of material risks may also include acquisition expenses, partial withdrawals, policy loans, annuitizations, account transfers and deposits, and/or option elections that contain an element of anti-selection.

2. The greater the uncertainty in the anticipated experience assumption, the larger the required margin, with the margin added or subtracted as needed to produce a larger modeled TAR than would otherwise result. For example, the company shall use a larger margin when:

   a. The experience data have less relevance or lower credibility.
   
   b. The experience data are of lower quality, such as incomplete, internally inconsistent or not current.
   
   c. There is doubt about the reliability of the anticipated experience assumption, such as, but not limited to, recent changes in circumstances or changes in company policies.
   
   d. There are constraints in the modeling that limit an effective reflection of the risk factor.

3. In complying with the sensitivity testing requirements in Section 12.B.6 above, greater analysis and more detailed justification are needed to determine the level of uncertainty when establishing margins for risk factors that produce greater sensitivity on the stochastic reserve.
4. A margin is permitted but not required for assumptions that do not represent material risks.

5. A margin should reflect the magnitude of fluctuations in historical experience of the company for the risk factor, as appropriate.

6. The company shall apply the method used to determine the margin consistently on each valuation date but is permitted to change the method from the prior year if the rationale for the change and the impact on the stochastic reserve is disclosed.

D. Expense Assumptions

1. General Prudent Estimate Expense Assumption Requirements

In determining prudent estimate expense assumptions, the company:

a. May spread certain information technology development costs and other capital expenditures over a reasonable number of years in accordance with accepted statutory accounting principles as defined in the Statements of Statutory Accounting Principles.

Guidance Note: Care should be taken with regard to the potential interaction with the inflation assumption below.

b. Shall assume that the company is a going concern.

c. Shall choose an appropriate expense basis that properly aligns the actual expense to the assumption. If values are not significant, they may be aggregated into a different base assumption.

Guidance Note: For example, death benefit expenses should be modeled with an expense assumption that is per death incurred.

d. Shall reflect the impact of inflation.

e. Shall not assume future expense improvements.

f. Shall not include assumptions for federal income taxes (and expenses paid to provide fraternal benefits in lieu of federal income taxes) and foreign income taxes.

g. Shall use assumptions that are consistent with other related assumptions.
h. Shall use fully allocated expenses.

Guidance Note: Expense assumptions should reflect the direct costs associated with the block of contracts being modeled, as well as indirect costs and overhead costs that have been allocated to the modeled contracts.

i. Shall allocate expenses using an allocation method that is consistent across company lines of business. Such allocation must be determined in a manner that is within the range of actuarial practice and methodology and consistent with applicable ASOPs. Allocations may not be done for the purpose of decreasing the stochastic reserve.

Guidance Note: For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

j. Shall reflect expense efficiencies that are derived and realized from the combination of blocks of business due to a business acquisition or merger in the expense assumption only when any future costs associated with achieving the efficiencies are also recognized.

Guidance Note: For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

k. Shall reflect the direct costs associated with the contracts being modeled, as well as an appropriate portion of indirect costs and overhead (i.e., expense assumptions representing fully allocated expenses should be used), including expenses categorized in the annual statement as “taxes, licenses and fees” (Exhibit 3 of the annual statement) in the expense assumption.

l. Shall include acquisition expenses associated with business in force as of the valuation date and significant non-recurring expenses expected to be incurred after the valuation date in the expense assumption.

m. For contracts sold under a new policy form or due to entry into a new product line, the company shall use expense factors that are consistent with the expense factors used to determine anticipated experience assumptions for contracts from an existing block of mature contracts taking into account:

i. Any differences in the expected long-term expense levels between the block of new contacts and the block of mature contracts.

ii. That all expenses must be fully allocated as required
under Section 12.D.1.h above.

2. Margins for Prudent Estimate Expense Assumptions

The company shall determine margins for expense assumptions following Section 12.C.

VM-21 Section 13

Section 13: Allocation of the Aggregate Reserve to the Contract Level

VM-21 Section 1.B

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the stochastic reserve at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the stochastic reserve, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 10.A

Section 10: Contract Holder Behavior Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B and Section 12.

VM-31 Section 3.F.3.d

3. Liability Assumptions and Margins – A listing of the assumptions and margins used in the projections to determine the stochastic reserve, including a discussion of the source(s) and the rationale for each assumption:

a. Premiums and Subsequent Deposits – Description of premiums and subsequent deposits.
b. **Interest Crediting Strategy** – Description of the interest crediting strategy.

c. **Commissions** – Description of commissions, including any commission chargebacks.

d. **Expenses Other than Commissions** – Description and listing of insurance company expenses other than commissions, such as overhead, including:

i. Method used to allocate expenses to the contracts included in a principle-based valuation under VM-21 and a statement confirming that expenses have been fully allocated in accordance with VM-21 Section 12.D.1.h.

ii. Method used to apply the allocated expenses to model segments or sub-segments within the cash-flow model.

iii. Identification of types of costs that were spread, and for how many years, if any cost spreading was done pursuant to VM-21 Section 12.D.1.a.

iv. Method used to determine margins.

**VM-31 Section 3.F.13.c (new)**

c. **Sensitivity Tests** – For each distinct product type for which margins were established:

i. List the specific sensitivity tests performed for each risk factor or combination of risk factors, other than those discussed in Section 3.F.3.h.vi and 3.F.3.i.ii.

ii. Indicate whether the reserve was calculated based on the anticipated experience assumptions or prudent estimate assumptions for all other risk factors while performing the tests.

iii. Provide the numerical results of the sensitivity tests for both reserves and capital.

iv. Explain how the results of sensitivity tests were used or considered in developing assumptions.

**VM-31 Section 3.F.13.d (new)**

d. **Impact of Margin**

i. Company can perform the impact of margin analysis using off-cycle data. The analysis can be done less frequently than annual unless there is change or update in the margins, but not less frequently than every 3 years.

ii. **Impact of Margins for Each Risk Factor** – The impact of margins on the stochastic reserve for each risk factor, or group of risk factors, that has a material impact on the stochastic reserve, determined by subtracting (i) from (ii), expressed in both dollar amounts and percentages. For the purposes of this analysis, calculate the CTE without requiring that the scenario reserve for any scenario be no less than the cash surrender value.
(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, but with the reserve calculated based on the anticipated experience assumption for the risk factor and prudent estimate assumptions for all other risk factors.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iii. Aggregate Impact of Margins – the aggregate impact of all margins on the stochastic reserve for that group of contracts determined by subtracting (1) from (2), expressed in both dollar amounts and percentages. For the purposes of this analysis, calculate the CTE without requiring that the scenario reserve for any scenario be no less than the cash surrender value:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts, but with the reserve calculated based on anticipated experience assumptions for all risk factors prior to the addition of any margins.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iv. Impact of Implicit Margins – For purposes of the disclosures required in 13.d.ii and 13.d.iii above:

(1) If the company believes the method used to determine anticipated experience assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

(2) Since the company is not required to determine an anticipated experience assumption or a prudent estimate assumption for risk factors that are prescribed (i.e., interest rate movements, equity performance, default costs and net spreads on reinvestment assets), when determining the impact of margins, the prescribed assumption shall be deemed to be the prudent estimate assumption for the risk factor, and the company can elect to determine an anticipated experience assumption for the risk factor, based on the company’s anticipated experience for the risk factor. If this is elected, the company shall document the rationale and method used to determine the anticipated experience assumption.

Commented [RH6]: Regarding ACLI comment (EDIT): While we were not implying CTE(98) is equal to TAR, we acknowledge that since the directional impacts on CTE(70) and CTE(98) may differ, it is not true that the impact on CTE(98) must be positive. Delete guidance note. Request regulator input on whether they want a full TAR impact analysis or whether they are ok following up if the CTE(70) and CTE(98) directional impacts differ and the combined impact is unclear.

Deleted:
Brian Bayerle
Senior Actuary

January 14, 2022

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Re: APF 2021-11

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the December re-exposure of APF 2021-11.

ACLI remains supportive of requirements that ensure appropriate assumptions and margins are used in the computation of reserves. We do, however, continue to have concerns regarding the regulatory value of the sensitivity testing this APF would add to VM-21. During the December 8\textsuperscript{th} LATF discussion, regulators suggested these sensitivities should be required to help regulators better understand the risks and levels of the margins. ACLI would suggest, then, explicitly linking sensitivity testing to margin setting, and for LATF to consider what required sensitivities are truly value-added versus those that do not have clear regulatory value. For the former request, we suggest that all references to sensitivity testing include the qualifier "...to the extent needed to determine margins." These references include VM-20 9.A.7, VM-20 9.D.4, VM-21 10.C, and VM-31 3.D.4.h. For the latter request, perhaps at a future meeting regulators could walk through the required sensitivities in the valuation manual and better help companies understand how regulators are using them in their reviews.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
Hedging Drafting Group of LATF

Title of the Issue:
Reflect all future hedging strategies in VM-20 and VM-21. Revise hedge modeling to increase E factor (VM-21) or residual risk (VM-20) when future hedging strategies are not clearly defined.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

2. Add a definition for “future hedging strategy,” consistent with the definition for CDHS and the current VM-01 definition of “derivative program,” which VM-01 notes includes hedging programs.
3. Add a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology.
4. Reflect all of a company’s future hedging strategies, but reflect the additional error (VM-21) or residual risk (VM-20) that is presented by a future hedging strategy not being clearly defined.
5. Remove optionality for liquidating currently held hedges (despite liquidation not being a part of the company investment strategy) if not modeling a future hedging strategy.
6. New hedging strategies (<6 months experience) have an E factor of 1.0 for VM-21. For comparison, the current draft VM-22 only allows modeling hedges after they have been in place for 6 months. When only CDHS were modeled in VM-21, new hedging strategies with no experience had E factors as low as 0.5 even without meaningful analysis. This treatment was much too lenient for new hedging strategies.
### Dates

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**Notes:** APF 2020-12

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

**NAIC Staff Comments:**

W:\National Meetings\2010\...(TF\LHA)
The term “clearly defined hedging strategy” (CDHS) means a future hedging strategy for which the following attributes are clearly documented:

a. The specific risks being hedged (e.g., cash flow, fee income, policy interest credits, delta, rho, vega, etc.).

b. The hedging objectives.

c. The material risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).

d. The financial instruments used to hedge the risks.

e. The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.

f. The metrics, criteria, and frequency for measuring hedging effectiveness.

g. The conditions under which hedging will not take place and for how long the lack of hedging can persist.

h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.

i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.

j. The circumstances under which hedging strategy will not be effective in hedging the risks.

Guidance Note: For purposes of the CDHS documented attributes, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

The term “future hedging strategy” is a derivative program undertaken by a company to manage risks through one or more future hedging transactions, including the future purchase or sale of hedging instruments and the opening and closing of hedging positions.

A future hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as a future hedging strategy.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

a. The risk of a change in the fair value, the value on a statutory, GAAP, or other basis, or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or

b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.
A company may not exclude a group of policies for which there is one or more future hedging strategies supporting the policies from SR requirements, except in the case where all future hedging strategies supporting the policies are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the policies are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the DR and the SR, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of future hedging strategies supporting the policies, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For future hedging strategies supporting the policies, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation. VM-21 Section 1.B Principle 5 applies as a general principle for the modeling of future hedging strategies.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the SR as described in Section 5.E.
4. In circumstances where documentation outlining the future hedging strategies is incomplete, the company shall reflect the future hedging strategies not being clearly defined by increasing the SR as described in Section 5.E. To support no increase to the SR, there should be very robust documentation outlining each future hedging strategy. In particular, the SR shall be at least as great as the SR that would result if a future hedging strategy were not reflected in the SR, if the documentation is materially incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the SR to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the SR pursuant to Section 7.K.3 above.

**Guidance Note:** Section 5.E requires that the company “Determine any additional amount needed to capture any material risk included in the scope of these requirements but not already reflected in the cash-flow models using an appropriate and supportable method and supporting rationale.” In the case of a derivative program that is a future hedging strategy, Section 7.K.3 requires such an increase for disconnects between the hedge modeling and the future hedging strategy, while Section 7.K.4 requires such an increase for disconnects between the loosely defined future hedging strategy and what may actually take place.

**VM-20 Section 7.L (Remove entire Section 7.L)**

**VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)**

**VM-21 Section 4.A.4**

Modeling of Hedges

a. For a company that does not have a future hedging strategy supporting the contracts:
   
   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.

   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.

b. For a company with one or more future hedging strategies supporting the contracts, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

   i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.
ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.

iii. The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

VM-21 Section 4.D.4.b

Notwithstanding the above requirements, the SR shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the contracts are not affected by this requirement.

VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-23)

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the SR for a company that does not have a future hedging strategy supporting the contracts as discussed in Section 4.A.4.a.

VM-21 Section 6.B.3.b.ii

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as SR following Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

VM-21 Section 6.B.5
VM-21 Section 9

Section 9: Modeling of Hedges under a Future Hedging Strategy

A. Initial Considerations

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more future hedging strategies supporting the contracts, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the SR using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence.

Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

B. Modeling Approaches

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the SR otherwise calculated. Particular attention should be given to VM-21 Section 1.B Principle 5 for the modeling of future hedging strategies.
2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the SR otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the SR needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the SR attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

5. A safe harbor approach is permitted for reflection of future hedging strategies supporting the contracts for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of SR (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the future hedging strategies supporting the contracts (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the future hedging strategies supporting the contracts (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts, therefore following the requirements of Section 4.A.4.a.
3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the SR is given by:

\[ SR = CTE70 \text{ (best efforts)} + E \times \max[0, CTE70 \text{ (adjusted)} - CTE70 \text{ (best efforts)}] \]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses—both realized and unrealized—observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).
D. Additional Considerations for CTE70 (best efforts)

ii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with less than 6 months of history, E should be 1.0. However, E may be lower than 1.0 if at least 6 months of reliable experience is available and/or if the change in strategy is a minor refinement rather than a material change in strategy.

The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily 100% for material changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy).
- An increase in the error factor may not always be needed for minor refinements to the hedge strategy (e.g., moving from swaps to Treasury futures).

8. The company shall set the value of E reflecting the extent to which the hedging program is clearly defined. To support a value of E below 1.0, there should be very robust documentation outlining all future hedging strategies. To the extent that documentation outlining any of the future hedging strategies is incomplete, the value of E shall be increased. In particular, the value of E shall be 1.0 if documentation is materially incomplete for any of the individual CDHS attributes (a) through (i), as listed in VM-01.

Any increases required to the value of E to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the value of E to reflect a lack of historical experience or to reflect the back-testing results, subject to an overall ceiling of 1.0 for E.
If the company is following one or more future hedging strategies supporting the contracts, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the SR and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the SR, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the SR, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:

   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the SR otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

VM-31 Section 3.C.5

Assets and Risk Management – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any future hedging strategies supporting the policies, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.D.6.f

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the policies and any adjustments to the SR pursuant to VM-20 Section 7.K.3 and VM-20 Section 7.K.4, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. Documentation of any future hedging strategies should include documentation addressing each of the CDHS documentation attributes.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any future hedging strategies supporting the policies, is representative of and consistent with the company’s investment policy and that documentation of the CDHS attributes for any future hedging strategies supporting the policies are accurate.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the policies is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5

Deleted: clearly defined hedging strategies

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Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any future hedging strategies supporting the contracts, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the contracts, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation addressing each of the CDHS documentation attributes for any future hedging strategies supporting the contracts.

c. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

d. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a future hedging strategy supporting the contracts, confirmation that currently held hedge assets were included in the starting assets.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. Discussion of the projection horizon for the future hedge strategy as modeled and a comparison to the timeline for any anticipated future changes in the company’s hedge strategy.
   v. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   vi. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the SR, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vii. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   viii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the interaction of the model’s assumptions and documentation as to why the model-based prices are appropriate for determining the SR.
   ix. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.
e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:

i. The value of E, and the approach and rationale for the value of E used in the reserve calculation.

ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for E. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.

iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:

a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.

b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for E.

v. For companies that do not have 12 months of experience, the basis for the value of E that is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.

vi. The basis for the magnitude of adjustment or lack of adjustment for the value of E chosen based on the robustness of the documentation outlining the future hedging strategy.

g. Safe Harbor for Future Hedging Strategies – If electing the safe harbor approach for a future hedging strategy supporting the contracts, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

VM-31 Section 3.F.12.e

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account...
value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the SR.

VM-31 Section 3.F.16.a and Section 3.F.16.b

a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any future hedging strategies supporting the contracts, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and that documentation of the CDHS attributes for any future hedging strategies supporting the contracts are accurate.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the contracts is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
The Life Actuarial (A) Task Force met Jan. 27, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner and Rachel Hemphill (TX); Scott A. White, Vice Chair, represented by Craig Chupp (VA); JIm L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock, Ahmad Kamil, and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Judith L. French represented by Peter Weber (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Steve Boston (PA); and Jon Pike represented by Tomasz Serbinowski (UT).

1. Discussed Comments on an Actuarial Guideline on Asset Adequacy Testing

Mr. Andersen said the Task Force is part of a coordinated NAIC effort to address issues arising from the increase in insurers actively participating with private equity firms or the increasing complexity of assets. Some goals of the efforts include gaining a clearer picture of alternative assets used by insurers, investment management relationships, fee arrangements, affiliated arrangements, accounting, the classification of certain investments, rating agency practices, reinsurance practices, risk-based capital (RBC), and reserves. Mr. Andersen said the focus of the Task Force is on the effects of the modeling of complex assets on reserve adequacy testing. He said the concept of an actuarial guideline leading to clarity on these reserving issues was exposed in September 2021, with a follow-up concept document (Attachment Eight-A) exposed at the Fall National Meeting.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Eight-B) advocates a principle-based framework that leverages the expertise of appointed actuaries. He said the definition of complex assets should focus on the novel aspects of the assets and be flexible enough to adapt to new asset classes as they develop in response to changing economic environments. He said the ACLI is proposing a definition of complex assets, a set of disclosure requirements, and guidance on additional disclosures for year-end 2022 reporting. He said state insurance regulators consider materiality in the application of the guideline.

Jason Kehrberg (American Academy of Actuaries—Academy) said page 2 of the Academy comment letter (Attachment Eight-C) summarizes the Academy’s recommendation. He said the Academy suggests that additional disclosures and guidance may be warranted but warns against the implementation of constraints that could discourage investment in complex assets. He reviewed the Academy’s proposed documentation requirements for inflated net yields. Mr. Andersen said the concept of increasing margins for uncertainty in instances where there is limited or unreliable historical data will be key. Len Mangini (Academy) said disclosures should include the setting, testing, and governance of reserves. Mr. Leung asked what asset class constraints might discourage investments in those assets. Mr. Kehrberg gave the example of limiting a company’s portfolio to no more than 10% of a particular asset class. Mr. Andersen asked if the ACLI could provide company feedback on whether the VM-20, Requirements for Principle-Based Reserves for Life Products, asset constraints have led to a change in company asset strategies. Mr. Serbinowski asked if constraints on valuation rules applied to a particular asset class might be more acceptable by the Academy. Mr. Kehrberg said the Academy would prefer that the requirements be principle-based.
Aaron Sarfatti (Equitable) said the Equitable comment letter (Attachment Eight-D) encourages the Task Force to regard asset adequacy testing as the primary reserve. Steve Tizzoni (Equitable) said the strengthening of the asset adequacy testing standards is necessary to achieve harmonization across reserve determination and testing. He said more than disclosure is necessary to achieve reform. Mr. Mangini said Canada has previously dealt with the issue of constraints. He said companies were forced to map one of their exotic assets to a similar index and cap the returns on the asset to match the index returns. Mr. Serbinowski said having constraints will help moderate actuarial judgment.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com:/w:/r/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/LATF Calls/01 27/Jan 27 Minutes.docx
AG AAT exposure as follow-up to 12/8/21
LATF session

Please send your comments to Reggie Mazyck
(RMazyck@NAIC.Org)

By COB January 24
Regarding the concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing:

- Provide comments on the types of documentation that would be helpful to be provided in an asset adequacy testing memorandum to address the various risks associated with complex assets.

- Provide comments on the types of constraints that may be helpful to address concerns regarding non-uniform practices associated with modeling of complex assets in asset adequacy testing to ensure appropriate addressing of all key risks.

- Provide comments on the role of the Appointed Actuary in a case, for example, where the life insurer has experienced substantial increase in the complexity of assets, potentially supporting actuarial reserves.
Brian Bayerle  
Senior Actuary

January 24, 2022

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen  
Chief Life Actuary, Minnesota Department of Commerce

Re: December Exposure of Proposed Actuarial Guideline on Complex Assets in Asset Adequacy Testing

Dear Messrs. Boerner and Andersen:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the December exposure of the proposed Actuarial Guideline to address the modeling of complex assets in Asset Adequacy Testing (AAT).

Consistent with our prior letter, ACLI suggests an initial approach of providing disclosures within the Valuation Manual, coupled with more immediate guidance to address the immediate concerns of regulators. ACLI recommends three components for the regulatory guidance: 1) a clear definition of “complex assets” in VM-01; 2) requirements for disclosures in VM-30 based on the materiality of the assets, the level of complexity of the asset, and the assumed net yield of the asset; 3) state disclosure request for YE 2022 to reflect the requirements for the 2023 Valuation Manual.

1) Definition of Complex Assets

ACLI suggests the following preliminary definition for consideration by LATF; if deemed beneficial, there could be a guidance note that provides examples of the types of assets in and out of scope of this definition.

The term “complex assets” means structured securities and asset-backed securities with
a) materially different uncertainty in the timing and amount of cashflows than otherwise present in traditional bond investments, and
b) limited historical data available to set assumptions around the expected performance of such assets.

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The rationale of this definition was to provide a flexible, principle-based approach to enable regulators to better understand the assets under consideration. Simple comparison to the yield of rated traditional bonds may be inadequate due to significant differences in cash flows; further, focusing on yield alone may fail to capture risks associated with these assets.

2) Disclosure requirements

ACLJ suggests the following principles around disclosures for inclusion in VM-30:

i) Materiality: Consistent with our prior comment letter, guidance should include size/materiality thresholds for both the size of the block and the material use of complex assets. Immaterial current or projected amounts of complex assets should be exempt from additional disclosure requirements.

ii) Level of disclosure: Disclosure requirements should be linked to both the complexity and the net yield of the asset. The greater complexity and assumed net yields for such assets, the more robust the disclosures should be to justify the assumptions used in the projection of such assets.

iii) Transparency on initial and future yield assumptions: Disclosure requirements should support the initial and future yield assumptions, nature of the risks, and demonstrate that modeling adequately recognizes risks associated with such assets.

iv) Sensitivity testing: To the extent constraints or guardrails are deemed necessary to address regulator concerns in addition to enhanced disclosures, they should be considered in the context of sensitivity testing within the asset adequacy testing process.

3) Additional guidance on additional disclosures for YE 2022 reporting

ACLJ appreciates the concern of regulators regarding the use of these assets and would like to work with regulators to develop a path forward that maintains the asset adequacy requirements within VM-30 and provides guidance to companies before 2023. ACLJ suggests a guidance letter from LATF or individual regulators to provide these additional disclosures either within or as a supplement to the Actuarial Opinion for the reporting year before such an amendment can be operative in the Valuation Manual.

We appreciate the consideration of our comments and look forward to discussing on a future call.

Thank you.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
January 27, 2022

Mr. Mike Boerner  
Chair, Life Actuarial (A) Task Force (LATF)  
National Association of Insurance Commissioners

Re: Second exposure draft of concept and questions on a proposal for an actuarial guideline on asset adequacy testing focusing on the modeling of complex or high-yielding assets.

Dear Mr. Boerner,

The Asset Modeling and Reporting Task Force of the American Academy of Actuaries\(^1\) (the Task Force) is pleased to provide the following comments on the second exposure of concept and questions on a proposal for an actuarial guideline on asset adequacy testing (AAT), which reads as follows:

*Regarding the concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing:*

- Provide comments on the types of documentation that would be helpful to be provided in an asset adequacy testing memorandum to address the various risks associated with complex assets.
- Provide comments on the types of constraints that may be helpful to address concerns regarding non-uniform practices associated with modeling of complex assets in asset adequacy testing to ensure appropriate addressing of all key risks.
- Provide comments on the role of the Appointed Actuary in a case, for example, where the life insurer has experienced substantial increase in the complexity of assets, potentially supporting actuarial reserves.

The Task Force’s previous [comment letter](#) identified several actuarial standards of practice (ASOPs) that currently exist for actuaries when modeling complex or high-yielding assets in AAT. The Task Force is expanding upon its first letter in response to the additional context Fred Andersen presented at the 12/8/2021 LATF meeting.

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Complex and high-yielding assets can be beneficial to the insurance industry if the assets’ exposure and assumptions are appropriately disclosed and their risks are appropriately understood and modeled. While ASOPs and existing statutory guidance currently apply to actuaries when modeling complex or high-yielding assets in AAT, additional disclosures and principle-based guidance would provide regulators with sufficient information to evaluate how well such guidance has been followed. Therefore, the Task Force suggests that additional disclosures and perhaps principle-based guidance may be warranted. However, the Task Force does not recommend implementing constraints to discourage investment in such assets.

For the implementation of these additional disclosures and principle-based guidance, the Task Force suggests amending the 2023 Valuation Manual via an amendment proposal form (APF) in the first half of this year and referencing the APF as appropriate guidance for year-end 2022 AAT work. Given that APFs require new disclosures and demonstrations, states could “early adopt” them because APFs are considered informational. Thus, regulators could adopt the additional disclosures and principle-based guidance for year-end 2022 AAT work without the need for an actuarial guideline. This would not be true if an APF also contain prescriptions or constraints.

One benefit for regulators from following this approach would be comparisons of assumptions between VM-30 for AAT and VM-31 for principle-based reserving (PBR) modeling if disclosure requirements are added to VM-30. The Task Force also notes that there could be benefits to adding similar disclosures to VM-G, so that board members and senior management (i.e., non-actuaries) would be responsible for items such as asset assumptions, asset valuations, reasonableness of the affiliated advisory firm compensation, and performance fees related to the actual returns of the assets themselves.

Please see Attachment A for more specific comments on the eight areas of concern mentioned in Fred Andersen’s presentation at the 12/8/2021 LATF meeting.

Thank you for your consideration of these comments. Please contact Academy life policy analyst Khloe Greenwood (greenwood@actuary.org) with any questions.

Jason Kehrberg, MAAA, FSA
Chairperson, Asset Modeling and Reporting Task Force
American Academy of Actuaries
Attachment A—Specific comments on eight areas of concern mentioned in Fred Andersen’s presentation at the 12/8/2021 LATF meeting

1. Inflated net yields

With regards to inflated net yields, the Task Force notes that additional LATF guidance would be appropriate regarding considerations an actuary would need to address for modeling assets with net yields that materially exceed those of traditional insurance company investments (such as investment-grade issuer obligations with fixed payment streams, or structured assets purchased from affiliates). The Task Force recommends that the guidance include principle-based requirements for recognition of the risks associated with these higher-yielding assets, which would be applicable when an actuary is setting yield or total return assumptions on such assets. The Task Force recommends that risks include default risk, equity risk, prepayment variability (i.e., from residential mortgage-backed securities (RMBS) as well as callable bonds), extension risk (i.e., also for RMBS as well as cash flow waterfalls of subordinate tranches in non-agency structured securities), complexity of cash flows (e.g., structured notes), and illiquidity risk. Examples of appropriate principle-based guidance are listed below:

a. Including all material risks in the asset modeling (including the related asset liability management [ALM] impacts, for example the risk of selling other assets or borrowing at high rates if illiquid assets can’t be sold to meet policyholder obligations)

b. Considering specific, relevant, and credible historical experience for the higher-yielding assets in setting assumptions related to the asset risks

c. Using appropriate industry data, adjusted for the asset characteristics, when credible experience does not exist

d. Increasing margins for uncertainty in instances in which there is limited historical data, where the historical data is inconsistent, or where there is reason to believe most recent historical experience is not reliable

e. Considering the asset underwriting in determining appropriate assumptions for default

f. Considering the underlying assets (e.g., debt instruments, securitization structure) and timing of expected payments when modeling structured securities

g. Using modeling approaches that capture asset payment uncertainty, such as stress testing and stochastic modeling to set margins for uncertainty and/or in determining reserves that encompass moderately adverse conditions for all risks

h. Limiting borrowing, both cost and amount, such that it is reasonable under moderately adverse conditions

i. Considering the illiquidity of these assets and applying appropriate market value haircuts to assets if they must be sold in the future to meet policyholder obligations

j. Applying the above guidance as appropriate for hypothetical future assets (in other words, applying the above considerations for higher yielding reinvestment assets purchased during the projection as well as actual assets in-force at the start of the projection)
k. Recognizing that any extra yield also entails extra risk (which aligns in general with efficient markets), and assessing the potential for short-term stress scenarios

l. Requiring disclosure in the AOM of the above information, including details of the sources of additional yield (i.e., which portion is due to illiquidity, additional default, prepayment, subordinated tranches, etc.)

m. Recognizing any structural elements that are specific to different investment vehicles (e.g., funding commitments for private equity funds and redemption gates for hedge funds)

2. Internal modeling of asset values

With regards to documentation and disclosure, there are many ASOPs that an Appointed Actuary considers when developing an Actuarial Opinion. More specifically, in relation to complex assets, ASOP No. 7, *Analysis of Life, Health, or Property/Casualty Insurer Cash Flows*, clearly states prudent techniques that actuaries should consider when evaluating cashflows including sensitivity to economic factors, reviewing a range of scenarios, sensitivity testing of key factors (which is highlighted again in ASOP No. 55, *Capital Adequacy Assessment*), internal consistency across assumptions, length of projection period, limitations on asset liquidity and quality, cost of maintaining the assets, historical experience and other factors. ASOP No. 41, *Actuarial Communications*, specifically requires an actuary to communicate the extent of reliance and responsibility on others.

With regards to the role of an Appointed Actuary, other useful guidance for Appointed Actuaries to consider with respect to evaluating complex assets include:

a. ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life or Health Insurers*, provides guidance with respect to reliance on others for supporting analysis. It provides that when practicable, the actuary should review the analysis for reasonability and consistency.

b. ASOP No. 56, *Modeling*, indicates that “the actuary should assess whether the structure of the model is appropriate for the intended purpose.” The Reliance on Experts section further provides that the actuary may consider the extent to which the model has been reviewed or validated by experts in the applicable field including known material differences of opinion among experts. It also specifically provides for considering a review by another qualified professional.

c. The applicable asset adequacy actuarial practice notes also offer further industry practice, including purchasing software from multiple vendors and using independent checking spreadsheets. While this guidance is not binding, it provides helpful educational material for actuaries.

d. In conclusion, when using a model, there is already substantial practice for an appointed actuary and ASOP No. 56 specifically provides for considering a review by another qualified professional.

With regards to constraints, if insurance regulators determine that more constraints are necessary for the valuation of complex illiquid assets, then the Task Force suggests refining the definition of
“complex and illiquid assets” to follow consistent classifications already established under Fair Value Financial Accounting Standard (FAS) 157 (Accounting Standards Codification (ASC) 820), which classifies assets and liabilities as level 1, 2 and 3. This classification system is more “principles-based” by using the available information to determine the appropriate asset classification level:

a. Level 1—values are taken from quoted prices in an active market of identical assets and liabilities.

b. Level 2—values can be based on observable prices of similar assets and liabilities. These inputs are used in valuation techniques when there is no quoted price in an active market or where there is not enough frequency of transactions for identical assets.

c. Level 3—values require the use of unobservable inputs to determine the value of an asset or liability when there is no active market for identical or similar assets or liabilities and there are no observable inputs. The unobservable inputs require independent judgment regarding market participant assumptions about the assets or liabilities and should use available information that can be reasonably found without incurring undue costs.

This general classification would be consistent with GAAP terminology and cover all types of complex assets that are currently available as well as complex assets that may evolve in the future.

3. Collateralized loan obligation (CLO) performance

With regard to principle-based guidance, to address concerns about recent CLO recovery data, the Task Force recommends language similar to 1 above.

4. Investment manager relationships and investment expenses

With regard to considerations pertaining to investment manager relationships and investment expenses, a key issue is ensuring an unreasonable amount of money is not moving from the insurer to a potentially affiliated investment manager. There are various views on how the money exiting the insurer in different manners could be modeled. For AAT, some insurers set investment expense assumptions in a simplistic manner, not considering the complexity of the asset or costs incurred for asset acquisition and management. The Task Force’s comments focus on the AAT treatment, because the broader considerations are not necessarily actuarial in nature.

Actuaries typically reflect any existing contractual agreements for investment expenses in AAT modeling. If new agreements will be needed during the AAT projection horizon, actuaries develop appropriate assumptions for future investment expenses that are consistent with existing agreements, management practices, asset characteristics/complexity, projected scenarios, etc. This includes reflecting any material provisions at an appropriate level of detail (ASOP No. 56), e.g., not using blended investment expense rates that don’t consider material changes in the projected asset mix. Some actuaries may consider doing a dynamic validation of investment expenses with specific accounting for affiliate transactions.
5. **Creation of structured assets**

When modeling a structured asset, actuaries set considerations consistently regardless of whether a structured asset is securitized by the insurance company’s affiliated asset manager, a third-party asset manager, or an independent third party. Structured assets rely on the ability to model the underlying collateral as well as the loss structures/tranches of the investment.

Modeling structured assets purchased from an independent third party requires reliance on readily available market data, which could limit the actuaries’ ability to explicitly model the structure. However, if an insurer or its affiliate has direct involvement in the securitization, additional insight into the structure and underlying collateral could be used to enhance the asset model, project cash flows, and measure tail risk.

Here again, the Task Force points to the considerations in item 1 above.

6. **Offshore/affiliated reinsurance**

Insurers that use complex assets that have raised the concerns of regulators and prompted this request for comment may also use reinsurance or securitizations as risk mitigation tools for the products backed by these complex assets. Furthermore, the complex assets themselves may involve securitizations of underlying items. As discussed below, revised ASOP No. 11, *Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports* (effective December 1, 2022) would apply to actuaries involved with these insurers if they are subject to U.S. ASOPs. The Task Force recognizes that some insurers using complex assets may retain all their risks and the assets themselves might not be securitized. In that case, the following comments regarding revised ASOP No. 11 may not apply.

As stated in our summary comments on the first page of this letter, the Task Force suggests using an APF to create new disclosures in VM-20 and VM-31 based on ASOP No. 11 so that regulators can determine how well the requirements in ASOP No. 11 were followed. Additionally, the Task Force recommends education as an adjunct to the ASOP No. 11 guidance and the new disclosures given the new guidance in the recently revised ASOP No. 11.

With that context, the Task Force delves into reinsurance and newly revised ASOP No. 11, which has been adopted by the ASB and will be effective for actuaries’ work product produced on or after December 1, 2022. Its requirements would apply whether or not new disclosures take the form of an APF or an actuarial guideline, and whether or not a state chose to “early adopt” new disclosures if effectuated through an APF for the 2023 VM.

Section 1.2 of ASOP No. 11 states, “This standard applies to actuaries when performing actuarial services in connection with preparing, determining, analyzing, or reviewing financial reports for internal or external use that reflect reinsurance or similar risk transfer programs on life insurance, annuities, or health benefit plans.” This is clearly consistent with our prior comment letter suggesting that all product lines be in scope (e.g., life, annuities, LTD, LTC).
Section 2.16 broadly defines a Reinsurance Program to not only include formal reinsurance treaties but “similar risk transfer programs” and explicitly mentions securitizations. This clearly provides support for new disclosures where the assets themselves are securitizations of underlying items, but also for insurers that use securitizations rather than reinsurance to transfer portions of the risks, such as selling various tranches to other parties. It also includes insurers that use reinsurance to cede complex asset risks to a reinsurer (or a reinsurer ceding these risks to a retrocessionnaire).

Section 2.6 explicitly lists statutory financial statements, asset adequacy analysis reports, and experience reports as being in scope. This provides justification for adding parallel disclosures about the complex assets in question to both VM-30 and VM-31.

Section 2.17 defines Service Providers as adjunct parties to a reinsurance agreement that provide services integral to the reinsurance agreement. It explicitly lists investment advisors and investment managers as being Service Providers. We recommend that the new disclosures consider not just the investment assumptions and models, but also the role that such advisors or asset managers have as the actuary’s source of investment assumptions, models, and values.

Section 2.11 defines Non-Guaranteed Reinsurance Elements (NGREs) as “Any premium, charge, or benefit within a reinsurance program that affects reinsurance costs or values, [and] is not guaranteed in the reinsurance program.” Investment returns that affect reinsurance costs or values and are not guaranteed would meet the definition of an NGRE.

Section 3.2(a) indicates that the actuary should consider how treaty terms and conditions (including NGREs) impact expected reinsurance cash flows. This is relevant because asset performance can influence modeled cash flows and modeled asset performance depends on the form of the asset assumptions, the values they take, whether they are stochastic or scenario-based, etc.

Section 3.2(b) indicates that the actuary should take into account how activities performed by Service Providers impact reinsurance cash flows, 3.2(g) indicates that the actuary should take into account the impact of incentives and disincentives contained in fees paid to third parties, and 3.2(h) explicitly mentions the actuary taking into account the impact of the investment policy on reinsurance cash flows. Therefore, we suggest disclosures be added on advisor compensation, performance (or lack of performance), and details of the Investment Policy Statement and how it aligns with the assumptions and models to calculate of reserves and perform AAT on those reserves.

Section 3.3(a) requires the actuary consider the impact of reinsurance on the net retained business; 3.3(c) requires the actuary consider the reasonableness, individually and in aggregate, of assumptions regarding the risks associated with the net retained business that are impacted by the existence of a reinsurance program; and 3(d) requires the actuary consider the impact of the reinsurance program on the investment policy of the holder or manager of the assets associated with the net retained business. Together, these section 3.3 requirements may address the concern regulators have with the use of captives and “offshore reinsurance.” ASOP No. 11 requires U.S. actuaries involved with a domestic regulated entity to comply with section 3 for both ceded and
retained reserves and consider how the mere presence of reinsurance or securitizations impact the cash flows that are used to calculate reserves or test their adequacy. The regulator therefore has recourse to the domestic actuary even if some or all risks on a complex asset are transferred out of their jurisdiction, e.g., to an offshore entity outside the U.S. or into the capital markets.

In summary, regardless of whether risk is transferred using reinsurance or securitization, section 2 and section 3 of ASOP No. 11 require actuaries establishing reserves, actuaries involved with the PBR Actuarial Report, and Appointed Actuaries rendering the adequacy opinion reserves to consider the following in their work:

a. How an investment advisor or manager is compensated and how this might incent them.

b. The consequences of non-performance or underperformance of the assets or the investment advisor on both the ceded and retained cash flows.

c. The extent to which asset performance is an NGRE and thus could impact NGEs such as credited rates to insureds, or policyholder behavior through dynamic lapse formulas.

7. Trend toward higher-yielding, less liquid assets

These assets can be difficult to sell, so an important consideration for cash flow testing is whether results rely on an assumption that an illiquid asset can be sold, as well as the amount for which it can be sold. This trend is broad-based but is also currently small relative to the overall investment portfolios of life insurers.

As noted in the Task Force’s summary statements above, with appropriate additional disclosures and principle-based guidance, the Task Force notes that insurers can effectively use complex and high-yielding assets if actuaries follow the relevant requirements in the ASOPs. As such, the Task Force does not recommend implementing constraints to discourage investment in such assets given the advantages such assets can offer if their exposure and assumptions are appropriately disclosed, and their risks, including liquidity, are appropriately understood, and modeled. However, the Task Force also notes that what might have been a good AAT assumption when such assets comprise a few percent of total starting assets may need to be rethought as such assets become a more material percentage of starting assets, e.g., a large position in complex and high-yielding assets may warrant more sophisticated modeling and/or more granular assumptions.

Here again, the Task Force points to the considerations in item 1 above.
8. **Actuarial assumption impact**

The use of aggressive actuarial assumptions is not supported or in accordance with actuarial requirements for asset adequacy analysis. ASOP No. 22, for example, requires the actuary to consider whether the reserves and other liabilities being tested are adequate under moderately adverse conditions. If the underlying assumptions are aggressive then this would not meet the moderately adverse conditions requirement. Additionally, ASOP No. 22 was recently modified (with an effective date of June 2022) to provide more clarity in certain areas. A notable modification was the addition of specific guidance on trends in assumptions as well as margins for adverse deviation. If actuaries deviate from these requirements, then they must disclose the deviation along with the rationale for such deviation. Actuaries are also required to provide adequate disclosure of the assumptions such that one could determine their reasonability (e.g., ASOP No. 22, ASOP No. 41, and VM-30).

Regarding the reference to borrowing, it’s important that actuaries model the company’s actual investment and disinvestment policy as best they can as it is the cash flows from the assets that pay future claims and expenses. Models are simplified representations of processes, and an exact replication of the actual investment policy may be difficult to achieve. This may be due to model limitations and/or modeling requirements (e.g., new business cash flows are not modeled in asset adequacy analysis but will impact future cash flows). Borrowing may be modeled when it is part of the company investment policy or, for example, to limit excessive asset sales due to model limitations. In any event, consideration of the amount of borrowing modeled, the underlying borrowing rate, and the documentation and disclosure of such is addressed in various actuarial and regulatory documents:

a. ASOP No. 7 provides that to the extent the insurer’s investment strategy contemplates borrowing to cover negative cash flows, the actuary should consider whether the funds borrowed pursuant to the strategy are reasonable in relation to the insurer’s existing indebtedness, borrowing capacity, and cost of borrowing funds.

b. Under ASOP No. 56, the actuary should make reasonable efforts to confirm that the model structure, data, assumptions, governance and controls, and model testing and output validation are consistent with the intended purpose for which it is being used. In asset adequacy analysis/cash flow testing, this includes the projection of future asset cash flows in a manner representative of the actual investment policy. This includes the impact of the modeling of borrowing.

c. The 2017 Academy practice note *Asset Adequacy Analysis* discusses modeling practices when negative cash flow occurs. Small negative cash flow may be covered by short-term borrowing at the prevailing short-term rate applicable to the company. In instances of large amounts of borrowing, the actuary would typically check to see whether this is creating excessive leverage. If so, the investment and disinvestment assumptions would be changed or in some instances, the borrowing rate would be changed to the average reinvestment rate.

d. Although the following items do not directly apply to asset adequacy analysis, they further support the modeling of reasonable borrowing assumptions.
• RBC Instructions for C-3 Phase I—If negative cash flow is modeled by borrowing, the actuary needs to make sure that the amount and cost of borrowing are reasonable for that particular C-3 scenario.

• VM-21—The cost of borrowing cannot be lower than the rate at which positive cash flows are reinvested, although a Guidance Note indicates that this language is not intended to impose a literal requirement, but rather to prevent excessively optimistic borrowing assumptions. Note that VM-20 also has language regarding borrowing but it is less prescriptive and points to the company’s investment policy and cost of borrowing.

In summary, there are numerous requirements regarding assumptions that apply to asset adequacy analysis. Actuaries adhering to such requirements typically would not incorporate aggressive actuarial assumptions in asset adequacy analysis.

If the NAIC determines the current requirements are not specific enough to foster adherence, the Task Force suggests adding specific disclosure to VM-30, which documents the adherence of assumptions to the various requirements and points to considerations listed in item 1 above to help address any additional regulatory concerns, e.g., related to the modeling of borrowing.
Equitable appreciates the opportunity to further comment on the concept of developing an Actuarial Guideline on the modeling of complex or high-yielding assets in Asset Adequacy Testing (AAT).

As noted in our December 2021 letter, Equitable supports establishing an aggregate credit spread cap of a single-A corporate bond spread plus a modest illiquidity premium (c. 20bps) as a guardrail. The proposed constraint would cap the weighted-average spread across all assets. Our rationale is as follows:

A. **Harmonization with Principle-Based Reserve (PBR) methodologies:** NAIC has used PBR methodologies to establish liability reserves for life and annuity products, including spread caps on reinvestment and inforce assets. For those products governed under prior valuation rules, a spread constraint would provide a PBR-consistent methodology for liabilities where AAT is the *de facto* reserve in the current rate environment.

B. **Guardrail on Total Asset Requirements:** Reserve and Capital frameworks adjust to the risk / return profile of investments in their calculations. The lack of a spread constraint within current AAT calculations can facilitate a significant reduction in reserves – which is not accounted for in asset risk capital – and ultimately materially reduces total asset requirements. An aggregate spread constraint applied to all assets, including equities backing general account liabilities, provides a guardrail against overly optimistic reserves that lower the total asset requirement below what is prudent.

Additionally, a spread constraint guardrail serves as a preventative measure against the scenario of a regulator attempting to liquidate an insurer but finding that no buyer will underwrite with the same spread optimism and thus be obligated to take on material impairments. Further, we distinguish a guardrail ("boundary setting") from prescription ("parameter specification") and contend guardrails ultimately further long-run PBR adoption by avoiding the type abuses by a minority of companies that undermine confidence in the overall PBR framework.

C. **Aggregate Spread Constraint is Simpler and More Effective than a Targeted Constraint on Complex or High-yielding Assets:** A spread constraint in aggregate...
simplifies the regulatory framework by (a) removing the need to demarcate between complex and high-yielding assets vs. other assets and (b) reducing the regulator burden to “catch” overly optimistic assumptions of spread recognition in the complex and high-yielding assets. It is more effective than a targeted approach because it allows for offsetting levels of optimism and conservatism across a diverse investment portfolio, and because it safeguards the totality of the reserve from overly optimistic spread recognition. Moreover, regulators should take comfort that an aggregate guardrail safeguards against an underlying commercial motivation for optimism in spread recognition in complex or high-yielding assets – lower reserves and greater dividend capacity – which exist across all assets. Nevertheless, if the preference of regulators were to limit the scope of the spread constraint, we believe it could be applied to just the subset of complex and high-yielding assets. In this event, we would propose that the modest illiquidity premium reflected in our proposal could be increased moderately (e.g. an additional c. 20bps) as a result of the narrower scope focused on assets that are inherently more illiquid.

D. **Constraint is Easier to Monitor than Documentation:** A constraint is a lower burden for regulators to monitor as it reduces the reliance on the regulator to identify and challenge overly optimistic assumptions of spread recognition in complex and high-yielding assets. Documentation can enhance regulator understanding of the basis for spread recognition but does not reliably harmonize reserves or protect the integrity of the total asset requirement.

The remainder of this letter expands the first two arguments.

**A. Harmonization with Principle-Based Reserve (PBR) methodologies**

A spread constraint would support harmonization with broader liability governance for principle-based reserves as established in VM-20, VM-21, and VM-22. Equitable supports establishing an aggregate credit spread cap of a single-A corporate bond spread plus a modest illiquidity premium over all assets (not just complex). The single-A curve is recognized in the insurance industry as an appropriate measure of fair value and we believe that adding a modest illiquidity premium is appropriate to reflect the ability of insurers to realize such a premium given the long-dated nature of their liabilities. While harmonization could also be considered for risk free interest rates, it is not necessary to address immediately as part of the implementation of a credit spread guardrail.

While we support full harmonization of credit constraints across PBR and AAT frameworks, we modify narrowly the approach to VM-20 and VM-21. The inforce asset guardrail under VM-20 and VM-21 are primarily based on corporate bond defaults – not net yields – and thus do not sufficiently guardrail complex, high-yielding assets that can exhibit significantly higher defaults in stress environments. The reinvestment spread guardrails (50% ‘A’/50% ‘AA’ spreads, no illiquidity premium) are likely too restrictive. We therefore suggest applying a construct similar to the VM-20 and VM-21 reinvestment cap on such inforce assets but based on the current ‘A’ spreads with a modest (c.20bps) illiquidity premium. Such a spread constraint works similarly to the caps already contained with VM-20/VM-21 and thus would not be difficult to implement.
The chart below compares the spread constraints within VM-20, VM-21, the proposed VM-22 framework, and the NY Special Considerations Letter (NY SCL) to Equitable’s proposed AAT guardrail:

<table>
<thead>
<tr>
<th>Reserve Regime</th>
<th>Inforce Asset Requirements</th>
<th>Reinvestment Asset Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed AAT guardrail</td>
<td>Spreads on all assets capped at current ‘A’ spreads plus a modest illiquidity premium (c.20bps) in aggregate</td>
<td>Same as Inforce requirement</td>
</tr>
<tr>
<td>VM-20 and VM-21</td>
<td>Inforce assets subject to 85th percentile defaults and temporary (&lt;4yr) aggregate cap at BBB corporate spreads</td>
<td>Reinvestment spreads subject to a 50% ‘A’ / 50% ‘AA’ aggregate corporate bond spread cap without illiquidity premium</td>
</tr>
<tr>
<td>VM-22</td>
<td>Same as VM-20/VM-21</td>
<td>Reinvestment assets subject to aggregate cap based on 5% Treasury, 15% AA, 40% A, 40% BBB corporate spread mix</td>
</tr>
<tr>
<td>NY SCL (AAT)</td>
<td>Inforce assets subject to a spread cap based on long term averages of 50% A / 50% AA, and spread cap applied on an asset-by-asset basis</td>
<td>Same as Inforce requirement</td>
</tr>
</tbody>
</table>

Of the c.$6.5 TN in life insurance assets (excluding capital & surplus) at YE 2020 in the below chart, PBR approaches will govern approximately 70% by 2025. The remaining 30% of reserves under non-PBR approaches are primarily grandfathered business which would have otherwise been subject to VM-20 and secondarily other types of liabilities. This material block of non-PBR liabilities relies on the AAT reserving requirement when establishing reserves given the current low rate environment (where market rates are materially below the historical Statutory Valuation Law rates commonly in the range of 4-6%).

An aggregate spread guardrail for these $2.1 TN in non-PBR reserves would harmonize the regulatory liability governance framework, at least for assumed underlying investment returns, across all life insurance reserves.

1 This figure assumes VM-22 is implemented in 2025 and with no grandfathering of liabilities. All figures shown in chart are as of 12/31/20.
B. Guardrail on Total Asset Requirements

Higher spread assumptions under AAT reduce reserves – with a 175 bp increase in spread assumption on a 20yr GIC\(^2\) reducing reserves by 22% as of December 2020 as shown in the below chart. Structurally, this reserve reduction creates surplus which will only grow with investment optimism.

**Decrease in GIC Liability relative to A-rated credit curve**

![Graph showing decrease in liability](chart)

Source: Liability cashflow model with treasury assumptions as of 12/30/2020

The below chart illustrates how increased spread assumptions can generate surplus in excess of the C-1 capital. If higher than expected defaults or lower reinvestment yields in the future eroded this spread, it is apparent that the C-1 capital could be insufficient to support policyholder claims.

**Total asset requirement by spread assumption**

10yr GIC, % of assets

![Graph showing total asset requirement](chart)

Source: Liability cashflow model with treasury assumptions as of 12/30/2020

1 C1 capital is estimated as undiversified bond factor for NAIC 2 rated asset at 1.26% at 400% RBC ratio

\(^2\) The illustrated GICs in the two following charts are hypothetical, plain vanilla GICs maturing at initial principal with a 2.5% minimum guaranteed annual interest rate.
The above chart illustrates the relative impact of appropriately reflecting investment risk/return profiles in reserving. While capital can offset some of the investment risk, the current latitude in AAT could facilitate reductions in total assets which are multiples of the investment risk capital. Credit spread limits are an important part of a principle-based framework. Such limits ensure reserves do not rely on excessive amounts of credit spread in excess of industry investment and pricing practices.

NAIC observations of current practices – e.g., high spreads and reinvestment yield assumed to persist over 30 years, corporate bond defaults applied to other complex assets – support the need for a guardrail. However, the constraint would be designed to maintain the industry’s ability to compete based on investment strategies and differentiation in investment sourcing, illiquidity premium, etc. An effective constraint addresses the excessive optimism but does not infringe on competitive investment strategies.

* * * * * * * * *

Equitable appreciates the opportunity to comment on this exposed proposal and looks forward to working with regulators to reach an appropriate framework for modeling of complex and other assets within the Asset Adequacy Testing framework. We are available to discuss our comments further as desired.

Sincerely,

Aaron Sarfatti, ASA
Chief Risk Officer, Equitable
March 8, 2022

From: Seong-min Eom, Chair
       The Longevity Risk (E/A) Subgroup

To:   Mike Boerner, Chair
       The Life Actuarial (A) Task Force

Subject: The Report of the Longevity Risk (E/A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (E/A) Subgroup has not met since the Fall National Meeting. The subgroup will resume the meetings once the currently exposed VM-22 PBR methodology is finalized and adopted to develop and recommend longevity risk factor(s) for the product(s) that were excluded from the application of the current longevity risk factors.
March 31, 2022

From: Pete Weber, Chair
The Variable Annuities Capital and Reserve (E/A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Variable Annuities Capital and Reserve (E/A) Subgroup (VACR SG) to the Life Actuarial (A) Task Force

The VACR SG has not met since the Fall National Meeting. At the request of LATF, the Chair has made a request to the Society of Actuaries to expand the work they are currently carrying out for the VM-22 Standard Projection Amount Mortality DG to include variable annuities. More specifically, to develop mortality rates to be used as prescribed assumptions within the VM-21 Standard Projection Amount.
March 31, 2021

From: Fred Andersen, Chair  
The Experience Reporting (A) Subgroup

To: Mike Boerner, Chair  
The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup has not met since the Fall National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of variable annuity data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.
March 31, 2022

From: Ben Slutsker, Chair  
The VM-22 (A) Subgroup

To: Mike Boerner, Chair  
The Life Actuarial (A) Task Force

Subject: The Report of the VM-22 (A) Subgroup to the Life Actuarial (A) Task Force

The VM-22 (A) Subgroup has not met since the Fall National Meeting. Prior to the Fall National Meeting, the following events occurred:

- In July 2021, the American Academy of Actuaries’ proposed draft of VM-22 language was exposed, along with two sets of definitions for payout and accumulation annuity reserving categories.
- Eight comment letters were received from interested parties and Subgroup members during the public exposure period, three of which included specific mark-ups to the proposed VM-22 draft.
- All mark-ups and comment letters have been consolidated into a single redline version of the proposed VM-22 draft, which will serve as the basis for discussions going forward.

Calls for the Subgroup will start up again on April 13, the first of which will be a 90-minute call. The latest draft of the VM-22 proposal includes 378 comments, which are divided into four tiers:

1. The first tier focuses on foundational and critical issues, for which there are four topics:
   a. Structure of definitions and scope for VM-22 principle-based requirements
   b. Reinvestment guaranty on the mix of credit qualities
   c. Selecting one of the two exposed reserve category definitions for product aggregation
   d. Whether to develop a small company exemption, analogous to the exemption in VM-20

2. The second tier will focus on 26 highly substantive comments, which include items such as longevity reinsurance, the transition period, and scope of the exclusion test.

3. The third tier will focus on 88 moderately substantive, highly technical comments.

4. The fourth tier consists of the remaining 258 comments, which were deemed either editorial, non-substantive, or non-controversial. These comments already have associated preliminary revisions made in the draft to address and will be eventually re-exposed. Only items for which there are additional comments or objections will be addressed.

The Subgroup will proceed by focusing its discussion on first tier issues, and then working its way down through the other three tiers. The objective of this approach is to use the Subgroup’s time efficiently by focusing on the most substantive issues prior to discussing more detailed and less substantive items.

Aside from reviewing the draft VM-22 language, the Subgroup will continue working on developing a standard projection amount. The Subgroup has decided to recommend a standard projection amount to the Life Actuarial Task Force but has not decided on whether to recommend such as a disclosure-only
item or as a minimum floor. There are currently two NAIC drafting groups: one led by Seong-min Eom (NJ) working on development of mortality assumptions and another led by Vincent Tsang (IL) working on policyholder behavior assumptions. The goal will be to target a draft of the Standard Projection Amount to discuss during Subgroup calls in the Fall.

The Subgroup is also targeting a VM-22 field test to be held in the coming year. The current plan is for the field test to be run jointly by the Academy, ACLI, and NAIC. The goal will be to test the latest proposed non-variable annuity principles-based framework in comparison to the current statutory requirements and will include both reserve and capital calculations. A draft of specifications for the field test has been previously exposed by the Subgroup. The field test may also employ the use of a consultant to utilize for projections and analysis of the field test results. Note the timing of a field test for non-variable annuities is still being discuss and will be dependent on the timing of the NAIC Economic Scenario Field Test.

Lastly, Seong-min Eom (NJ) is leading the NAIC PRT Drafting Group, which is focusing on developing mortality assumptions for annuities covering the non-U.S. population, primarily from pension risk transfer transactions. The Drafting Group is seeking to identify a mortality assumption to use for reserving requirements prior to the implementation of principles-based reserves, which will also eventually be incorporated into principles-based reserves upon its effectiveness.
Actuarial Guideline ILVA
Nonforfeiture Requirements for Index Linked Variable Annuity Products Supported by Non-Unitized Accounts

Background

The purpose of this guideline is to specify the conditions under which an Index-Linked Variable Annuity (ILVA) is consistent with the definition of a variable annuity and exempt from Model 805 and specify nonforfeiture requirements consistent with variable annuities.

A number of insurers have developed and are issuing annuity products with credits based on the performance of an index with caps on returns, participation rates, spreads or margins, or other crediting elements, which include limitations on loss such as a floor or a buffer. These products are not unitized and do not invest directly in the assets whose performance forms the basis for the credits. However, unlike traditional non-variable indexed annuities, these annuities may reflect negative index returns.

There is no established terminology for these annuity products. These products go by several names, including structured annuities, registered index-linked annuities (RILA), or index-linked variable annuities, among others. This guideline refers to these products as index-linked variable annuities (ILVA).

Variable annuities are exempted from the scope of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities, however, NAIC Model 805 does not define the term "variable annuity".

NAIC Model 250, Variable Annuity Model Regulation, defines variable annuities as “contracts that provide for annuity benefits that vary according to the investment experience of a separate account” Section 7B of NAIC Model 250 provides that "to the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account" the contract shall satisfy the requirements of the NAIC Model 805.

The application of the NAIC Model 250 to a traditional variable annuity with unitized values is straightforward. The unitized feature provides an automatic linkage between annuity values and the investment experience of a separate account. Daily values (market values of the separate account assets) are the basis of all the benefits, including surrender values.

The fact that ILVA products are not unitized means they do not have values determined directly by the market prices of the underlying assets. Therefore, this guideline sets forth principles and requirements for determining values, including death benefit, withdrawal amount, annuitization amount or surrender values, such that an ILVA is considered a variable annuity and thereby exempt from Model 805. An ILVA that does not comply
with the principles and requirements of this guideline is not considered a variable annuity and therefore is subject to Model 805.

Drafting Note: This guideline interprets the term “variable annuity” for purposes of exemption from Model 805. It is not intended to modify the definition of a variable annuity under Model 250.

Scope

This guideline applies to any index-linked annuity exempt from the NAIC Model 805 on the basis that it is a variable annuity provided through non-unitized separate account(s) and includes index-linked crediting features that are built into policies or contracts (with or without unitized subaccounts) or added to such by rider, endorsement, or amendment.

This guideline does not apply to an annuity contract or a subaccount of an annuity contract that is subject to the requirements of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities.

Principles

This guideline is based on the following principles:

1. There exists a package of derivative assets that replicates the index credits provided by an index strategy at the end of an index term.
2. The value of the package of derivative assets can be determined daily using assumptions consistent with observable market values.
3. Interim Values defined in the contract provide equity to both the contract holder and the company where the Interim Values are consistent with the value of the Hypothetical Portfolio over the index term.

Definitions

“Derivative Asset Proxy” means a package of hypothetical derivative assets designed to replicate credits provided by an Index Strategy at the end of an Index Term.

“Fixed Income Asset Proxy” is a hypothetical fixed income asset.

“Hypothetical Portfolio” means a hypothetical portfolio composed of a Fixed Income Asset Proxy and a Derivative Asset Proxy.

“Interim Value” mean the Strategy Value at any time other than the start date and end date of an Index Term.

“Index Strategy” means a method used to determine index credits with specified index or indices and cap, buffer, participation rate, spread, margin or other index crediting elements.
“Index Strategy Base” means the notional amount used to determine index credits that does not change throughout the Index Term except for withdrawals, transfers, deposits, and explicit charges.

“Index Strategy Term” means the period of time from the term start date to the term end date over which an index change and index credit is determined.

“Strategy Value” means the value, attributable to an Index Strategy, used in determining values including death benefit, withdrawal amount, annuitization amount or surrender values.

**Text**

Index Strategy Base must equal the Strategy Value at an Index Term start date.

The value of the Fixed-Income Asset Proxy:

a. At the beginning of the Index Term equals the Index Strategy Base less Derivative Asset Proxy value;
   b. At the end of the Index Term equals the Index Strategy Base; and
   c. Earns interest at a level rate.

The value of the Hypothetical Portfolio at any time is the sum of the Fixed-Income Asset Proxy value and the Derivative Asset Proxy value less a provision for the cost of unwinding the hedge positions not to exceed 10 bps.

Contracts in the scope of this guideline must provide Interim Values that are consistent with the value of the Hypothetical Portfolio over the index term.

If a contract provides Interim Values determined using a methodology other than a Hypothetical Portfolio methodology as described in this guideline, the company must demonstrate that the contractually defined Interim Values will be materially consistent with the Interim Values that would be produced using the Hypothetical Portfolio methodology for each combination of Index Strategy and Index Strategy Term under a reasonable number of economic scenarios.

Drafting Note: Acceptable economic scenarios over which consistency should to be demonstrated is yet to be determined. Considerations are the Academy Interest Rate Generator and/or defined deterministic scenarios including shocks that trigger Index Strategy parameters including but not limited to caps, floors and buffers.

The company must provide an actuary’s certification that the provisions of this guideline are being met.
Assumptions used to value the Derivative Asset Proxy including yields, implied volatility, risk-free rate, and dividend yield must be consistent with the observable market prices of derivative assets, whenever possible.

ILVA nonforfeiture benefits must comply with Section 7 of Model 250 with net investment return consistent with the requirements for determining Interim Values in this guideline.

The company (or actuary) must describe the Derivative Asset Proxy and the assumptions used to calculate its value at any time.

Effective Date
Index-Linked Variable Annuity (A) Subgroup
Virtual Meeting
March 9, 2022

The Index-Linked Variable Annuity (A) Subgroup met March 9, 2022. The following Subgroup members participated: Peter Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Vincent Tsang (IL); Derek Wallman (NE); David Wolf (NJ); Bill Carmello and Michael Cebula (NY); Mike Boerner, Rachel Hemphill, and Mengting Kim (TX); Craig Chupp (VA); and David Hippen (WA).

1. Heeded a Presentation on Interim Nonforfeiture Values

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI interim value presentation (Attachment Fourteen-A) shows that Method 2 of the proposal jointly submitted by the ACLI and the Committee of Annuity Insurers (CAI) discussed on the Feb. 16 Subgroup call provides a fair and equitable value and allows consumers to track their assets. Rachel D’Anna (Brighthouse Financial), Allen Tang (Brighthouse Financial), and Michael Drislane (Brighthouse Financial) presented an analysis incorporating historical scenarios to compare the application of Method 2 to the application of the interim value determination in the initial version of the index-linked variable annuity (ILVA) guideline proposal. Mr. Tang said the results are presented over one-year, three-year, and six-year scenarios. He said the slides demonstrate that on average, when looking at 1,000 plausible scenarios, the pro rata method produces an expected value that is within 1% of the value provided when using the proposed interim value method.

Mr. Weber said the Subgroup seems to favor Method 1 of the ACLI/CAI proposal. He asked how the pro rata method compares with Method 1. Ms. D’Anna said Method 1 allows for a different range of options. She said the initial proposal would fit within that range of options. She opined that a comparison of the pro rata method to other Method 1 options would yield results like those observed in the comparison of the initial proposal. Mr. Serbinowski expressed discomfort with blanketly accepting the pro rata method based on the demonstration of the success of one specific pro rata method. Ms. D’Anna said wording can be developed to address that issue. Mr. Hippen said the initial guidance seemed to be structured to prevent abusive products. He suggested that protective language is needed. He suggested that the ACLI expand its demonstration to include various product designs, including designs that are not acceptable. Mr. Serbinowski asked if it might be possible to develop a pro rata value certification method. Ms. D’Anna said that sounds reasonable. Mr. Wallman asked if consumers could be given a choice between the initial proposal and the pro rata method.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.

https://NAICSsupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/ILVA/03 09/Mar 9 Minutes.docx
RILA Interim Value Approaches
March 9, 2022

Historical Analysis

• Interim values determined using actual observable market data between 2013 – 2021; initial investment of $100,000

• Pro-Rata Interim Value
  – Equal to initial investment plus change in index value subject to accrued cap/buffer
  – Cap and buffer accrued linearly throughout contract term

• Black-Scholes Interim Value
  – Equal to hypothetical portfolio value
  – Fixed Income Asset + Derivative Asset (OTM Call, ATM Call, OTM Put)

Stochastic Analysis

• 1000 real-world scenarios generated from two robust economic scenario generators
  – American Academy of Actuaries (AAA)
  – Moody’s Real-World Scenarios
Market growth with some volatility

Term: One Year  
Cap: 12%  
Buffer: 10%  
Index: S&P500  
Start Date: 3/25/2013  
End Date: 3/26/2014

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Severe market drop towards end of term

Term: One Year  
Cap: 12%  
Buffer: 10%  
Index: S&P500  
Start Date: 5/31/2019  
End Date: 5/29/2020

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-33% Covid-19 Dip

Term: One Year
Cap: 12%
Buffer: 10%
Index: S&P500
Start Date: 2/21/2020
End Date: 2/22/2021

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Negative Return in Year 1

Term: Three Years
Cap: 30%
Buffer: 15%
Index: S&P500
Start Date: 6/24/2015
End Date: 6/29/2018

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<td>0.00%</td>
<td>6.70%</td>
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<td>Black-Scholes</td>
<td>0.14%</td>
<td>0.07%</td>
<td>6.69%</td>
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<td>Difference</td>
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<td>-0.07%</td>
<td>0.01%</td>
<td>1.75%</td>
<td>1.66%</td>
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</table>
**Average 7% Annual Return**

- **Term:** Three Years
- **Cap:** 30%
- **Buffer:** 15%
- **Index:** S&P500
- **Start Date:** 4/26/2017
- **End Date:** 4/30/2020

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<tr>
<th>Interim Value Adjustment</th>
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<td>13.58%</td>
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<td>Black-Scholes</td>
<td>0.43%</td>
<td>7.75%</td>
<td>10.91%</td>
<td>18.75%</td>
<td>23.10%</td>
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<tr>
<td>Difference</td>
<td>0.41%</td>
<td>2.25%</td>
<td>2.68%</td>
<td>1.25%</td>
<td>1.90%</td>
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</table>

**Average 9% Annual Return**

- **Term:** Six Years
- **Cap:** 45%
- **Buffer:** 25%
- **Index:** S&P500
- **Start Date:** 7/30/2014
- **End Date:** 7/31/2020

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<th>Y3</th>
<th>Y4</th>
<th>Y5</th>
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<td>Black-Scholes</td>
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<td>20.27%</td>
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<td>Difference</td>
<td>0.91%</td>
<td>0.22%</td>
<td>2.23%</td>
<td>-0.10%</td>
<td>-0.08%</td>
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Average 10% Annual Return

Term: Six Years
Cap: 45%
Buffer: 25%
Index: S&P500
Start Date: 11/27/2013
End Date: 11/29/2019

Interim Value Adjustment

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<th>Difference</th>
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<tr>
<td>Y2</td>
<td>15.00%</td>
<td>12.27%</td>
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<tr>
<td>Y3</td>
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<td>17.34%</td>
<td>4.32%</td>
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<tr>
<td>Y4</td>
<td>30.00%</td>
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<tr>
<td>Y5</td>
<td>37.50%</td>
<td>36.71%</td>
<td>0.79%</td>
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Stochastic Analysis Summary – 6 Year Term, 25% Buffer

- Average difference between Pro-Rata and Black-Scholes “Interim Value Adjustment”
- On average, both approaches produce “Interim Value Adjustment” within 1.00% of each other
- Approaches tend to converge towards end of term
- One and Three Year Terms produce similar results
Stochastic Analysis Summary – 6 Year Term, 10% Buffer

- Average difference between Pro-Rata and Black-Scholes “Interim Value Adjustment”
- Approaches tend to converge towards end of term

<table>
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<tr>
<th>Percentile Range</th>
<th># Scenarios</th>
<th>AAA Economic Scenario Generator</th>
<th>Moody’s Economic Scenario Generator</th>
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<tr>
<td></td>
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<td>Y1</td>
<td>Y2</td>
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<tr>
<td>0.50 - 99.50%</td>
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<td>1.55%</td>
<td>1.85%</td>
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</tbody>
</table>

100% Cap, 10% Buffer
2Based on cumulative Index Return
Index-Linked Variable Annuity (A) Subgroup
Virtual Meeting
March 2, 2022

The Index-Linked Variable Annuity (A) Subgroup met March 2, 2022. The following Subgroup members participated: Peter Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Vincent Tsang (IL); Derek Wallman (NE); David Wolf (NJ); Bill Carmello and Michael Cebula (NY); Mike Boerner, Sandra Dodson, Rachel Hemphill, and Mengting Kim (TX); Craig Chupp (VA); and David Hippen (WA). Also participating was: William Leung (MO).

1. Discussed Comments on the ILVA Actuarial Guideline

Mr. Weber said comments from the American Academy of Actuaries (Academy) and joint comments from the American Council of Life Insurers (ACLI) and the Committee of Annuity Insurers (CAI) were heard on the Feb. 16 call. He indicated that a drafting group is incorporating some of those comments into the next draft of the Indexed-Linked Variable Annuity (ILVA) actuarial guideline. He said the ACLI/CAI provided an alternative guideline proposing two methods for determining interim values. He noted that some Subgroup members were supportive of Method 1 of the ACLI/CAI alternative guideline. Most Subgroup members were not supportive of Method 2.

David Hanzlik (CUNA Mutual Group) said the CUNA Mutual Group comments (Attachment Fifteen-A) are supportive of the ACLI/CAI alternative, as they address the core concerns raised in the CUNA Mutual Group letter. He said a specific concern is that the proposed ILVA guideline does not accommodate a product design that credits the full index performance, subject to a cap and floor. He said Method 2 of the ACLI/CAI alternative guideline accommodates that product design.

Sarah Wood (Insured Retirement Institute—IRI) said the IRI comment letter (Attachment Fifteen-B) is supportive of the ACLI/CAI comments, including the alternative actuarial guideline. She said the IRI is concerned about the potential market disruption if products that currently provide pro rata interim values are not accommodated. Mr. Serbinowski asked if there are acceptable alternatives, such as setting an effective date far enough into the future so companies could develop compliant products, that could effectively address the potential market disruption issue. Mr. Weber said the market disruption issue is better suited for discussion by the Life Insurance and Annuities (A) Committee. He suggested that the guideline could include a drafting note that informs the Committee on the issue and provides a recommendation. Mr. Serbinowski said the guideline should not be applied to existing contracts. He said an effective date should be chosen that allows companies time to develop new products that comply with the guideline.

Jonathan Clymer (Prudential) said the Prudential comment letter (Attachment Fifteen-C) focused on the explicit fee versus the spread-based approach. He said the currently marketed ILVA products are fundamentally designed as a spread-based product. He said the proposed guideline may have many interpretations, including some that are not beneficial to consumers. He noted that such interpretations could disrupt the marketplace by limiting consumer choice, harming product simplicity, and stifling innovation. He said the Prudential comment letter suggests a clarification to the proposed guideline that would allow either a spread-based or fee-based approach. He said the spread-based approach would be accomplished by requiring an actuarial certification that the spreads are reasonable. Mr. Serbinowski asked if the ACLI Method 1 sufficiently addresses the Prudential concerns. Mr. Clymer responded that if both the spread-based and fee-based approaches are allowed, the concern will be sufficiently addressed.
Mr. Leung asked if an actuarial guideline has the authority to supersede existing model regulations. Mr. Serbinowski suggested removing any references to general accounts or separate accounts from the guideline. He said it should focus on the application of nonforfeiture values to these products for any products that claim exemption from the Standard Nonforfeiture Law for Individual Deferred Annuities (#805).

Mr. Weber said some comments will be incorporated into the proposed guideline. He said the drafting group would work to have a revised draft for discussion during the March 31 Life Actuarial (A) Task Force meeting.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.

https://NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/ILVA/03 02/Mar 2 Minutes.docx
January 27, 2022

Via Electronic Delivery to rmazyck@naic.org

Mr. Peter Weber, Chair
Mr. Tomasz Serbinowski, Vice Chair
Index-Linked Variable Annuity (A) Subgroup
National Association of Insurance Commissioners
1100 Walnut Street Ste 1500
Kansas City, MO 64106

Dear: Messrs. Weber and Serbinowski

On behalf of the companies of CUNA Mutual Group (CUNA Mutual), we are pleased to provide comments to the National Association of Insurance Commissioner’s (NAIC) Index-Linked Variable Annuity (A) Subgroup (Subgroup) on the proposed Actuarial Guideline ILVA: The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts (Actuarial Guideline). CUNA Mutual is the nation’s leading provider of financial products and services to credit unions and credit union members. Through our companies, we serve as an insurer, a retirement plan services provider, a broker dealer, and a registered investment advisor. We make available various insurance and investment products to credit unions, millions of credit union members, and middle-income consumers across the United States. As part of the cooperative movement, we embrace the credit union philosophy of “people helping people” and believe a brighter financial future should be accessible to everyone.

Like the Subgroup, CUNA Mutual is focused on working to address the retirement savings crisis facing our country today. We appreciate Subgroup efforts to develop a uniform standard for Index-Linked Variable Annuity (ILVA) interim values which we hope will result in increased consumer access to ILVA products and protections. CUNA Mutual has been serving consumers in the ILVA space for over eight years and our experience shows ILVAs are an incredibly impactful tool in helping middle market customers create guaranteed retirement income. We take pride in helping those who make a modest income. It is in the spirit of supporting our customers that we offer these comments.

While we share the Subgroup’s interest in providing a framework for states to approve ILVAs as a form of variable annuity under the NAIC’s Variable Annuity Model Regulation #250 (Model Regulation 250), we believe changes are required to the proposed Actuarial Guideline to ensure it is workable. As drafted, we believe the Actuarial Guideline may prevent ILVAs currently on the market from qualifying as available to consumers going forward. Without amendment, the proposed Actuarial Guideline could cause significant market disruption, limit industry’s ability to offer these valuable products, and impede future ILVA product innovation.
CUNA Mutual endorses the comments and industry proposal submitted by the American Council of Life Insurers and Committee of Annuity Insurers (Industry). Industry’s proposal provides a workable, alternative Actuarial Guideline for Model Regulation 250 which establishes a principles-based framework and provides equity to both contract owners and ILVA issuers. The Industry proposal accommodates a broad spectrum of ILVA products on the market today and enables product innovation in the future.

If the Industry draft does not advance, we recommend the Subgroup instead use NAIC’s Modified Guaranteed Annuity Model Regulation #255 (Model Regulation 255) as the basis for industry standards related to ILVAs, amend Model Regulation 250, or create a new, principles-based Model Regulation framework.

The following concerns and recommendations are most critical to CUNA Mutual to ensure ongoing marketplace opportunities for the company’s ILVA products.

**Adjust scope to carve out and allow ILVAs with interim values in which full index performance is immediately recognized.**

CUNA Mutual recommends the Subgroup adjust the scope of the Actuarial Guideline to carve out and allow ILVAs with interim values in which full index performance is immediately recognized. The company offers two ILVAs under which the contracts immediately credit the index return, bounded by a constant cap and floor during each crediting term. These contracts are simple to understand and use and ensure transparent equity to the customer and issuer. The mechanics are illustrated in the charts below. A 1-year Index Term with 11.5% cap and -10% floor is assumed.

Note that under the steady index increase and decrease examples the policyholder return matches the index until the cap and floor are reached.
“Method 2” in Industry’s revised proposed actuarial guideline would accommodate these designs.

**Clarify that spread based products are acceptable.**

The drafting note on page 4 of the draft Actuarial Guideline states, “any profit provisions, spreads, and expenses should be reflected as explicit charges disclosed in the contract.” CUNA Mutual respectfully recommends this sentence be omitted. ILVAs are fundamentally spread based, which enables simplicity, transparency, and the financial value our customers seek.

**Adjust ILVA guidance basing interim values on derivative assets to ensure reasonable equity between decrementing and persisting contract holders.**

To ensure reasonable equity between decrementing and persisting contract holders, CUNA Mutual suggests the Subgroup adjust ILVA guidance basing interim values on derivative assets. Specifically, CUNA Mutual respectfully recommends the Subgroup make the following adjustments to the Actuarial Guidance:

- In the “Text” section, add an assumption that permits accounting for the costs of unwinding derivatives prior to expiration. The current draft assumes frictionless trading of equity derivatives, raising an equity issue as it allows decrementing contract holders to shift these costs to persisting contract holders. Consumers accept and are comfortable with breakage costs when contracts are ended mid-stream and the Actuarial Guideline should recognize these costs.

- Add a provision that allows interim value to account for unamortized option costs versus the current Fixed-Income Asset Proxy approach. Such a provision would accommodate smoother amortization of option costs ensuring decrementing and persisting policyholders accrue benefits at the same rate. The current Actuarial Guideline draft can introduce discontinuities into option cost amortization. In turn, this may tilt benefits to decrementing policyholders at the expense of persisting policyholders. The Industry intends to provide a numerical example demonstrating this concern.

“Method 1” in Industry’s revised proposed actuarial guideline contains language that accommodate these recommendations.

**Amend language concerning interest rate related market value adjustments to ensure alignment with underlying risks.**

The proposed Actuarial Guideline includes a defined Fixed-Income Asset Proxy, which implies fixed income assets must have the same maturity date as the Index Term end date. In practice, many index terms are shorter (e.g., 1 year) than CDSC periods and actual investment strategies used to support the contractual guarantees. To ensure alignment with underlying risks, CUNA Mutual supports revisions to clarify that the guideline does not limit how interest rate market value adjustments may be applied. CUNA Mutual believes the Industry’s proposed draft appropriately clarifies this issue.
Confirm the Actuarial Guideline is not intended to clarify the NAIC’s Modified Guaranteed Annuity Model Regulation #255 and does not exclude ILVAs from qualifying under Model Regulation #255.

ILVAs meet the requirements of the NAIC’s Modified Guaranteed Annuity Model Regulation #255 (Model Regulation 255). While the Subgroup seeks to clarify marketplace opportunities for ILVAs under Model Regulation 250 through the Actuarial Guideline, CUNA Mutual respectfully requests that nothing in the Actuarial Guideline should be construed to limit ILVAs as permitted under Model Regulation 255. Though Model Regulation 255 is not widely adopted in states, there are jurisdictions where industry currently relies on Model Regulation 255 to deliver ILVAs to consumers.

In closing, CUNA Mutual appreciates the Subgroup’s consideration of these comments. Like others in the industry, we work hard each day to bring financial products and services to the people who need them most. ILVAs are fundamentally spread based products and insurer practices regarding how underlying assets are held vary. We believe any Actuarial Guideline promulgated by the Subgroup should confirm these critical aspects of the product to ensure their viability for middle market consumers who are increasingly choosing ILVAs as a source of guaranteed retirement income.

Please reach out with any questions or if we can offer additional information to support these comments.

Sincerely,

David L. Hanzlik
VP, Annuity & Retirement Solutions
January 27, 2022

Submitted electronically to rmazyck@naic.org

NAIC Index-Linked Variable Annuity Subgroup
Peter Weber, Chair & Tomasz Serbinowski, Vice-Chair

Re: Proposed Actuarial Guideline ILVA (“The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts”)

Dear Mr. Weber and Mr. Serbinowski:

On behalf of our members, the Insured Retirement Institute, Inc. (“IRI”)1 appreciates the opportunity to comment on the proposed Actuarial Guideline (“Proposal”) put forth by the Index-Linked Variable Annuity Subgroup (“Subgroup”). We acknowledge the significant work by the Subgroup to put forth this Proposal, but we believe that significant changes are needed to make this workable for the industry.

IRI received and reviewed the comments on the Proposal by the American Council of Life Insurers (“ACLI”) and the Committee of Annuity Insurers (“CAI”), dated January 27, 2022. With ACLI and CAI’s permission, IRI shared this letter with our membership.

Following discussion with our members, IRI supports ACLI and CAI’s comments with respect to its requests and recommendations regarding the Proposal, including the Alternative Actuarial Guideline that is being put forth for consideration.

We would also like to take this opportunity to reiterate some key issues of concern for our members as it relates to the current Proposal. As you know, there are different approaches to determining interim values, and while we support the need for guidance to state regulators in reviewing Registered Index-Linked Annuity (“RILA”) product filings, the current Proposal as it stands is too restrictive and eliminates certain approaches to determining values (such as the prorated interim value approach). This is problematic because it would cause serious disruption to the current market, which would be detrimental to the industry and consumers alike.

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1 IRI is the leading association for the entire supply chain of insured retirement strategies, including life insurers, asset managers, and distributors such as broker-dealers, banks, and marketing organizations. IRI members account for more than 95 percent of annuity assets in the U.S., the top 10 distributors of annuities ranked by assets under management and are represented by financial professionals serving millions of Americans. IRI champions retirement security for all through leadership in advocacy, awareness, research, and the advancement of digital solutions within a collaborative industry community.
Additionally, the allowance of different approaches to determining values leads to innovation and a variety of product options, which ultimately benefits consumers who are looking to achieve their financial goals. To further innovation and prevent market disruption, our members support an approach that maintains flexibility and is principles-based. As such, we respectfully request that the Subgroup consider the recommendation, including the Alternative Actuarial Guideline, put forth in ACLI’s and CAI’s comment letter.

On behalf of IRI and our members, thank you again for the opportunity to provide these comments. We would be happy to discuss further with you and look forward to continued collaboration and partnership with the Subgroup.

Sincerely,

Sarah E. Wood

Sarah Wood
Director, State Policy & Regulatory Affairs
Insured Retirement Institute
swood@irionline.org
January 27, 2022

Mr. Peter Weber, Chair
Mr. Tomasz Serbinowski, Vice Chair
National Association of Insurance Commissioners
LATF Index-Linked Variable Annuity (ILVA) (A) Subgroup

Re: ILVA Subgroup Exposure of Actuarial Guideline ILVA: The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts

Dear Messrs. Weber and Serbinowski:

Prudential Financial thanks the Index Linked Variable Annuity Subgroup ("Subgroup") for the opportunity to comment on the exposure of “Actuarial Guideline ILVA – The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts” (“Exposure”). We appreciate the Subgroup’s efforts in drafting the Exposure and exposing for a period of public comment. The draft forms a basis for Index Linked Variable Annuities (“ILVA”) however, we believe an enhancement is necessary to reflect the design model of products in the marketplace. This modification would maximize customer access while enhancing simplicity and allowing for future innovation.

The main consideration that the Exposure should address is that the ILVA product is fundamentally designed as a spread based product and not as an explicit fee product. The Exposure could be interpreted to require that the profit provisions, spread, and expenses be presented as an explicit fee disclosed in the contract which differs from the design of the product in the marketplace. The explicit fee approach would remove simplicity and result in an unnecessary disruption to the ILVA marketplace and impact consumer product choice.

Our proposal would be a clarification in language of the Exposure to promote consumer choice to spread based or explicit fee type products. Specifically, we recommend a new requirement, in the form of an actuarial certification to regulators attesting that spreads are reasonable based upon the current economic environment.

Our proposed language (redlines) is as follows:

Drafting Note: The difference is expected to be small, as any profit provisions, spreads, and expenses may be reflected as explicit charges disclosed in the contract. If profit provisions, spreads, and expenses are not reflected as explicit charges disclosed in the contract, then the company must provide an actuarial certification to regulators that the spreads recognized to cover profit provisions and expenses are reasonable in the current economic environment. Analysis would be available upon request. Any explicit charges deducted at the beginning of the Index Term would decrease the Index Option Value for the purpose of the comparison to the Hypothetical Portfolio value. There may need to be a provision for recognition of periodic charges to be assessed over the Index Term in the comparison required above.
We view the analysis for this actuarial certification consistent with the Securities and Exchange Commission’s (SEC) Reasonableness Memorandums. These SEC memorandums confirm that the fees being charged are in-line with the fees within the industry and therefore are reasonable. Insurers would perform a similar analysis around the index parameters to confirm that they are reasonable based upon the competitors’ index parameters. This analysis would be disclosed to regulators upon request.

Prudential feels that the proposal, as outlined, would allow for a viable solution via the additional certification that would avoid any unnecessary disruption in the ILVA marketplace and preserve consumer choice.

Thank you for consideration of these comments.

Jonathan Clymer, FSA, MAAA
Vice President & Actuary
The Index-Linked Variable Annuity (A) Subgroup met Feb. 16, 2022. The following Subgroup members participated: Peter Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Vincent Tsang (IL); Derek Wallman (NE); Kevin Clarkson and David Wolf (NJ); Bill Carmello and Michael Cebula (NY); Mike Boerner, Mengting Kim, and Rachel Hemphill (TX); Craig Chupp (VA); and David Hippen (WA).

1. Discussed Comments on the ILVA Actuarial Guideline

Beth Keith (American Academy of Actuaries—Academy) said the Academy comment letter (Attachment Sixteen-A) provided conceptual comments, not recommendations for specific changes. She said the comments covered three areas within the actuarial guideline: 1) the scope; 2) the terminology; and 3) the hypothetical portfolio considerations. Mr. Chupp and Mr. Serbinowski questioned whether it is necessary for the proxy values proposed in recommendation 11 to be calculated monthly. Ms. Keith agreed to have her group consider that issue.

Brian Bayerle (American Council of Life Insurers—ACLI) and Stephen Roth (Committee of Annuity Insurers—CAI) said their organizations’ views are jointly presented in their comment letter (Attachment Sixteen-B). Mr. Bayerle said they are concerned that the guideline could affect all spread-based products, resulting in market disruptions. He said they believe the guideline is too prescriptive and may not allow the flexibility to change as with economic conditions. He noted that they have an operational concern related to the guideline’s effect on company separate accounts, which may also affect how the registered indexed-linked annuities (RILAs) are viewed by the U.S. Securities and Exchange Commission (SEC). He said the industry-proposed draft guideline (Attachment Sixteen-C) addresses these issues. A spreadsheet (Attachment Sixteen-D) is provided to illustrate some of their concerns about the proposed actuarial guideline. Subgroup members agreed that the ACLI and the CAI should demonstrate why Method 2 in the spreadsheet example should be considered a viable option.

Mr. Weber said discussion of the remaining comments will continue on the March 2 Subgroup call.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.

https://NAICSsupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/LIFE INS and ANNUITIES (A) COMMITTEE/Life Actuarial (A) TF/ILVA/02 16/Feb 16 Minutes.docx
January 27, 2022

Mr. Peter Weber
Chair, Index-Linked Variable Annuity (A) Subgroup
National Association of Insurance Commissioners (NAIC)

Re: Proposed Actuarial Guideline ILVA, The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts (“Proposed Actuarial Guideline”)

Dear Mr. Weber,

The American Academy of Actuaries1 Index-Linked Variable Annuity Work Group (the “Work Group”) appreciates the opportunity to provide comments on the Proposed Actuarial Guideline.

Currently there is a wide range of practices related to index-linked variable annuity (ILVA) nonforfeiture that are not reflected in the actuarial guideline. This is a complex topic with a relationship to several NAIC model laws with many components to address. At this time, the Work Group is not providing any specific language changes, but offers the following conceptual comments for your consideration:

Scope of Actuarial Guideline:

1. The work group suggests more clarification related to the application of the Proposed Actuarial Guideline to Models 805, 250, and 255. Specifically, if an ILVA product falls under this Proposed Actuarial Guideline, it is unclear how the various provisions of the model laws are addressed by this guideline or would otherwise continue to apply. Of additional interest is how an index account (with a guaranteed zero floor) offered in a fixed index annuity (FIA) could be treated within an ILVA.

2. The Proposed Actuarial Guideline states that it “does not apply to products supported by a general account.” Therefore, these scenarios would not be considered: non-insulated separate accounts supported by general accounts; insulated separate accounts supported by general accounts (if there is a shortfall); and the assets/derivatives supporting ILVA products often held in the general account. Therefore, we encourage using broader language to identify the scope of the guideline.

3. The Proposed Actuarial Guideline recognizes that not all ILVA products reflect the market value of fixed income assets; however, there is text within the draft that assumes market values are used. For example, the assumptions text appears to be written with the

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
assumption that the fixed-income asset proxy value reflects market values. The Work Group suggests that the guideline should allow for different approaches consistently throughout the text.

4. The drafting note in the Proposed Actuarial Guideline is not clear, and seems to imply that all ILVA products have explicit charges. However, some ILVA products are spread-based or a combination of spread- and fee-based. Therefore, the Work Group suggests clarifying this drafting note.

Terminology within Actuarial Guideline:

5. The Work Group found the term “Index Option Value” to be unclear, because it would be expected that this term describes the value of an option rather than an entire contract value. The Work Group recommends using Indexed Account Value as it would better describe the index portion of the contract value.

6. The Work Group notes that it may be easier to define hypothetical portfolio value, fixed-income asset proxy value, and the derivative asset proxy value, because most uses of these defined terms seem to be referring to their values. The guideline could then specify in its definitions that the fixed-income asset proxy value may be a market or book value depending on product design and that the derivative asset proxy value should be a market value.

7. The Proposed Actuarial Guideline states that the product filing must quantify the maximum difference between the value of the hypothetical portfolio and the index option value at the beginning of the index term. However, it is unclear how these values could be different because they are defined to be equal. The Work Group encourages clarification.

Hypothetical portfolio considerations in Actuarial Guideline:

8. The third principle in the Proposed Actuarial Guideline states that the hypothetical portfolio must be designed to perfectly hedge the benefit guarantees at the end of the term. The Work Group suggests additional clarification regarding: is the expectation of a perfect hedge for each individual who persists or for the aggregate in-force population (which would recognize various decrements)?

9. The Proposed Actuarial Guideline allows the determination of interim values to be based on actual assets or a hypothetical portfolio of assets. The use of actual assets could lead to very different interim values for two products that are otherwise similar, because there is a wide variety of current company approaches to these assets. With respect to hedge assets, the use of a hypothetical portfolio of static hedges may produce more understandable and/or consistent interim values across insurers.

10. The Proposed Actuarial Guideline states that the assumptions used to value the hypothetical portfolio should be based on market prices. However, if there are market prices, then it is expected those prices would be used to determine values, and assumptions would not be needed. If there are no market prices, then assumptions would be needed, but they could not be based on market prices. Therefore, the Work Group encourages clarification.
11. The Proposed Actuarial Guideline allows the hypothetical portfolio to be valued using static or dynamic assumptions. For proxy values that reflect market values, the assumptions should be dynamic and reviewed frequently, potentially as often as monthly intervals.

The Academy’s Work Group appreciates the efforts of the Index-Linked Variable Annuity (A) Subgroup on this Proposed Actuarial Guideline. If you have any questions or would like further dialogue on the above topics, please contact Khloe Greenwood, life policy analyst, at greenwood@actuary.org.

Sincerely,

Beth Keith, MAAA, FSA
Chairperson, Index-Linked Variable Annuities Work Group
American Academy of Actuaries
January 27, 2022

Mr. Peter Weber, Chair
Mr. Tomasz Serbinowski, Vice Chair
National Association of Insurance Commissioners
LATF Index-Linked Variable Annuity (ILVA) (A) Subgroup

RE: ILVA Subgroup Exposure of Actuarial Guideline ILVA: The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts

Dear Messrs. Weber and Serbinowski:

The American Council of Life Insurers (ACLI)1 and the Committee of Annuity Insurers (CAI)2 appreciate the opportunity to submit comments on the ILVA Subgroup’s exposure of Actuarial Guideline ILVA: The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts (Exposure).

We recognize the considerable effort that went into producing the Exposure. Your leadership of the Interstate Insurance Product Regulation Commission’s (IIPRC) Actuarial Working Group formed a foundation which enabled the Subgroup to develop the Exposure in a timely manner. Guidance providing state regulators with a consistent understanding of the elements to consider in reviewing registered index-linked annuity (RILA) or ILVA product filings is critical to facilitating the continued growth and evolution of a product segment that provides customers with important access to insurance guarantees. RILA products are fundamentally spread-based products; they eliminate barriers that can be created by explicit fees which make it harder for people to get needed protections for their family and their retirement.

We appreciate that the Exposure initiates a starting point to demonstrate how these products might fit into the current NAIC framework for variable annuity nonforfeiture considerations but, in our opinion, there are critical changes that need to be addressed to ensure a final guideline will be workable. There are technical aspects of the Exposure which do not align with the realities of how RILA products are...

1 The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

2 The Committee of Annuity Insurers is a coalition of life insurance companies that issue annuities. It was formed in 1981 to address legislative and regulatory issues relevant to the annuity industry and to participate in the development of public policy with respect to securities, state regulatory and tax issues affecting annuities. The CAI’s current 31 member companies represent approximately 80% of the annuity business in the United States.
manufactured, and instituting the Interim Value framework as drafted could adversely impact the core design principles used to create RILAs. Additionally, it appears to us that the Exposure is too restrictive and would not meet some of the Subgroup’s own objectives, including fostering product innovation responsive to the lifetime income challenge that retirement presents for millions of Americans.

We understand that the Subgroup does not want to see the RILA market disrupted, particularly since it is clearly meeting an investor need that was not previously being met with other annuity or investment products. Neither do we. Consequently, the ACLI and CAI have worked diligently throughout the comment period to create a revised proposed Actuarial Guideline (Proposal) which builds on the Exposure, is principles-based, recognizes the diversity of RILA designs in the marketplace and would accommodate ongoing innovation. We respectfully request that the Subgroup consider exposing the Proposal, as a refinement of the Exposure, for public comment. We believe it can work as an Actuarial Guideline (AG) under Model 250. However, if upon review, the Subgroup does not believe that modification of the Exposure, as reflected in the Proposal, is a workable alternative, then we would suggest that an approach other than an AG under Model 250 may need to be considered (revision to variable annuity definition in Model 250, creation of a new model regulation, etc.).

Some Key Points About RILAs

As you know, the RILA market has seen substantial growth over the past several years. This is due in part to the fact that RILAs, because they lie between conventional fixed indexed annuities and conventional unit-linked variable annuities on the risk/reward spectrum, are consistent with the investment objectives and risk tolerances of many retirement savers. But it is also due to the diversity of RILA product designs, the number of carriers offering these products, and the fact that RILAs are being distributed and offered through a variety of different distribution channels that have afforded meaningful RILA choices to consumers.

RILAs are registered as securities with the U.S. Securities and Exchange Commission. Investors receive robust prospectus disclosures about the features of the specific RILA they are considering, including examples demonstrating how the Interim Value calculations work in a variety of economic scenarios. Prospectus disclosures also detail the particular investment risks associated with that RILA’s features (including risk of loss and any product feature limitations) that should be considered before purchasing the product. In addition, of course, recommendations made to a retail customer to purchase a RILA must follow the best interest procedures required by the SEC’s Regulation Best Interest.

Unlike conventional variable annuities, RILAs are fundamentally spread-based products, not fee-based products. Insurers manufacture RILA products by investing in fixed income assets with a return that covers the cost of liability benefits, expenses and profit/risk margins. In this respect, RILAs share many core manufacturing concepts with fixed indexed annuities. The spread-based chassis is also similar to other products treated as variable annuities that are exempt from the NAIC’s Standard Nonforfeiture Law for Individual Deferred Annuities (Model 805), such as modified guaranteed (MGA or MVA) annuities. As we will demonstrate in the examples discussed below, a spread-based manufacturing model can improve the customer value proposition (relative to a fee-based model) due to the insurer’s ability to invest in longer-term assets while prudently managing asset/liability risks. While the application of the Model 250 definition of a variable annuity may not be as straightforward for RILAs as it is for conventional unit-linked variable annuities, the relationship between contract benefits and the

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3 Note that in this context, the terms “spread-based” and “fee-based” are used to refer to a product manufacturing model, not the mechanics of the crediting strategies offered within index-linked products (where spreads and fees may be among the crediting parameters applied to index performance).
value of derivative instruments that can be used to replicate index credits demonstrates the necessary conditions for RILAs to be treated as variable annuities under Model 250.

Because RILAs provide variable benefits, insurers use separate accounts for their RILA products. However, for some insurers, the ability to offer attractive index-linked crediting strategies and other product features is often related to the ability to hold some of the assets supporting RILAs in insurers’ general accounts. Therefore, there are a variety of practices regarding the “geography” of separate account and general account assets supporting RILAs. This flexibility does not impact the core value proposition of the product because the separate account structure does not need to provide unitized values for a RILA, and the flexibility is beneficial because it allows insurers to take the approach that they determine can deliver the product most efficiently to the market. We recognize that the details of separate account operations are not the focus of the Exposure, but this topic is relevant to the dialog, and we want to underscore the importance that unintended interpretation of provisions in an AG focused on Interim Values does not result in restrictions in other areas.

The Proposal

As noted above, in our opinion, critical changes need to be made to the Exposure to make it workable. The attached Proposal builds upon the Exposure but reflects certain important changes to the Principles and Text sections. Certain terms have been added to the Definitions section that relate to the revised Text. Clarifying statements and changes also have been made to the Background and Scope sections.

The fundamental starting point is the principles that should govern RILA/ILVA Interim Values. The Proposal is built on a core principle with which everyone agrees: any methodology employed to calculate Interim Values must provide equity to both contract holders (whether persisting or terminating) and the company based on the risks assumed during an Index Term. This closely tracks the first principle in the Exposure. However, because RILAs are not unit-linked, Interim Value mechanics are integrated with other asset/liability risk management considerations. The Proposal recognizes that a range of approaches can be taken to maintain equity with these considerations in mind. Additionally, for the reasons noted previously, any AG under Model 250 needs to recognize that RILAs are fundamentally spread-based products and that insurers employ a variety of practices with respect to where assets supporting the products are maintained. For this reason, it is both too simplistic and too restrictive to further define equity to mean that Interim Values must approximate the actual market values of the separate account assets as the Exposure does.

Instead, as reflected in the Proposal, the relationship between contract benefits and the value of derivative instruments that can be used to replicate index credits demonstrates the necessary conditions for RILAs to be treated as variable annuities under Model 250. Therefore, the second principle set forth in the Proposal recites that there may exist a hypothetical portfolio of derivative assets that is designed to replicate the index credits provided by an Index Strategy at the end of an Index Term. The third principle is that the Interim Value must demonstrate a relationship between the value of that hypothetical derivative portfolio and the contract benefits over the course of an Index Term, and further that this relationship should be materially consistent in a variety of economic environments.

The Text section in the Proposal builds upon these three principles. It begins by expressly acknowledging that Interim Values can be determined using multiple methods so long as the method used is consistent with the principles. It then references and summarizes two example methods that generally correspond to methods currently in the marketplace. The summaries of those two methods are intended to provide a safe harbor for Interim Value methods corresponding to what is described.
Illustrative Examples

To supplement the proposed revisions to the Actuarial Guideline, we have constructed several illustrative examples. The attached Excel file ("ACLI and CAI Interim Value Demonstrations 1-27-22.xlsx") provides a detailed explanation of the analysis. These examples are intended to highlight the previously mentioned technical concerns about the Exposure and how the Proposal improves the alignment between key product manufacturing concepts and the framework for Interim Values. We’d like to focus in particular on the following observations:

- Because RILAs are manufactured as spread-based products, the insurer’s fixed income investment horizon is often longer than the term of the index-linked crediting strategies. The option budget available to determine the crediting parameters (cap rate, participation rate, etc.) is a function of the yield earned on these fixed income assets and the target spread determined by the insurer. Our concern is that the conditions outlined in the Exposure regarding the value of the Fixed Income Asset Proxy are inconsistent with this reality. To achieve a conceptually similar outcome that produces a more intuitive emergence of Interim Values, the Proposal provides an alternative framework that focuses on amortization of the option budget rather than the accrual of a hypothetical zero-coupon bond.

- The Excel file also includes an example comparing the determination of the option budget for a hypothetical RILA under spread-based and fee-based manufacturing models. This example demonstrates that the spread-based approach has the potential to deliver better customer value through both a higher option budget and the absence of a fee assessed against the account value. This is not meant to be an exhaustive comparison of different product designs, but reinforces the importance of aligning the Interim Value framework with the core principles used to manufacture RILA products.

- In addition to highlighting the technical concerns with the Exposure, the examples provide illustrative Interim Values under both Method 1 and Method 2 from the Proposal. A range of economic scenarios are pre-populated in the Excel file, and the results can be compared in both tabular and graphical formats. While there are differences in the calculation mechanics between Method 1 and Method 2, the examples show that they provide a similar emergence of Interim Values. This also reinforces the concept that even though Method 2 does not involve a direct valuation of derivative assets, the value of the Derivative Asset Proxy and the Interim Value are materially consistent in a variety of economic environments.

Conclusion

The ACLI and the CAI appreciate the opportunity to comment on the Exposure. We stand ready to help the Subgroup achieve its goals while also working to ensure that our members can continue to effectively serve the investment and retirement needs of their customers with innovative RILA products that offer attractive benefits and protections. It is in that spirit that we urge the Subgroup to carefully consider the Proposal and our request that it be exposed for public review and comment. We look forward to continued collaboration with the Subgroup to develop guidance to satisfy our shared objective of equity to both contract holders and insurers in the design and administration of RILA/ILVA products.

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4 As noted in the Excel file, some RILAs include explicit fees that are used to increase the insurer’s option budget. These products are still fundamentally spread-based and are manufactured differently than conventional unit-linked variable annuities.
Respectfully submitted,

AMERICAN COUNCIL OF LIFE INSURERS (ACLI)

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COMMITTEE OF ANNUITY INSURERS (CAI)
For the Committee of Annuity Insurers, By:

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Proposed Actuarial Guideline from the American Council of Life Insurers (ACLI) and the Committee of Annuity Insurers (CAI) (January 27, 2022)

Actuarial Guideline ILVA
The Application of Model 250 to Variable Products Supported by Non-Unitized Separate Accounts

Background

Variable annuities are exempted from the scope of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities. The Model does not define the term "variable annuity". NAIC Model 250, Variable Annuity Model Regulation, provides requirements for nonforfeiture benefits for those variable annuities defined as "contracts that provide for annuity benefits that vary according to the investment experience of a separate account or accounts maintained by the insurer as to the policy or contract."

Section 7B of Model 250 provides that "to the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account" the contract shall satisfy the requirements of Model 805.

The application of the Model 250 to a traditional variable annuity with unit-linked values is straightforward. The unit-linked feature provides an automatic linkage between annuity values and the investment experience of a separate account. Market values of the separate account assets are the basis of contractual benefits, including surrender values.

In recent years, a number of insurers have introduced new annuity products with index-linked crediting features. Credits are based on the performance of an index, subject to the limits of certain parameters (cap rates, participation rates, etc.) when the index return is positive, and a level of downside protection when the index return is negative. These annuity products are not unit-linked and do not invest in the underlying indices whose performance forms the basis for the index-linked credits. However, derivative instruments can be used to replicate the index-linked credits. Changes in the values of these derivative instruments over the course of a crediting period can create an indirect relationship between asset values and annuity benefits.

There is no established terminology for these annuity products. These products go by several names, including hybrid annuities, structured annuities, registered index-linked annuities, or index-linked variable annuities, among others. This guideline refers to them as index-linked variable annuities (ILVA).

The fact that ILVA products are not unit-linked means they don't have values determined by the market values of the underlying assets. They provide a structure instead where underlying assets held by the insurer will be managed to ensure that contractual liabilities can be satisfied. During an indexed crediting term, they provide interim values defined by contractual provisions to account for withdrawals, death benefits, etc. that may occur during an index term.
ILVA products are registered with the SEC because they are subject to the Securities Act of 1933, but they are not considered variable annuities under the Investment Act of 1940 because they do not provide a pass-through of separate account investment experience. As stated previously, a variable annuity under Model 250 means a policy or contract that provides annuity benefits that vary according to the investment experience of a separate account or accounts managed by the company for policies and contracts. Model 250 by its terms does not require that:

1. Annuity benefits vary directly with, or reflect a pass-through of, the investment experience of a separate account or accounts (i.e., daily unit-linked values), or
2. Assets be invested to perfectly replicate index credits provided.

The purpose of this guideline is to clarify the application of Models 805 and 250 to ILVAs. Specifically, the guideline provides conditions under which a non-unit-linked product can be considered to provide annuity benefits that vary according to the investment experience of a separate account, and therefore meet the requirements of a variable annuity under Model 250 and be exempt from Model 805.

Scope

This guideline applies to any annuity contract exempt from Model 805 and subject to Model 250, on the basis that it is variable and that it is not unit-linked. This guideline is not meant to clarify Model 255 (Modified Guaranteed Annuity Model Regulation) and does not exclude ILVAs from qualifying under Model 255.

This guidance applies to index-linked crediting features that are provided through contracts or policies supported by an underlying non-unit-linked separate account(s) (with or without unit-linked subaccounts) or contracts or policies added to such by rider, endorsement, or amendment. This guidance applies to both insulated and non-insulated separate account products.

This guideline does not apply to products subject to the requirements of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities.

Definitions

“Interim Value” means the value, attributable to one or more index options, used in determining contractual values such as the death benefit, transfer amount, withdrawal amount, annuitization amount or surrender value at any time other than the start date and end date of an index term.

“Index Strategy” means a method used to determine index credits with a specified index or indices and cap, trigger, contingent yield, buffer, barrier, floor, participation rate, spread, fee, margin or other index crediting elements.

“Index Option Base” means the well-defined base value in an index option on any date. This value reflects any Index Strategy allocations at the start of the Index Term, adjusted for any subsequent transaction activity (withdrawals, fee deductions, index credits, etc.).
"Index Term" means the period of time from the term start date to the term end date. A term may end due to contract holder actions or product features (e.g., a specified end date, a “lock-in” feature, etc.).

“Derivative Asset Proxy” means a package of hypothetical derivative assets designed to replicate index credits provided by an Index Strategy at the end of an Index Term.

“Interest Rate MVA” means a market value adjustment that reflects the change in the market value of hypothetical fixed income assets due to interest rate and/or credit spread movements, as well as investment and reinvestment risk.

**Principles**

This guideline is based on the following principles:

1. The Interim Value methodology must provide equity to both the contract holder and the company based upon the risks assumed during an Index Term.
2. There may exist a hypothetical portfolio of derivative assets designed to replicate the index credits provided by an Index Strategy at the end of an Index Term.
3. The Interim Value methodology must demonstrate a relationship between the value of the hypothetical portfolio of derivative assets and the contract benefits over the course of an Index Term. This relationship should be materially consistent in a variety of economic environments.

**Text**

Interim values can be determined using multiple methods. Two potential methods consistent with the above principles are described below. Other methods can be used provided that consistency with the principles can be demonstrated.

**Example Method 1**

In the first method, the Interim Value is based on the value of the derivative assets designed to replicate index credits at the end of the Index Term, as represented by the market value of the Derivative Asset Proxy. Because the initial cost to purchase the derivative assets represents a fixed cost to hedge a benefit provided at the end of the Index Term, the initial value of the Derivative Asset Proxy may be amortized over the length of the Index Term.

The Interim Value (without accounting for any applicable Interest Rate MVA) at any time during an Index Term is the Index Option Base, plus the current value of the Derivative Asset Proxy, less the unamortized initial value of the Derivative Asset Proxy. Note that many reasonable methods exist to amortize the initial value of the Derivative Asset Proxy. Examples include (but are not limited to):

1. Linear amortization over the Index Term
2. Accrual of a zero-coupon bond yield over the Index Term
Assumptions used to value the Derivative Asset Proxy may include implied volatility, risk-free rate, dividend yield, and other parameters required for the valuation method of the derivatives. These assumptions:

1. Must be supported by market prices of the underlying derivative instruments at the start of the Index Term. If well-defined market prices and/or closed form valuation models do not currently exist due to the nature of the Index Strategy, then the method for estimating must be described in the Actuarial Memorandum;
2. May be static throughout the Index Term or may be dynamic. If dynamic assumptions are used, the assumptions must be based on market prices or estimated values of the Derivative Asset Proxy at the time of valuation;
3. May include provisions for frictional costs (transaction costs, bid/ask spread, etc.) that impact the value of the Derivative Asset Proxy if exited prior to the end of the Index Term.

The Interim Value may also include an Interest Rate MVA and/or other provisions to manage risks and costs of exiting before the end of the Index Term, such as a pro-rata ceiling limit.

On the term end date, the Interim Value (without accounting for any applicable Interest Rate MVA) must equal the Index Option Base (including index credits).

**Example Method 2**

The second Interim Value method approximates the value of the Derivative Asset Proxy and defines the Interim Value during an Index Term in a transparent and simple fashion based on index performance, the crediting parameters for a given Index Strategy, and the time elapsed in the Index Term. It provides accrual from the initial Index Option Base to the Index Option Base plus the intrinsic value of the Derivative Asset Proxy. The Interim Value will generally move with the value of the derivative assets designed to replicate index credits at the end of the Index Term.

Under this method:

1. On the term end date, the Interim Value (without accounting for any applicable Interest Rate MVA) must equal the Index Option Base (including index credits).
2. During the Index Term, the Interim Value (without accounting for any applicable Interest Rate MVA) must grade into the upside crediting potential (cap rate, participation rate, etc.) and the downside protection (buffer protection, floor protection, etc.) at least as quickly as linearly.

**Certifications**

The company (or actuary) must describe the Interim Value methodology and the assumptions used to calculate its value at any time. The company must provide an actuary's certification that the provisions of this guideline are being met.
Scholes

The firm of Scholes Limited has made an in-depth study of the potential market for a new product and intends to offer a comprehensive range of options for marketing and distribution.

The financial analysis indicates that the potential market for the new product is extensive, with a significant number of consumers expressing interest in the product.

In conclusion, the firm of Scholes Limited is confident that the new product will be well-received by the market and that it will be profitable for the firm to invest in its development and marketing.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
APF to fix language that is hard to follow.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document
where the amendment is proposed:

Section 3.F.9.h.ii
January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify
the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the
verbiage. (You may do this through an attachment.)

VM-31 Section 3.F.9.h.ii:
ii. Documentation that the implied volatility scenarios generated do not result in a lower TAR than that obtained by
assuming that the implied volatility – at all ITM levels – at a given time step in a given scenario is equal to the realized
volatility of the underlying asset scenario over the same time period as required by VM-21 Section 8.D.3.

For a company not using the safe harbor described in Section 9.B.5, any implied volatility scenarios generated using
a non-prescribed scenario generator shall not result in a TAR less than that obtained by assuming that the implied
volatility level – at all ITM levels – at a given time step in a given scenario is equal to the realized volatility of the
underlying asset scenario over the same time period. In other words, the TAR shall not be reduced by
assumptions of any realizable spread between implied volatility and realized volatility. For the
purposes of demonstrating compliance with this standard, a company may rely on only the
values from the stochastic calculations and exclude impacts from the additional
standard projection and the alternative methodology.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

VM-31 Section 3.F.9.h.ii: Sentence is confusing and doesn’t make sense grammatically. Revised based on the parallel
language in VM-21, which this VM-31 reporting item is intended to verify:

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by
the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

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Notes: APF 2022-02

© 2022 National Association of Insurance Commissioners 1
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
General cleanup, including updating cross-references, better consistency between VM-20 and VM-21, where reasonable, and making clarifying edits:

1. **Update cross-references:** Add a reference to the newly added VM-21 Section 12 (general assumption setting) alongside the reference to Section 10 in the Guidance Note after Principle 3 in VM-21.

2. **Update cross-references:** Existing section references are too general to be useful for the asset spread assumptions discussed in VM-21 Section 4.D.4.a.iii and 4.D.4.a.iv.

3. **VM-20/VM-21 Consistency:** VM-21 Sections 4.D.5.a and 4.D.5.b should be made consistent with VM-20; new Sections 4.D.5.c and 4.D.5.d were also added to be consistent with VM-20 where appropriate.

4. **Clarifying Edits:** Avoid the SPA partial withdrawal assumptions from requiring modeling less than the RMD amount for tax qualified contracts with ages greater than or equal to the RMD age in VM-21 Section 6.C.4.

5. **Update cross-references:** Correct section reference errors in VM-21 Sections 6.C.4 and 6.C.5.

6. **Clarifying Edits:** Revenue sharing income assumption requirements need clarification, and language needs cleaning up in VM-20, VM-21, and VM-31.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

   Issue 1: VM-21 Section 1.B
   Issue 3: VM-21 Section 4.D.5
   Issue 4: VM-21 Section 6.C.4
   Issue 5: VM-21 Section 6.C.4 and 6.C.5

January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

   See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
1. Add a reference to the newly added Section 12 (general assumption setting Section 12 added by APF 2021-11 for the 2023 Valuation Manual) alongside the reference to Section 10 in the Guidance Note after Principle 3.


4. The current SPA partial withdrawals assumption does not consider the RMD requirement for tax qualified contracts with ages greater than or equal to the federal RMD age. Some companies assumed this was intended to be reflected, but it should be clarified in VM-21.


6. Both VM-20 and VM-21 need to clarify that the haircut prescribed for the non-contractually guaranteed revenue sharing is only a guardrail which is neither redundant to nor a substitution for the margin determination requirements of VM-20 Section 9.G.6 and VM-21 Section 4.F.5.c. Two guidance notes from VM-20 should be added to VM-21 for appropriate consistency. The reporting requirement language which is already in VM-31 should be removed from VM-20 and the reporting requirement in VM-31 is augmented and clarified.

VM-21 Section 1.B (Guidance Note after Principle 3)

**Guidance Note:** The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 4.D.4.a.iii and Section 4.D.4.a.iv

iii. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in VM-20 Section 9.F.8.a through Section 9.F.8.c. (For purposes of this subsection, “public” incorporates both registered and 144a securities.) The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F.8.d for interest rate swap spreads;

VM-21 Section 4.D.5

5. Cash Flows from Invested Assets
   a. Cash flows from general account fixed income assets and derivative asset programs associated with these assets, including starting and reinvestment assets, shall be reflected in the projection as follows:
      i. Model gross investment income and principal repayments in accordance with the contractual provisions of each asset and in a manner consistent with each scenario. Grouping of assets is allowed if the company can demonstrate that grouping does not materially underestimate the modeled reserve that would have been obtained using a seriatim approach.
ii. Reflect asset default costs as prescribed in VM-20 Section 9.F and anticipated investment expenses through deductions to the gross investment income.
iii. Model the proceeds arising from modeled asset sales and determine the portion representing any realized capital gains and losses.
iv. Reflect any uncertainty in the timing and amounts of asset cash flows related to the paths of interest rates, equity returns or other economic values directly in the projection of asset cash flows. Asset defaults are not subject to this requirement, since asset default assumptions must be determined by the prescribed method in VM-20 Section 9.F.

b. Cash flows from general account equity assets—i.e., non-fixed income assets having substantial volatility of returns, such as common stocks and real estate—and derivative asset programs associated with these assets, including starting and reinvestment assets, shall be reflected in the projection as follows:
   i. Determine the grouping for asset categories and the allocation of specific assets to each category in a manner that is consistent with that used for separate account assets, as discussed in Section 4.A.2.
   ii. Project the gross investment return including realized and unrealized capital gains in a manner that is consistent with the stochastically generated scenarios.
   iii. Model the timing of an asset sale in a manner that is consistent with the investment policy of the company for that type of asset. Reflect expenses through a deduction to the gross investment return using prudent estimate assumptions.

c. Determine cash flows for each projection interval for all other general account assets by modeling asset cash flows on other assets that are not described in Sections 4.D.5.a and 4.D.5.b using methods consistent with the methods described in Sections 4.D.5.a and 4.D.5.b. This includes assets that are a hybrid of fixed income and equity investments.
d. Determine cash flows or total investment returns as appropriate for each projection interval for all separate account assets as follows:
   i. Determine the grouping for each variable fund and subaccount (e.g., bonds funds, large cap stocks, international stocks, owned real estate, etc.) as described in Section 4.A.2.
   ii. Project the total investment return for each variable fund and subaccount in a manner that is consistent with the prescribed returns described in Section 4.A.2 and Section 8.C.3.

VM-21 Section 6.C.4 (Intro)

4. Partial Withdrawals

Partial withdrawals required contractually or previously elected (e.g., a contract operating under an automatic withdrawal provision, or that has voluntarily enrolled in an automatic withdrawal program, on the valuation date) are to be deducted from the Account Value in each projection interval consistent with the projection frequency used, as described in Section 4.F, and according to the terms of the contract. However, if a GMWB or hybrid GMIB contract’s automatic withdrawals results in partial withdrawal amounts in excess of the GMWB’s guaranteed maximum annual withdrawal amount or the maximum amount above which withdrawals reduce the GMIB basis by the same dollar amount as the withdrawal amount (the “dollar-for-dollar maximum withdrawal amount”), such automatic withdrawals shall be revised such that they equal the GMWB’s guaranteed maximum annual withdrawal amount or the GMIB’s dollar-for-dollar maximum withdrawal amount. However, for tax qualified contracts with ages greater than or equal to the federal RMD age, if the prescribed withdrawal amount is below the RMD amount, the withdrawal amount may be reset to the RMD amount.

Guidance Note: Companies are expected to model withdrawal amounts consistent with the RMD amount where applicable and where practically feasible; however, it is understood that this level of modeling sophistication may not be available for all companies.
For any contract not on an automatic withdrawal provision as described in the preceding paragraph, depending on the guaranteed benefit type, other partial withdrawals shall be projected as follows but shall not exceed the free partial withdrawal amount above which surrender charges are incurred and may be floored at the RMD amount for tax qualified contracts with ages greater than or equal to the federal RMD age:

**VM-21 Section 6.C.5**

5. Withdrawal Delay Cohort Method

To model the initial withdrawal for certain GMWBs and hybrid GMIBs as discussed in Sections 6.C.4.h and 6.C.4.j, the actuary shall adopt a modeling approach whereby a contract is split into several copies (referred to as "cohorts"), each of which is subsequently modeled as a separate contract with a different initial withdrawal period. The contract Account Value, bases for guaranteed benefits, and other applicable characteristics shall be allocated across the cohorts based on different weights that are determined using the method discussed below in this section.

**VM-21 Section 4.A.5.f**

1. The amount of net revenue-sharing income assumed in a given scenario shall be applied with a margin to reflect any uncertainty but shall not exceed the sum of (i) and (ii), where:
   
   i. Is the contractually guaranteed net revenue-sharing income projected under the scenario; and
   
   ii. Is the company’s estimate of non-contractually guaranteed net revenue-sharing income before reflecting any margins for uncertainty multiplied by the following factors:

   - 1.00 in the first projection year.
   - 0.95 in the second projection year.
   - 0.90 in the third projection year.
   - 0.85 in the fourth projection year.
   - 0.80 in the fifth and all subsequent projection years.

   **Guidance Note:** Provisions such as one that gives the entity paying the revenue-sharing income the option to stop or change the level of income paid would prevent the income from being guaranteed. However, if such an option becomes available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed up to the time the option first becomes available.
7. The company is responsible for reviewing the revenue-sharing agreements that apply to that group of policies and verifying compliance with these requirements.

8. The amount of net revenue-sharing income assumed in a given scenario shall be applied with a margin to reflect any uncertainty but shall not exceed the sum of (a) and (b), where:
   a. Is the contractually guaranteed GRSI, net of applicable expenses, projected under the scenario.
   b. Is the company’s estimate of non-contractually guaranteed net revenue-sharing income before reflecting any margins for uncertainty multiplied by the following factors:

VM-31 Section 3.D.7.c

c. Revenue-Sharing Margins – The level of margin in the prudent estimate assumptions for revenue-sharing income and description of the rationale for the margin for uncertainty. Also, a demonstration that the amounts of net revenue-sharing income, after reflecting margins, do not exceed the limits set forth in VM-20 Section 9.G.8.

VM-31 Section 3.F.7.c

c. Revenue-Sharing Margins – The level of margin in the prudent estimate assumptions for revenue-sharing income and a description of the rationale for the margin for uncertainty. Also, a demonstration that the amounts of net revenue-sharing income, after reflecting margins, do not exceed the limits set forth in VM-21 Section 4.A.5.f.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:
Hedging Drafting Group of LATF

Title of the Issue:
Reflect all future hedging strategies in VM-20 and VM-21. Revise hedge modeling to increase E factor (VM-21) or residual risk (VM-20) when future hedging strategies are not clearly defined.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

2. Add a definition for “future hedging strategy,” consistent with the definition for CDHS and the current VM-01 definition of “derivative program”, which VM-01 notes includes hedging programs.
3. Add a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology.
4. Reflect all of a company’s future hedging strategies, but reflect the additional error (VM-21) or residual risk (VM-20) that is presented by a future hedging strategy not being clearly defined.
5. Remove optionality for liquidating currently held hedges (despite liquidation not being a part of the company investment strategy) if not modeling a future hedging strategy.
6. New hedging strategies (<6 months experience) have an E factor of 1.0 for VM-21. For comparison, the current draft VM-22 only allows modeling hedges after they have been in place for 6 months. When only CDHS were modeled in VM-21, new hedging strategies with no experience had E factors as low as 0.5 even without meaningful analysis. This treatment was much too lenient for new hedging strategies.
* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

W:\National Meetings\2010\TF\LHA\
The term “clearly defined hedging strategy” (CDHS) means a future hedging strategy for which the following attributes are clearly documented:

a. The specific risks being hedged (e.g., cash flow, fee income, policy interest credits, delta, rho, vega, etc.).
b. The hedging objectives.
c. The material risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
d. The financial instruments used to hedge the risks.
e. The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.
f. The metrics, criteria, and frequency for measuring hedging effectiveness.
g. The conditions under which hedging will not take place and for how long the lack of hedging can persist.
h. The group or area, including whether internal or external, responsible for implementing the hedging strategy.
i. Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
j. The circumstances under which hedging strategy will not be effective in hedging the risks.

Guidance Note: For purposes of the CDHS documented attributes, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

The term “future hedging strategy” is a derivative program undertaken by a company to manage risks through one or more future hedging transactions, including the future purchase or sale of hedging instruments and the opening and closing of hedging positions.

A future hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as a future hedging strategy.

The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:

a. The risk of a change in the fair value, the value on a statutory, GAAP, or other basis, or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more future hedging strategies supporting the policies, from SR requirements, except in the case where all future hedging strategies supporting the policies are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the policies are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the DR and the SR, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of future hedging strategies supporting the policies, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For future hedging strategies supporting the policies, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation. VM-21 Section 1.B Principle 5 applies as a general principle for the modeling of future hedging strategies.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the SR as described in Section 5.E.
4. In circumstances where documentation outlining the future hedging strategies is incomplete, the company shall reflect the future hedging strategies not being clearly defined by increasing the SR as described in Section 5.E. To support no increase to the SR, there should be very robust documentation outlining each future hedging strategy. In particular, the SR shall be at least as great as the SR that would result if a future hedging strategy were not reflected in the SR, if the documentation is materially incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the SR to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the SR pursuant to Section 7.K.3 above.

Guidance Note: Section 5.E requires that the company “Determine any additional amount needed to capture any material risk included in the scope of these requirements but not already reflected in the cash-flow models using an appropriate and supportable method and supporting rationale.” In the case of a derivative program that is a future hedging strategy, Section 7.K.3 requires such an increase for disconnects between the hedge modeling and the future hedging strategy, while Section 7.K.4 requires such an increase for disconnects between the loosely defined future hedging strategy and what may actually take place.

VM-20 Section 7.L (Remove entire Section 7.L)

VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges

a. For a company that does not have a future hedging strategy supporting the contracts:

i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.

ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.

b. For a company with one or more future hedging strategies supporting the contracts, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

Deleted: L. Clearly Defined Hedging Strategy

A clearly defined hedging strategy must identify:

- The specific risks being hedged (e.g., cash flow, policy interest rate, etc.)
- The hedge objectives
- The hedge trading rules, including the permitted tolerances from hedging objectives
- The metrics for measuring hedging effectiveness
- The criteria used to measure hedging effectiveness
- The frequency of measuring hedging effectiveness
- The conditions under which hedging will not take place
- The person or persons responsible for implementing the hedging strategy
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified
- The circumstances under which hedging strategy will not be effective in hedging the risks
- Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 16—Derivatives in the AP&P Manual.

Deleted: The term “clearly defined hedging strategy” (CDHS) is defined in VM-01. In order to be designated as a CDHS, the strategy must meet the principles outlined in Section 1.B (particularly Principle 3) and shall, at a minimum, identify:

- The specific risks being hedged (e.g., delta, rho, vega, etc.)
- The hedge objectives
- The risks not being hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.)
- The financial instruments used to hedge the risks
- The hedge trading rules, including the permitted tolerances from hedging objectives
- The metrics for measuring hedging effectiveness
- The criteria used to measure hedging effectiveness
- The frequency of measuring hedging effectiveness
- The conditions under which hedging will not take place
- The person or persons responsible for implementing the hedging strategy

Deleted: O. Measurement of Hedging Effectiveness

The measurement of hedging effectiveness shall be determined in a manner that is appropriate for the specific hedging strategies involved. The measurement period shall reflect the time horizon of the hedging strategy, and the measurement method shall consider the specific risks being hedged.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements is not a clearly defined hedging strategy.

Deleted: The measurement of hedging effectiveness for purposes of this guidance shall be determined in a manner as defined in SSAP No. 16—Derivatives in the AP&P Manual.
ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 (“best efforts”) representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 (“adjusted”) which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor (E) determined following the guidance of Section 9.C.4.

iii. The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

VM-21 Section 4.D.4.b

Notwithstanding the above requirements, the SR shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the contracts are not affected by this requirement.

VM-21 Section 6.B.3.a.ii - Footnote (Footnote at Bottom of Page 21-23)

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the SR for a company that does not have a future hedging strategy supporting the contracts as discussed in Section 4.A.4.a.

VM-21 Section 6.B.3.b.ii

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as SR following Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

VM-21 Section 6.B.5
Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a future hedging strategy supporting the contracts.

**VM-21 Section 9**

**Section 9: Modeling of Hedges under a Future Hedging Strategy**

**A. Initial Considerations**

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more future hedging strategies supporting the contracts, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the SR using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

**B. Modeling Approaches**

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in an increase in the amount of the SR otherwise calculated. Particular attention should be given to VM-21 Section 1.B Principle 5 for the modeling of future hedging strategies.
2. The fundamental characteristic of the first type of method, referred to as the "explicit method," is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the "implicit method," is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the SR otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the SR needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the SR attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the "Greeks" other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

5. A safe harbor approach is permitted for reflection of future hedging strategies supporting the contracts for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio.

C. Calculation of SR (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the future hedging strategies supporting the contracts (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the future hedging strategies supporting the contracts (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts, therefore following the requirements of Section 4.A.4.a.
3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the SR is given by:

\[ \text{SR} = \text{CTE70 (best efforts)} + E \times \max[0, \text{CTE70 (adjusted)} – \text{CTE70 (best efforts)}] \]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:

   a. For companies that model hedge cash flows directly ("explicit method"), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g., reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

   To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The company may also support the choice of a low value of \( E \) by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

   b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

      i. Determine the hedge asset gains and losses—both realized and unrealized—incurred over the month attributable to equity, interest rate, and implied volatility movements.

      ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

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iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80–125%) consistently across the back-testing period.

vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

7. A company that does not have 12 months of experience to date shall set E to a value that reflects the amount of experience available, and the degree and nature of any change to the hedge program. For a material change in strategy, with less than 6 months of history, E should be 1.0. However, E may be lower than 1.0 if at least 6 months of reliable experience is available and/or if the change in strategy is a minor refinement rather than a material change in strategy.

The following examples are provided as guidance for determining the E factor when there has been a change to the hedge program:

- The error factor should be temporarily 100% for material changes in hedge methodology (e.g., moving from a fair-value based strategy to a stop-loss strategy).

- An increase in the error factor may not always be needed for minor refinements to the hedge strategy (e.g., moving from swaps to Treasury futures).

8. The company shall set the value of E reflecting the extent to which the hedging program is clearly defined. To support a value of E below 1.0, there should be very robust documentation outlining all future hedging strategies. To the extent that documentation outlining any of the future hedging strategies is incomplete, the value of E shall be increased. In particular, the value of E shall be 1.0 if documentation is materially incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the value of E to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the value of E to reflect a lack of historical experience or to reflect the back-testing results, subject to an overall ceiling of 1.0 for E.

D. Additional Considerations for CTE70 (best efforts)
If the company is following one or more future hedging strategies supporting the contracts, the fair value of the portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70 (best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted), the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the SR and fair value calculations shall be done without requiring the scenario reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of the current hedging strategy (including currently held hedge positions) for purposes of reducing the SR, the company should review actual historical hedging effectiveness. The company shall evaluate the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, the mix of business and other items that are likely to result in materially adverse results. This includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the SR, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:

   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the SR otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

VM-31 Section 3.C.5

Assets and Risk Management – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any future hedging strategies supporting the policies, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.D.6.f

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the policies and any adjustments to the SR pursuant to VM-20 Section 7.K.1 and VM-20 Section 7.K.2, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. Documentation of any future hedging strategies should include documentation addressing each of the CDHS documentation attributes.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any future hedging strategies supporting the policies, is representative of and consistent with the company’s investment policy and that documentation of the CDHS attributes for any future hedging strategies supporting the policies are accurate.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the policies is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5
Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any future hedging strategies supporting the contracts, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the contracts, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
   iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation addressing each of the CDHS documentation attributes for any future hedging strategies supporting the contracts.

b. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

d. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a future hedging strategy supporting the contracts, confirmation that currently held hedge assets were included in the starting assets.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. Discussion of the projection horizon for the future hedge strategy as modeled and a comparison to the timeline for any anticipated future changes in the company’s hedge strategy.
   v. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   vi. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the SR, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vii. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   viii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the SR.
   ix. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges.
e. Error Factor (E) and Back-Testing – Description of E, the error factor, and formal back-tests performed, including:
   i. The value of E, and the approach and rationale for the value of E used in the reserve calculation.
   ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-test showing that the model is able to replicate the hedging results experienced in a way that justifies the value used for E. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.
   iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
       a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
       b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.
   iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for E.
   v. For companies that do not have 12 months of experience, the basis for the value of E that is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available and the degree and nature of any changes made to the hedge strategy.
   vi. The basis for the magnitude of adjustment or lack of adjustment for the value of E chosen based on the robustness of the documentation outlining the future hedging strategy.

f. Safe Harbor for Future Hedging Strategies – If electing the safe harbor approach for a future hedging strategy supporting the contracts, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

g. Hedge Model Results – Disclosure of whether the calculated CTE 70 (best efforts) is below both the fair value and CTE 70 (adjusted), and if so, justification for why that result is reasonable, as discussed in VM-21 Section 9.D.

VM-31 Section 3.F.12.c

CTEPA – If using the CTEPA method, a summary including:
   i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

   ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account
value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the SR.

VM-31 Section 3.F.16.a and Section 3.F.16.b

a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any future hedging strategies supporting the contracts, is consistent with the company’s current investment strategy except where the modeled investment strategy may have been substituted with the alternative investment strategy, and that documentation of the CDHS attributes for any future hedging strategies supporting the contracts are accurate.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the contracts is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
March 23, 2022

Mr. Mike Boerner
Chair
National Association of Insurance Commissioners (NAIC)
Life Actuarial Task Force (LATF)

Re: APF 2020-12; Hedging strategies in VM-20 and VM-21

Dear Mr. Boerner,

The American Academy of Actuaries\(^1\) Life Valuation Committee (LVC) appreciates the opportunity to provide comments on APF 2020-12 regarding hedging in VM-20 and VM-21.

As various Academy Life Practice Council (LPC) groups have stated in the past, the LVC believes companies should model their investment strategies as part of a principle-based reserve calculation, which includes the modeling of hedging activities. With respect to VM-21, the LPC/LVC recommends that a principle-based approach for hedges that applies margins for modeling and strategy risks be adopted. This eliminates the need for VM-21 metrics such as conditional tail expectation (CTE) 70 (adjusted) and the error “E” factor that results in questionable measurements of the error/residual risk margin for hedging strategies.

Additionally, the LVC does not believe the concept of a clearly defined hedging strategy (CDHS) or “future hedging strategy” definition is needed in a principle-based approach. However, we understand that the NAIC may wish to incorporate guardrails that would highlight the necessity for companies to reflect higher margins for certain hedging strategies.

Below are additional comments and recommendations for three of the stated reasons contained in the proposal.

1. **Reflect all of a company’s future hedging strategies but reflect the additional error (VM-21) or residual risk (VM-20) that is presented by a future hedging strategy not being clearly defined.**

   The LVC agrees that companies should be required to model their hedging strategies and recommends that a more principle-based approach (conceptually similar to the current VM-20) in determining the margin for error/residual risk be incorporated in VM-21.

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
The VM-21 approach currently uses a weighted average of CTE70 (best efforts) and CTE70 (adjusted) to determine an error/residual margin. CTE70 (adjusted) is determined by only using hedge assets held by the company as of the valuation date. It assumes the investment strategy for such hedge assets is to runoff the assets or to convert them to cash/other general account assets. Neither of these options may be representative of the company’s actual hedging policy. A metric that does not reflect a company’s investment policy is not principle-based and is less likely to properly reflect the error/residual risk one is trying to measure. Additionally, we note that if CTE70 (adjusted) is less than CTE70 (best efforts), the error/residual risk is assumed to be $0. This is also not principle-based and fails to properly measure the underlying risk. In order to properly measure the underlying risk, companies should model their investment strategy (CTE70 best efforts) and then apply an appropriate level of margin.

A VM-20-like principle-based approach to modeling hedge cash flows is consistent with how other cash flows are projected; margins are added to best estimate cash flows with the level of such margins based on the confidence in the modeling of the cash flows. Such an approach avoids issues associated with trying to bifurcate hedging between in force and future hedges or multiple hedging strategies. It also eliminates the current lack of a margin when CTE70 (adjusted) is less than CTE70 (best efforts).

2. **Remove optionality for liquidating currently held hedges (despite liquidation not being a part of the company investment strategy) if not modeling a future hedging strategy.**

The LVC recommends that companies model their investment strategies, with appropriate margins. Companies should not have the option to liquidate currently held hedges as this would not be consistent with their investment strategy. Moving to a VM-20-like principle-based approach in the modeling of hedges would remove the need for this option.

3. **New hedging strategies (<6 months experience) have an E factor of 1.0 for VM-21. For comparison, the current draft VM-22 only allows modeling hedges after they have been in place for 6 months. When only CDHS were modeled in VM-21, new hedging strategies with no experience had E factors as low as 0.5 even without meaningful analysis. This treatment was much too lenient for new hedging strategies.**

The reserve requirement should encourage companies to adopt strategies that serve to reduce risk. Limiting E factors for new hedging strategies can have the unintended effect of discouraging hedging strategies that reduce risk. Adopting the principle-based approach in VM-20 would eliminate the need for an E factor and allow companies to pursue hedging strategies without the potential for an increase in reserve created by artificial limits.

Investment strategies, including hedging strategies, will change over time. These changes may be marginal, such as minor modifications to sector allocations, credit limits, or hedge targets. At other times—such as during changes in a company’s risk appetite—the changes may be more substantial. In either event, changes in strategies should be reflected in the reserves as they are adopted by the company. Redeterminations of the error/residual margin calculations should be required when significant changes occur and be supported by robust simulation testing or other meaningful analysis. Changes should be clearly disclosed with adequate supporting documentation.
Thank you for your consideration of these comments. We would be pleased to answer any questions you may have and to provide additional support as needed. Please feel free to contact Devin Boerm, the Academy’s deputy director of public policy, to arrange for discussion of these comments.

Sincerely,

Craig Morrow
Chairperson, Life Valuation Committee
American Academy of Actuaries

CC: Reggie Mazyck, NAIC
Brian Bayerle  
Senior Actuary  
March 21, 2022  
Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  
Re: APF 2020-12  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments on the re-exposure of APF 2020-12.  

Historically, many carriers have understood the PBR framework to require an insurer to satisfy elevated CDHS criteria for hedging strategies to be included within PBR modeling. This approach was established in consideration of (a) regulator concerns about assuming ongoing future hedging activity, (b) the existence of strategies with non-statutory targets, and (c) modeling challenges associated with the incorporation of hedge cash flows in stochastic models.  

The APF proposes to consider future hedging activity as a form of reinvestment, with CDHS criteria becoming minimum documentation requirements.  

ACLI can potentially support the APF but believes that several improvements are needed, as follows:  

1. A long runway should be provided for implementation;  
2. Provisions for indexed credit derivative programs should be incorporated;  
3. The existing VM-21 E factor guidance for new or substantially modified strategies should be retained;  
4. The CTE70 (adjusted) run in VM-21 should allow companies to use either a run-off or liquidation basis;  
5. The exception within the definition of “future hedging strategy” should be clarified, and time should be given for further industry review; and  
6. Outreach should be conducted to provide assurance that the proposed changes will not reintroduce undesirable incentives that led to the VA reform project.  

Each of these provisions is explained below.  

1. A long runway should be provided for implementation
The APF requires all “future hedging strategies” to be incorporated within PBR models. Implementing this on an explicit basis (or, in VM-21, developing the formal analysis to support an implicit basis), will require advanced modeling and analytical capabilities that some carriers do not currently possess. At present, a company that does not have a CDHS under VM-21 performs a simple run-off or cash-out of existing hedges. For non-PBR purposes such as business planning, stochastic modeling is typically not required, and it is common to layer the effects of hedging on top of modeled cash flows.

The APF will require some carriers to make significant new investments in modeling infrastructure, involving systems, coding, testing, and controls. Some may require external resources. In short, significant lead time would be necessary for this APF to be enacted smoothly and successfully throughout the industry.

We do not believe it is realistic for this APF to take effect prior to the 2024 Valuation Manual. For some carriers, a more expeditious implementation may be possible, but it would be necessary to insert a transition regime to accommodate carriers that need time to develop the necessary modeling infrastructure. An extended implementation runway or transition regime would also aid carriers with capital planning, should the APF have material financial impacts.

2. Provisions for indexed credit derivative programs should be incorporated

ACLI believes that indexed credit derivative programs must be reflected in PBR models to produce a reasonable valuation of indexed products, including IUL and RILAs. These derivative programs are used to support crediting rates, are fundamental to product design, and more closely resemble ALM general account crediting rate investment strategies than GMxB hedging strategies.

The APF, however, can be interpreted as applying a “one size fits all” approach to derivative programs. ACLI disagrees with this philosophy from a proportionality standpoint: it seems appropriate for straightforward derivative payoffs that offset indexed interest credits to merit different treatment relative to dynamic strategies that involve daily trading.

We recommend two modifications. First, the existence of an indexed credit derivative program should not eliminate the ability for a VM-20 product to satisfy the VM-20 stochastic exclusion test, as currently dictated by VM-20, Section 6.A.1.b. We see little reason why VM-20 should always require stochastic modeling for indexed products. If an indexed product, including derivatives, has material interest rate and/or equity price risk, the Stochastic Exclusion Test will still require the calculation of the Stochastic Reserve.

Second, within VM-21, the APF should include an approach similar to the American Academy of Actuaries’ VM-22 proposal that haircuts the returns of indexed credit derivative programs in the Stochastic Reserve and eliminates the CTE70 (adjusted) calculation. In its VM-22 presentation, the American Academy of Actuaries proposed a haircut as low as 1% for indexed products. Although this haircut needs additional calibration, ACLI supports the language and approach used in the VM-22 draft.
These two changes would “right-size” the treatment of indexed credit derivative programs based on the nature and risk of the investment strategy and align treatment across VM sections.

3. **Existing VM-21 E factor guidance for new or substantially modified strategies should be retained**

ACLI supports the principle that VM-21 E factors should be higher when greater uncertainty exists, such as when a new strategy is introduced or when a strategy is not “clearly defined.”

For VM-21 strategies with less than six months of history, the APF, while consolidating the guidance between sections 9.A.7 and 9.C.5, proposes significant increases to the E factors. While we support consolidating the guidance, we do not support the E factor increases.

The APF would require the E factor to be 1.0 for VM-21 CDHS strategies with less than six months of history, effectively establishing the Stochastic Reserve as the maximum of CTE70 (best efforts) and CTE70 (adjusted) for the first six months after the introduction of a new or substantially modified hedging strategy. At present, strategies can have E factors less than 1.0 using at least three months of experience, mock testing, or implementation of the strategy on similar products.

The rigor around a CDHS, as well as VM-G requirements, should alleviate concerns about “window dressing” and eliminate the need for a blanket six-month “waiting period.” In addition, the formation of a hedging strategy is always subject to internal governance, which includes an assessment of the effects of the strategy on multiple frameworks (e.g., GAAP/IFRS, internal economic, liquidity, and tax). In most states, the filing of a derivatives use plan is required. These guardrails mitigate against the possibility of “window dressing”.

We also view mock testing as useful for establishing an E factor and hedging credit during the initial months following the introduction of a new or substantially modified hedging strategy in light of the internal governance that underpins hedging activity. We would support the development of regulatory guidance for mock testing practices, but we would need to better understand regulatory concerns to address the substance of this guidance.

We consider the current E factor guidance for new or substantially modified strategies to be conceptually appropriate. By disallowing specified alternatives for historical experience, the APF requires an E factor of 1.0. Disallowing these alternatives would introduce unrealistic prudence, cliff effects, and volatility, leading to perverse disincentives to hedge or to improve existing strategies. The Task Force should retain the current provisions of VM-21 that allow new strategies to have E factors less than 1.0.

4. **The CTE70 (adjusted) run in VM-21 should allow companies to use either a run-off or liquidation basis**

The APF is unclear regarding the VM-21 CTE70 (adjusted) run, which is used in both the Stochastic Reserve and the Standard Projection Amount. At present, CTE70 (adjusted) is CTE70
“assuming the company has no CDHS, therefore following the requirements of Section 4.A.4.a.” The APF rewrites the first part of this provision to say that CTE70 (adjusted) is CTE70 “assuming the company has no future hedging strategies supporting the contracts,” which implies liquidation. But rewritten Section 4.A.4.a says that “existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets,” which, if anything, implies run-off. The guidance appears contradictory and unclear.

ACLI believes that company optionality is the preferred solution. Because CTE70 (adjusted) is an artificial construct, neither the runoff of in-force hedges nor liquidation is necessarily a good representation of the company’s actual strategy. The more reasonable approach might depend on the nature of the program and the tenor of the derivative instruments used. We recommend that both runoff and liquidation options be permitted, at the discretion of the company.

5. The exception within the definition of “future hedging strategy” should be clarified, and time should be given for further industry review

The APF defines “future hedging strategy” as “a derivative program undertaken by a company to manage risks through one or more future hedging transactions.” The definition includes an exception: “A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as a future hedging strategy.”

This language needs careful consideration, because it defines whether a derivative program is to be subject to or excluded from PBR modeling and documentation requirements. To avoid ambiguity, ACLI recommends the following wording clarifications, followed by additional time for study: “A derivative program undertaken by a company to manage strategy involving the offsetting of the risks associated with products falling under the scope of different requirements of the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as a future hedging strategy.”

6. Outreach should be conducted to provide assurance that the proposed changes will not reintroduce undesirable incentives that led to the VA reform project

The updated variable annuity framework was intended to address drivers of the old framework that led carriers to form captive reinsurers. Oliver Wyman’s discussions with carriers indicated that many captives were intended to address challenges related to hedging. For example, hedging strategies designed to manage financial outcomes under non-statutory frameworks were producing unintuitive outcomes when applied to the statutory reserves and capital. To mitigate these outcomes, major changes were made to AG43/VM-21 and C3P2, and an interest-rate only accounting solution (SSAP 108) was introduced.

The APF proposes to overhaul the treatment of hedging within the new framework. By promoting the reflection of additional hedging within PBR models and including provisions that are not sufficiently principle-based, the APF may exacerbate the challenges that carriers face when
managing to both statutory and non-statutory frameworks. The APF may run the risk of reversing, at least in part, the outcomes of the VA reform project.

It has been our understanding that the Valuation Analysis Working Group had been planning to contact individual carriers to discuss the potential effects of the APF. It is unclear if any carrier has been contacted to date. We urge the Task Force members who are members of VAWG to undertake this outreach prior to finalization of this APF.

Thank you for your consideration,

B Barfeili

cc: Reggie Mazyck, NAIC
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.

**Identification:**
Hedging Drafting Group of LATF

**Title of the Issue:**
Reflect all future hedging strategies in VM-20 and VM-21. Revise hedge modeling to increase E factor (VM-21) or residual risk (VM-20) when future hedging strategies are not clearly defined.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:


January 1, 2022 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

2. Add a definition for “future hedging strategy,” consistent with the definition for CDHS and the current VM-01 definition of “derivative program”, which VM-01 notes includes hedging programs.
3. Add a definition for “hedging transactions,” taken from the APPM but modified slightly to be consistent with Valuation Manual terminology.
4. Reflect all of a company’s future hedging strategies, but reflect the additional error (VM-21) or residual risk (VM-20) that is presented by a future hedging strategy not being clearly defined.
5. Remove optionality for liquidating currently held hedges if the company does not have a future hedging strategy. Language has been added for consideration to keep this optionality for the adjusted run for a company that does have a future hedging strategy (which would not be modeled in the adjusted run), as the drafting group is interested in additional input on this item. A reporting item to disclose the impact of any such liquidation is added, to provide additional regulator comfort if this optionality is included in the final adopted edits.
6. New hedging strategies (those without at least 12 months experience or 3 months of experience and robust mock testing) have an E factor of 1.0 for VM-21, unless they are new hedging strategies backing a newly introduced or newly acquired product or block of business, which may have an E factor as low as 0.3. Moreover, with prior domestic regulator approval, which should mitigate regulator concerns that strategy changes implemented just before year end may allow for manipulation of results, robust
mock testing is sufficient to allow an E factor lower than 1.0. Note that the current draft VM-22 only allows modeling hedges after they have been in place for 6 months, and we would recommend that be revised to be in line with these changes. When only CDHS were modeled in VM-21, new hedging strategies with no experience had E factors as low as 0.5 even without meaningful analysis. This treatment was much too lenient for new hedging strategies.
The term “clearly defined hedging strategy” (CDHS) means a future hedging strategy for which the following attributes are clearly documented:

- The specific risks being hedged (e.g., cash flow, fee income, policy interest credits, delta, rho, vega, etc.).
- The hedging objectives.
- The material risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.).
- The financial instruments used to hedge the risks.
- The hedging strategy’s trading rules, including the permitted tolerances from hedging objectives.
- The metrics, criteria, and frequency for measuring hedging effectiveness.
- The conditions under which hedging will not take place and for how long the lack of hedging can persist.
- The group or area, including whether internal or external, responsible for implementing the hedging strategy.
- Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
- The circumstances under which hedging strategy will not be effective in hedging the risks.

Guidance Note: For purposes of the CDHS documented attributes, “effectiveness” need not be measured in a manner as defined in SSAP No. 86—Derivatives in the AP&P Manual.

- The term “future hedging strategy” is a derivative program undertaken by a company to manage risks through one or more future hedging transactions, including the future purchase or sale of hedging instruments and the opening and closing of hedging positions.

A future hedging strategy may be dynamic, static or a combination thereof. A strategy involving the offsetting of the risks associated with products falling under the scope of different requirements within the Valuation Manual (e.g., VM-20, VM-21, or VM-22) does not qualify as a future hedging strategy.

- The term “hedging transaction” means a derivative(s) transaction which is entered into and maintained to reduce:
  a. The risk of a change in the fair value, the value on a statutory, GAAP, or other basis, or cash flow of assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has a forecasted acquisition or incurrence; or
  b. The currency exchange rate risk or the degree of foreign currency exposure in assets and liabilities which the company has acquired or incurred or has a firm commitment to acquire or incur or for which the company has forecasted acquisition or incurrence.
VM-20 Section 6.A.1.b

A company may not exclude a group of policies for which there is one or more future hedging strategies supporting the policies from SR requirements, except in the case where all future hedging strategies supporting the policies are solely associated with product features that are determined to not be material under Section 7.B.1 due to low utilization.

VM-20 Section 7.E.1.g

Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the policies are not affected by this requirement.

VM-20 Section 7.K

K. Modeling of Derivative Programs

1. When determining the DR and the SR, the company shall include in the projections the appropriate costs and benefits of derivative instruments that are currently held by the company in support of the policies subject to these requirements. The company shall also include the appropriate costs and benefits of anticipated future derivative instrument transactions associated with the execution of future hedging strategies supporting the policies, as well as the appropriate costs and benefits of anticipated future derivative instrument transactions associated with non-hedging derivative programs (e.g., replication, income generation) undertaken as part of the investment strategy supporting the policies, provided they are normally modeled as part of the company’s risk assessment and evaluation processes.

2. For each derivative program that is modeled, the company shall reflect the company’s established investment policy and procedures for that program; project expected program performance along each scenario; and recognize all benefits, residual risks and associated frictional costs. The residual risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, etc.). Frictional costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. For future hedging strategies supporting the policies, the company may not assume that residual risks and frictional costs have a value of zero, unless the company demonstrates in the PBR Actuarial Report that “zero” is an appropriate expectation. VM-21 Section 1.B. Principle 5 applies as a general principle for the modeling of future hedging strategies.

3. In circumstances where one or more material risk factors related to a derivative program are not fully captured within the cash-flow model used to calculate CTE 70, the company shall reflect such risk factors by increasing the SR as described in Section 5.E.
4. In circumstances where documentation outlining the future hedging strategies is incomplete, the company shall reflect the future hedging strategies not being clearly defined by increasing the SR as described in Section 5.E. To support no increase to the SR, there should be very robust documentation outlining each future hedging strategy. In particular, the SR shall be at least as great as the SR that would result if a future hedging strategy were not reflected in the SR, if the documentation is materially incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the SR to reflect that documentation is not available to support that the future hedging strategies are clearly defined shall be in addition to increases to the SR pursuant to Section 7.K.3 above.

Guidance Note: Section 5.E requires that the company “Determine any additional amount needed to capture any material risk included in the scope of these requirements but not already reflected in the cash-flow models using an appropriate and supportable method and supporting rationale.” In the case of a derivative program that is a future hedging strategy, Section 7.K.3 requires such an increase for disconnects between the hedge modeling and the future hedging strategy, while Section 7.K.4 requires such an increase for disconnects between the loosely defined future hedging strategy and what may actually take place.

VM-20 Section 7.L (Remove entire Section 7.L)

VM-21 Section 1.D.2 (Delete entire definition and renumber subsequent sections VM-21 Section 1.D.3 and VM-21 Section 1.D.4)

VM-21 Section 4.A.4

Modeling of Hedges
a. For a company that does not have a future hedging strategy supporting the contracts:
   i. The company shall not consider the cash flows from any future hedge purchases or any rebalancing of existing hedge assets in its modeling, since they are not included in the company’s investment strategy supporting the contracts.
   ii. Existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the starting assets.

b. For a company with one or more future hedging strategies supporting the contracts, the detailed requirements for the modeling of hedges are defined in Section 9. The following paragraphs are a high-level summary and do not supersede the detailed requirements.

Deleted: L. Clearly Defined Hedging Strategy
   A clearly defined hedging strategy must identify:
   - The specific risks being hedged (e.g., cash flow, policy interest credits, delta, rho, vega, etc.)
   - The hedge objectives.
   - The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.)
   - The financial instruments used to hedge the risks.
   - The hedge trading rules, including the permitted tolerances from hedging objectives.
   - The metrics for measuring hedging effectiveness.
   - The criteria used to measure hedging effectiveness.
   - The frequency of measuring hedging effectiveness.
   - The conditions under which hedging will not take place.
   - The person or persons responsible for implementing the hedging strategy.
   - Areas where basis, gap or assumption risk related to the hedging strategy have been identified.
   - The circumstances under which hedging strategy will not be effective in hedging the risks.
   - Hedging strategies involving the offsetting of the risks associated with other products outside of the scope of these requirements are not a clearly defined hedging strategy.

Guidance Note: For purposes of the above criteria, “effectiveness” need not be measured in a manner as defined in SSAP No. 16—Derivatives in the AP&P Manual.

Deleted: The term “clearly defined hedging strategy” (CDHS) is defined in VM-01. In order to be designated as a CDHS, the strategy must meet the principles outlined in Section 1.B (particularly Principle 3) and shall, at a minimum, identify:
   - The specific risks being hedged (e.g., delta, rho, vega, etc.)
   - The hedge objectives.
   - The risks that are not hedged (e.g., variation from expected mortality, withdrawal, and other utilization or decrement rates assumed in the hedging strategy, etc.)
   - The financial instruments that will be used to hedge the risks.
   - The hedge trading rules, including the permitted tolerances from hedging objectives.
   - The metrics for measuring hedging effectiveness.
   - The criteria used to measure hedging effectiveness.
   - The frequency of measuring hedging effectiveness.
   - The conditions under which hedging will not take place.
   - The person or persons responsible for implementing the hedging strategy.

Guidance Note: It is important to note that strategies involving the offsetting of the risks associated with V/A guarantees with other products outside of the scope of these requirements (e.g., equit... [1]

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Deleted: The hedge assets may then be considered in one of two ways:

Deleted: (b) Include the asset cash flows from any contractual payments and maturity values in the projection model, or

No hedge positions — in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such as...

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i. The appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the projections used in the determination of the SR.

ii. The projections shall take into account the appropriate costs and benefits of hedge positions expected to be held in the future through the execution of the future hedging strategies supporting the contracts. Because models do not always accurately portray the results of hedge programs, the company shall, through back-testing and other means, assess the accuracy of the hedge modeling. The company shall determine a SR as the weighted average of two CTE values; first, a CTE70 ("best efforts") representing the company’s projection of all of the hedge cash flows, including future hedge purchases, and a second CTE70 ("adjusted") which shall use only hedge assets held by the company on the valuation date and no future hedge purchases. These are discussed in greater detail in Section 9. The SR shall be the weighted average of the two CTE70 values, where the weights reflect the error factor \( \frac{1}{2} \) determined following the guidance of Section 9.C.4.

iii. The company is responsible for verifying compliance with all requirements in Section 9 for all hedging instruments included in the projections.

iv. The use of products not falling under the scope of these requirements (e.g., equity-indexed annuities) as a hedge shall not be recognized in the determination of accumulated deficiencies.

**VM-21 Section 4.D.4.b**

Notwithstanding the above requirements, the SR shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of future hedging strategies supporting the contracts are not affected by this requirement.

**VM-21 Section 6.B.3.a.ii – Footnote (Footnote at Bottom of Page 21-23)**

Throughout this Section 6, references to CTE70 (adjusted) shall also mean the SR for a company that does not have a future hedging strategy supporting the contracts as discussed in Section 4.A.4.a.

**VM-21 Section 6.B.3.b.ii**

Calculate the Prescribed Projections Amount as the CTE70 (adjusted) using the same method as that outlined in Section 9.C (which is the same as SR following Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts) but substituting the assumptions prescribed by Section 6.C. The calculation of this Prescribed Projections Amount also requires that the scenario reserve for any given scenario be equal to or in excess of the cash surrender value in aggregate on the valuation date for the group of contracts modeled in the projection.

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Cash flows associated with hedging shall be projected in the same manner as that used in the calculation of the CTE70 (adjusted) as discussed in Section 9.C or Section 4.A.4.a for a company without a future hedging strategy supporting the contracts.

### VM-21 Section 9

#### Section 9: Modeling of Hedges under a Future Hedging Strategy

**A. Initial Considerations**

1. Subject to Section 9.C.2, the appropriate costs and benefits of hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements shall be included in the calculation of the SR, determined in accordance with Section 3.D and Section 4.D.

2. If the company is following one or more future hedging strategies supporting the contracts, in accordance with an investment policy adopted by the board of directors, or a committee of board members, the company shall take into account the costs and benefits of hedge positions expected to be held by the company in the future along each scenario based on the execution of the hedging strategy, and it is eligible to reduce the amount of the SR using projections otherwise calculated. The investment policy must clearly articulate the company’s hedging objectives, including the metrics that drive rebalancing/trading. This specification could include maximum tolerable values for investment losses, earnings, volatility, exposure, etc. in either absolute or relative terms over one or more investment horizons vis-à-vis the chance of occurrence. Company management is responsible for developing, documenting, executing and evaluating the investment strategy, including the hedging strategy, used to implement the investment policy.

3. For this purpose, the investment assets refer to all the assets, including derivatives supporting covered products and guarantees. This also is referred to as the investment portfolio. The investment strategy is the set of all asset holdings at all points in time in all scenarios. The hedging portfolio, which also is referred to as the hedging assets, is a subset of the investment assets. The hedging strategy is the hedging asset holdings at all points in time in all scenarios. There is no attempt to distinguish what is the hedging portfolio and what is the investment portfolio in this section. Nor is the distinction between investment strategy and hedging strategy formally made here. Where necessary to give effect to the intent of this section, the requirements applicable to the hedging portfolio or the hedging strategy are to apply to the overall investment portfolio and investment strategy.

4. This particularly applies to restrictions on the reasonableness or acceptability of the models that make up the stochastic cash-flow model used to perform the projections, since these restrictions are inherently restrictions on the joint modeling of the hedging and non-hedging portfolio. To give effect to these requirements, they must apply to the overall investment strategy and investment portfolio.

**B. Modeling Approaches**

1. The analysis of the impact of the hedging strategy on cash flows is typically performed using either one of two types of methods as described below. Although a hedging strategy normally would be expected to reduce risk provisions, the nature of the hedging strategy and the costs to implement the strategy may result in a

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...
in an increase in the amount of the SR otherwise calculated. Particular attention should be given to VM-21 Section 1.B Principle 5 for the modeling of future hedging strategies.

2. The fundamental characteristic of the first type of method, referred to as the “explicit method,” is that hedging positions and their resulting cash flows are included in the stochastic cash-flow model used to determine the scenario reserve, as discussed in Section 3.D, for each scenario.

3. The fundamental characteristic of the second type of method, referred to as the “implicit method,” is that the effectiveness of the current hedging strategy on future cash flows is evaluated, in part or in whole, outside of the stochastic cash-flow model. There are multiple ways that this type of modeling can be implemented. In this case, the reduction to the SR otherwise calculated should be commensurate with the degree of effectiveness of the hedging strategy in reducing accumulated deficiencies otherwise calculated.

4. Regardless of the methodology used by the company, the ultimate effect of the current hedging strategy (including currently held hedge positions) on the SR needs to recognize all risks, associated costs, imperfections in the hedges and hedging mismatch tolerances associated with the hedging strategy. The risks include, but are not limited to: basis, gap, price, parameter estimation and variation in assumptions (mortality, persistency, withdrawal, annuitization, etc.). Costs include, but are not limited to: transaction, margin (opportunity costs associated with margin requirements) and administration. In addition, the reduction to the SR attributable to the hedging strategy may need to be limited due to the uncertainty associated with the company’s ability to implement the hedging strategy in a timely and effective manner. The level of operational uncertainty varies indirectly with the amount of time that the new or revised strategy has been in effect or mock tested.

Guidance Note: No hedging strategy is perfect. A given hedging strategy may eliminate or reduce some but not all risks, transform some risks into others, introduce new risks, or have other imperfections. For example, a delta-only hedging strategy does not adequately hedge the risks measured by the “Greeks” other than delta. Another example is that financial indices underlying typical hedging instruments typically do not perform exactly like the separate account funds, and hence the use of hedging instruments has the potential for introducing basis risk.

A safe harbor approach is permitted for reflection of future hedging strategies supporting the contracts for those companies whose modeled hedge assets comprise only linear instruments not sensitive to implied volatility. For companies with option-based hedge strategies, electing this approach would require representing the option-based portion of the strategy as a delta-rho two-Greek hedge program. The normally modeled option portfolio would be replaced with a set of linear instruments that have the same first-order Greeks as the original option portfolio. Calculation of SR (Reported)

1. The company shall calculate CTE70 (best efforts)—the results obtained when the CTE70 is based on incorporating the future hedging strategies supporting the contracts (including both currently held and future hedge positions) into the stochastic cash-flow model on a best efforts basis, including all of the factors and assumptions needed to execute the future hedging strategies supporting the contracts (e.g., stochastic implied volatility). The determination of CTE70 (best efforts) may utilize either explicit or implicit modeling techniques.

2. The company shall calculate a CTE70 (adjusted) by recalculating the CTE70 assuming the company has no future hedging strategies supporting the contracts, therefore following the requirements of Section 4.A.4.a.
However, for a company with a future hedging strategy supporting the contracts, existing hedging instruments that are currently held by the company in support of the contracts falling under the scope of these requirements may be considered in one of two ways for the CTE70 (adjusted):

a) Include the asset cash flows from any contractual payments and maturity values in the projection model; or
b) No hedge positions – in which case the hedge positions held on the valuation date are replaced with cash and/or other general account assets in an amount equal to the aggregate market value of these hedge positions.

Guidance Note: If the hedge positions held on the valuation date are replaced with cash, then as with any other cash, such amounts may then be invested following the company’s investment strategy.

A company may switch from method a) to method b) at any time, but it may only change from b) to a) with the approval of the domiciliary commissioner.

3. Because most models will include at least some approximations or idealistic assumptions, CTE70 (best efforts) may overstate the impact of the hedging strategy. To compensate for potential overstatement of the impact of the hedging strategy, the value for the SR is given by:

\[ SR = CTE70 \text{(best efforts)} + E \times \max[0, CTE70 \text{(adjusted)} - CTE70 \text{(best efforts)}] \]

4. The company shall specify a value for \( E \) (the “error factor”) in the range from 5% to 100% to reflect the company’s view of the potential error resulting from the level of sophistication of the stochastic cash-flow model and its ability to properly reflect the parameters of the hedging strategy (i.e., the Greeks being covered by the strategy), as well as the associated costs, risks and benefits. The greater the ability of the stochastic model to capture all risks and uncertainties, the lower the value of \( E \). The value of \( E \) may be as low as 5% only if the model used to determine the CTE70 (best efforts) effectively reflects all of the parameters used in the hedging strategy. If certain economic risks are not hedged, yet the model does not generate scenarios that sufficiently capture those risks, \( E \) must be in the higher end of the range, reflecting the greater likelihood of error. Likewise, simplistic hedge cash-flow models shall assume a higher likelihood of error.

5. The company shall conduct a formal back-test, based on an analysis of at least the most recent 12 months, to assess how well the model is able to replicate the hedging strategy in a way that supports the determination of the value used for \( E \).

6. Such a back-test shall involve one of the following analyses:

a. For companies that model hedge cash flows directly (“explicit method”), replace the stochastic scenarios used in calculating the CTE70 (best efforts) with a single scenario that represents the market path that actually manifested over the selected back-testing period and compare the projected hedge asset gains and losses against the actual hedge asset gains and losses – both realized and unrealized – observed over the same time period. For this calculation, the model assumptions may be replaced with parameters that reflect actual experience during the back-testing period. In order to isolate the comparison between the modeled hedge strategy and actual hedge results for this calculation, the projected liabilities should accurately reflect the actual liabilities throughout the back-testing period; therefore, adjustments that facilitate this accuracy (e.g. reflecting actual experience instead of model assumptions, including new business, etc.) are permissible.

To support the choice of a low value of \( E \), the company should ascertain that the projected hedge asset gains and losses are within close range of 100% (e.g., 80–125%) of the actual hedge asset gains and losses. The
company may also support the choice of a low value of E by achieving a high R-squared (e.g., 0.80 or higher) when using a regression analysis technique.

b. For companies that model hedge cash flows implicitly by quantifying the cost and benefit of hedging using the fair value of the hedged item (an “implicit method” or “cost of reinsurance method”), calculate the delta, rho and vega coverage ratios in each month over the selected back-testing period in the following manner:

   i. Determine the hedge asset gains and losses—both realized and unrealized—incur ed over the month attributable to equity, interest rate, and implied volatility movements.

   ii. Determine the change in the fair value of the hedged item over the month attributable to equity, interest rate, and implied volatility movements. The hedged item should be defined in a manner that reflects the proportion of risks hedged (e.g., if a company elects to hedge 50% of a contract’s market risks, it should quantify the fair value of the hedged item as 50% of the fair value of the contract).

   iii. Calculate the delta coverage ratio as the ratio between (i) and (ii) attributable to equity movements.

   iv. Calculate the rho coverage ratio as the ratio between (i) and (ii) attributable to interest rate movements.

   v. Calculate the vega coverage ratio as the ratio between (i) and (ii) attributable to implied volatility movements.

   vi. To support the company’s choice of a low value of E, the company should be able to demonstrate that the delta and rho coverage ratios are both within close range of 100% (e.g., 80−125%) consistently across the back-testing period.

   vii. In addition, the company should be able to demonstrate that the vega coverage ratio is within close range of 100% in order to use the prevailing implied volatility levels as of the valuation date in quantifying the fair value of the hedged item for the purpose of calculating CTE70 (best efforts). Otherwise, the company shall quantify the fair value of the hedged item for the purpose of calculating CTE70 (best efforts) in a manner consistent with the realized volatility of the scenarios captured in the CTE (best efforts).

c. Companies that do not model hedge cash flows explicitly, but that also do not use the implicit method as outlined in Section 9.C.6.b above, shall conduct the formal back-test in a manner that allows the company to clearly illustrate the appropriateness of the selected method for reflecting the cost and benefit of hedging, as well as the value used for E.

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appropriate prudent estimate to account for additional uncertainty in anticipated hedging experience beyond
that of a robust hedging program already in existence. E may also be lower than 1.0 if the change in strategy
is a minor refinement rather than a material change in strategy, though still subject to the minimum error
factor specified in Section 9.C.4 and with an appropriate prudent estimate to account for any additional
uncertainties associated with the refinement.

The following examples are provided as guidance for determining the E factor when there has been a change to
the hedge program. These examples are not intended to be exhaustive, and a company must support the
determination of whether a hedge methodology change is material based on a review of the company’s specific
change in methodology.

1. The error factor should be temporarily 100% for material changes in hedge methodology (e.g., moving
from a fair-value based strategy to a stop-loss strategy) without robust mock testing.
2. An increase in the error factor may not always be needed for minor refinements to the hedge strategy (e.g.,
moving from swaps to Treasury futures).

8. The company shall set the value of E reflecting the extent to which the hedging program is clearly defined.
To support a value of E below 1.0, there should be very robust documentation outlining all future hedging
strategies. To the extent that documentation outlining any of the future hedging strategies is incomplete,
the value of E shall be increased. In particular, the value of E shall be 1.0 if documentation is materially
incomplete for any of the individual CDHS attributes (a) through (j), as listed in VM-01.

Any increases required to the value of E to reflect that documentation is not available to support that the
future hedging strategies are clearly defined shall be in addition to increases to the value of E to reflect a
lack of historical experience or to reflect the back-testing results, subject to an overall ceiling of 1.0 for E.

Guidance Note: Companies must use judgment both in determining an E factor and in applying this
requirement in the case where there are multiple future hedging strategies, particularly where some may be
CDHS and some may not be CDHS. In this case, the SR should be ensured to be no less than the CTE(70)
reflecting the future hedging strategies that are CDHS and not reflecting those that are not CDHS.
Companies with multiple future hedging strategies with very different levels of effectiveness or with
multiple future hedging strategies that include both CDHS and non-CDHS should discuss with their
domestic regulator.

D. Additional Considerations for CTE70 (best efforts)

If the company is following one or more future hedging strategies supporting the contracts, the fair value of the
portfolio of contracts falling within the scope of these requirements shall be computed and compared to the CTE70
(best efforts) and CTE70 (adjusted). If the CTE70 (best efforts) is below both the fair value and CTE70 (adjusted),
the company should be prepared to explain why that result is reasonable.

For the purposes of this analysis, the SR and fair value calculations shall be done without requiring the scenario
reserve for any given scenario to be equal to or in excess of the cash surrender value in aggregate for the group of
contracts modeled in the projection.

E. Specific Considerations and Requirements

1. As part of the process of choosing a methodology and assumptions for estimating the future effectiveness of
the current hedging strategy (including currently held hedge positions) for purposes of reducing the SR, the
company should review actual historical hedging effectiveness. The company shall evaluate the
appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the
strategy, the mix of business and other items that are likely to result in materially adverse results. This
includes an analysis of model assumptions that, when combined with the reliance on the hedging strategy, are likely to result in adverse results relative to those modeled. The parameters and assumptions shall be adjusted (based on testing contingent on the strategy used and other assumptions) to levels that fully reflect the risk based on historical ranges and foreseeable future ranges of the assumptions and parameters. If this is not possible by parameter adjustment, the model shall be modified to reflect them at either anticipated experience or adverse estimates of the parameters.

2. A discontinuous hedging strategy is a hedging strategy where the relationships between the sensitivities to equity markets and interest rates (commonly referred to as the Greeks) associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets are subject to material discontinuities. This includes, but is not limited to, a hedging strategy where material hedging assets will be obtained when the variable annuity account balances reach a predetermined level in relationship to the guarantees. Any hedging strategy, including a delta hedging strategy, can be a discontinuous hedging strategy if implementation of the strategy permits material discontinuities between the sensitivities to equity markets and interest rates associated with the guaranteed contract holder options embedded in the variable annuities and other in-scope products and these same sensitivities associated with the hedging assets. There may be scenarios that are particularly costly to discontinuous hedging strategies, especially where those result in large discontinuous changes in sensitivities (Greeks) associated with the hedging assets. Where discontinuous hedging strategies contribute materially to a reduction in the SR, the company must evaluate the interaction of future trigger definitions and the discontinuous hedging strategy, in addition to the items mentioned in the previous paragraph. This includes an analysis of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.

3. A strategy that has a strong dependence on acquiring hedging assets at specific times that depend on specific values of an index or other market indicators may not be implemented as precisely as planned.

4. The combination of elements of the stochastic cash-flow model—including the initial actual market asset prices, prices for trading at future dates, transaction costs and other assumptions—should be analyzed by the company as to whether the stochastic cash-flow model permits hedging strategies that make money in some scenarios without losing a reasonable amount in some other scenarios. This includes, but is not limited to:
   a. Hedging strategies with no initial investment that never lose money in any scenario and in some scenarios make money.
   b. Hedging strategies that, with a given amount of initial money, never make less than accumulation at the one-period risk-free rates in any scenario but make more than this in one or more scenarios.

5. If the stochastic cash-flow model allows for such situations, the company should be satisfied that the results do not materially rely directly or indirectly on the use of such strategies. If the results do materially rely directly or indirectly on the use of such strategies, the strategies may not be used to reduce the SR otherwise calculated.

6. In addition to the above, the method used to determine prices of financial instruments for trading in scenarios should be compared to actual initial market prices. In addition to comparisons to initial market prices, there should be testing of the pricing models that are used to determine subsequent prices when scenarios involve trading financial instruments. This testing should consider historical relationships. For example, if a method is used where recent volatility in the scenario is one of the determinants of prices for trading in that scenario, then that model should approximate actual historic prices in similar circumstances in history.

VM-31 Section 3.C.5
Assets and Risk Management – A brief description of the asset portfolio, and the approach used to model risk management strategies, such as hedging, and other derivative programs, including a description of any future hedging strategies supporting the policies, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.D.6.f

Risk Management – Detailed description of model risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the policies and any adjustments to the SR pursuant to VM-20 Section 7.K.3 and VM-20 Section 7.K.4, specific to the groups of policies covered in this sub-report and not discussed in the Life Summary Section 3.C.5. Documentation of any future hedging strategies should include documentation addressing each of the CDHS documentation attributes.


a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled company investment strategy, including any future hedging strategies supporting the policies, is representative of and consistent with the company’s investment policy and that documentation of the CDHS attributes for any future hedging strategies supporting the policies are accurate.

b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the policies is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-20 and in compliance with all applicable ASOPs, and the alternative investment strategy as defined in VM-20 Section 7.E.1.g reflects the prescribed mix of assets with the same WAL as the reinvestment assets in the company investment strategy.

VM-31 Section 3.E.5

Assets and Risk Management – A brief description of the general account asset portfolio, and the approach used to model risk management strategies, such as hedging and other derivative programs, including a description of any future hedging strategies supporting the contracts, and any material changes to the hedging strategies from the prior year.

VM-31 Section 3.F.8

Hedging and Risk Management – The following information regarding the hedging and risk management assumptions used by the company in performing a principle-based valuation under VM-21:

a. Strategies – Detailed description of risk management strategies, such as hedging and other derivative programs, including any future hedging strategies supporting the contracts, specific to the groups of contracts covered in this sub-report.
   i. Descriptions of basis risk, gap risk, price risk and assumption risk.
   ii. Methods and criteria for estimating the a priori effectiveness of the strategy.
iii. Results of any reviews of actual historical hedging effectiveness.

b. CDHS – Documentation addressing each of the CDHS documentation attributes for any future hedging strategies supporting the contracts.

c. Strategy Changes – Discussion of any changes to the hedging strategy during the past 12 months, including identification of the change, reasons for the change, and the implementation date of the change.

d. Hedge Modeling – Description of how the hedge strategy was incorporated into modeling, including:
   i. Differences in timing between model and actual strategy implementation.
   ii. For a company that does not have a future hedging strategy supporting the contracts, confirmation that currently held hedge assets were included in the starting assets.
   iii. Evaluations of the appropriateness of the assumptions on future trading, transaction costs, other elements of the model, the strategy, and other items that are likely to result in materially adverse results.
   iv. Discussion of the projection horizon for the future hedge strategy as modeled and a comparison to the timeline for any anticipated future changes to the company’s hedge strategy.
   v. If residual risks and frictional costs are assumed to have a value of zero, a demonstration that a value of zero is an appropriate expectation.
   vi. Any discontinuous hedging strategies modeled, and where such discontinuous hedging strategies contribute materially to a reduction in the SR, any evaluations of the interaction of future trigger definitions and the discontinuous hedging strategy, including any analyses of model assumptions that, when combined with the reliance on the discontinuous hedging strategy, may result in adverse results relative to those modeled.
   vii. Disclosure of any situations where the modeled hedging strategies make money in some scenarios without losing a reasonable amount in some other scenarios, and an explanation of why the situations are not material for determining the CTE 70 (best efforts).
   viii. Results of any testing of the method used to determine prices of financial instruments for trading in scenarios against actual initial market prices, including how the testing considered historical relationships. If there are substantial discrepancies, disclosure of the substantial discrepancies and documentation as to why the model-based prices are appropriate for determining the SR.
   ix. Any model adjustments made when calculating CTE 70 (adjusted), in particular, any liquidation or substitution of assets for currently held hedges. If there is liquidation or substitution of assets for currently held hedges, disclosure of the impact on the adjusted run.

e. Error Factor ($E$) and Back-Testing – Description of $E$, the error factor, and formal back-tests performed, including:
   i. The value of $E$, and the approach and rationale for the value of $E$ used in the reserve calculation.
   ii. For companies that model hedge cash flows using the explicit method, as described in VM-21 Section 9.C.6.a, and have 12 months of experience, an analysis of at least the most recent 12 months of experience and the results of a back-testing that showing the model is able to replicate the hedging results experienced in a way that justifies the value used for $E$. Include at least a ratio of the actual change in market value of the hedges to the modeled change in market value of the hedges at least quarterly.
   iii. For companies that model hedge cash flows using the implicit method, and have 12 months of experience, as described in VM-21 Section 9.C.6.b, the results of a back-test in which (a) actual hedge asset gains and losses are compared against (b) proportional fair value movements in hedged liability, including:
      a) Delta, rho and vega coverage ratios in each month over the back-testing period, which may be presented in a chart or graph.
b) The implied volatility level used to quantify the fair value of the hedged item, as well as the methodology undertaken to determine the appropriate level used.

iv. For companies that do not model hedge cash flows using either the explicit method or the implicit method, as described in VM-21 Section 9.C.6.c, and have 12 months of experience, the results of the formal back-test conducted to validate the appropriateness of the selected method and value used for E.

v. For companies that do not have 12 months of experience, the basis for the value of E that is chosen based on the guidance provided in VM-21 Section 9.C.7, considering the actual history available, mock testing performed, and the degree and nature of any changes made to the hedge strategy.

vi. The basis for the magnitude of adjustment or lack of adjustment for the value of E chosen based on the robustness of the documentation outlining the future hedging strategy.

g. Safe Harbor for Future Hedging Strategies – If electing the safe harbor approach for a future hedging strategy supporting the contracts, as discussed in VM-21 Section 9.C.8, a description of the linear instruments used to model the option portfolio.

VM-31 Section 3.F.12.c

CTEPA – If using the CTEPA method, a summary including:

i. Disclosure (in tabular form) of the scenario reserves using the same method and assumptions as those used by the company to calculate CTE 70 (adjusted) as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), as well as the corresponding scenarios reserves substituting the assumptions prescribed by VM-21 Section 6.C.

ii. Summary of results from a cumulative decrement projection along the scenario whose reserve value is closest to the CTE 70 (adjusted), as outlined in VM-21 Section 9.C (or the SR following VM-21 Section 4.A.4.a for a company that does not have a future hedging strategy supporting the contracts), under the assumptions outlined in VM-21 Section 6.C. Such a cumulative decrement projection shall include, at the end of each projection year, the projected proportion (expressed as a percent of the total projected account value) of persisting contracts as well as the allocation of projected decrements across death, full surrender, account value depletion, elective annuitization, and other benefit election.

iii. Summary of results from a cumulative decrement projection, identical to (ii) above, but replacing all assumptions outlined in VM-21 Section 6.C with the corresponding assumptions used in calculating the SR.

VM-31 Section 3.F.16.a and Section 3.F.16.b

a. Investment Officer on Investments – A certification from a duly authorized investment officer that the modeled asset investment strategy, including any future hedging strategies supporting the contracts, is consistent with the company’s current investment strategy except where the modeled reinvestment strategy may have been substituted with the alternative investment strategy, and that documentation of the CDHS attributes for any future hedging strategies supporting the contracts are accurate.
b. Qualified Actuary on Investments – A certification by a qualified actuary, not necessarily the same qualified actuary that has been assigned responsibility for the PBR Actuarial Report or this sub-report, that the modeling of any future hedging strategies supporting the contracts is consistent with the company’s actual future hedging strategies and was performed in accordance with VM-21 and in compliance with all applicable ASOPs.
Actuarial Guideline AAT – DRAFT FOR LATF CONSIDERATION

APPLICATION OF THE VALUATION MANUAL FOR TESTING THE ADEQUACY OF LIFE INSURER
RESERVES

Background

The NAIC Valuation Manual (VM-30) contains actuarial opinion and supporting actuarial memorandum requirements, including requirements for asset adequacy testing. Regulators have observed a lack of uniform practice in the implementation of asset adequacy testing. The variety of practice in incorporating the risk of complex assets into testing does not provide regulators comfort as to reserve adequacy. Examples of complex assets are structured securities, including asset-backed securities and collateralized loan obligations, as well as assets originated by the company or affiliated or contracted entity. An initial increase of this activity has been noted in support of general account annuity blocks; however, recent activity was noted in other life insurer blocks.

This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for asset adequacy testing performed by life insurers. In particular, this Guideline:

1. Helps ensure reserve adequacy and claims-paying ability in moderately adverse conditions, including conditions negatively impacting cash flows from complex assets;

2. Clarifies how margins for uncertainty are established such that the greater the uncertainty the larger the margin and resulting reserve;

3. Ensures recognition that higher expected gross returns from assets are, to some extent, associated with higher risk, and that assumptions fit reasonably within the risk-return spectrum;

4. Requires sensitivity testing regarding complex assets currently supporting or assumed to provide future support for life insurer business;

5. Identifies expectations in practice regarding the valuation of complex assets;

6. Establishes a process for researching and monitoring the risks associated with complex assets;

7. Reflects that while complex assets tend to have higher uncertainty regarding timing and amount of cash flows than in more traditional investments, because complex assets are difficult to classify, and the regulatory concern is regarding the projected net yields and cash flows from those assets, the focus of the Guideline will be on assets deemed to be high-yield assets; and

8. Requires additional documentation of investment fee income relationships with affiliated entities or entities close to the company.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date, effective for a future valuation year. This Guideline will cease to apply to annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported in the December 31, 2022 and subsequent annual statutory financial
2. **Scope**

This Guideline shall apply to all life insurers with:

A. Over $5 billion of actuarial reserves or

B. Over $500 million of actuarial reserves and over 5% of supporting assets in the category of Projected High Net Yield Assets, as defined in Section 3.B.

Actuarial reserve amounts are included in the amounts in A and B whether directly written or assumed through reinsurance and are determined before any reinsurance ceded credit.

3. **Definitions**

A. **Investment Grade Net Yield Benchmark.** A net yield calculated as \( i + ii - iii \):

   i. For current assets, the Treasury rate at the asset purchase date for the time to maturity associated with the asset; for reinvestment assets, the Treasury rate related to the projected interest rate scenario at the projected asset purchase date for the time to maturity associated with the asset.

   ii. The spread found in Table F for existing assets and Table H for reinvestment assets, found in the VM-20 / VM-21 / VM-22 Tables tab on the principle-based reserve page of the NAIC website (NAIC website), using PBR Credit Rating 9 and the weighted average life of the associated asset.

   iii. The default cost found in Table A on the NAIC website, using PBR Credit Rating 9 and the weighted average life of the associated asset.

   iv. For assets such as equities or equity-like instruments without a clear weighted average life, apply judgment in establishing an appropriate weighted average life for this exercise and disclose the approach applied. If judgment is difficult to apply due to the circumstances, apply a weighted average life of 20 years.

B. **Projected High Net Yield Assets.** Assets where assumed, future net yields (net of default risk and other risk impacting timing and amount of cash flows) are higher than the Investment Grade Net Yield Benchmark. Included are currently held assets and reinvestment assets, including equities and equity-like instruments.

   i. Aggregation considerations

   (a) The comparison between assumed net yields from each asset and the Investment Grade Net Yield Benchmark shall be done at a level of granularity that is consistent with or more granular than how the assets are grouped, i.e., compressed, in the asset adequacy testing model.

   (b) For companies that model assets for each Committee on Uniform Securities Identification Procedures (CUSIP) number, this exercise is intended to be performed for each individual CUSIP.

   (c) For companies that group similar assets for asset adequacy testing modeling purposes, the companies may provide results at such level, or alternatively, for each individual asset.

   ii. For assets that do not have an explicit weighted average life or term to maturity (such as equities or equity-like instruments), the company shall disclose the method used to determine the appropriate weighted
average life used for comparing to the Investment Grade Net Yield Benchmark.

iii. For purposes of the comparison between assumed net yields from each asset and the Investment Grade Net Yield Benchmark, investment expenses shall be excluded.

4. Asset Adequacy Considerations for Analysis of Business Supported by Any Projected High Net Yield Assets

   A. The actuarial memorandum should provide documentation on net return assumptions, including gross asset spreads, default costs, recovery rate assumptions. The memorandum should also identify and explain the types of risks present in the projected high net yield assets.

   B. The actuarial memorandum shall detail the process to determine the assumed net yields on currently held assets and assets projected to be obtained in the future (reinvestments).

      i. This includes specifically identifying the assumed gross asset yield and all key components deducted to arrive at the assumed net asset yield, including but not limited to credit risk, liquidity risk, and investment expenses.

      ii. Include considerations of the underlying assets (e.g., debt instruments, securitization structure) and timing of expected payments when modeling.

      iii. An explanation shall also be provided for any future reinvestment strategy assumptions that differ from current practices and experience.

   C. For projected high net yield assets, a detailed explanation shall be provided in the actuarial memorandum describing the extent to which higher expected gross returns from these assets are associated with higher risk. It shall also include, for the aspect of any higher expected gross returns not assumed to be associated with higher risk, an explanation of how overperforming assets with expected returns lying outside the risk-return spectrum can be assumed to persist and be available for reinvestments throughout the projection period.

      Provide commentary on factors that could impact whether the conditions that may have contributed to past high net yields for certain asset classes would continue or not continue into the future in a moderately adverse environment including the potential of increased demand for such assets leading to declining available yield.

   D. The actuarial memorandum should provide commentary on how, related to projected high net yield assets, there is consistency with the standard valuation law concept that margins for uncertainty should be established such that the greater the uncertainty the larger the margin and resulting reserve. Asset-related factors identified as being volatile and impactful through sensitivity testing or other means should contain an appropriate margin to reflect this volatility and impact.

   E. Where significant risks associated with a complex asset are not adequately captured with traditional modeling techniques associated with simple assets like corporate bonds, more rigorous modeling of those risks should occur.

      i. Where necessary to adequately reflect the risk, multi-scenario testing of those risks specific to complex assets should be performed.

         (a) For example, investments that may provide a higher expected return in part due to limited information, niche skill sets, or other factors may require unique scenarios (for instance to adequately capture credit or liquidity risk) to fully encompass potential sources of loss.

         (b) Asset cash flows should be appropriately projected to reflect anticipated liquidity in a stressed market. If current models do not support analysis of this type of risk, then new model aspects should be developed; otherwise, if such model aspects are not developed, sufficient additional conservatism to reflect this risk shall be applied.
(c) To the extent that the process for modeling or otherwise evaluating the risks is complex, and the potential for disconnect between reality and modeling increases, an additional margin to assumption(s) should be applied. Any such margin shall be applied in the direction of asset adequacy testing results being less favorable.

ii. Note that a robust conditional tail expectation calculation considering all key risks specific to complex assets would likely show tail losses (from low probability, high impact events) affect asset adequacy results.

iii. A company may use simplifications, approximations, and modeling efficiency techniques if the company can demonstrate that the use of such techniques does not make asset adequacy testing results more favorable. These techniques may be less appropriate if the amount of complex, high-yielding assets becomes a higher percentage of total assets.

iv. Actuarial Standards of Practice (ASOPs), including ASOP No. 7 and No. 56 contain additional guidance on the use of models in the analysis of cash flows.

F. In asset adequacy testing, when an asset is projected to be available for sale, a fair value of that asset is established. Per fair value methodology, fair value should represent the price at which the security could be sold, based on market information. Fair value should only be determined internally (by the insurance or investment management company) when the market-based value cannot be obtained. When the fair value of complex assets is determined internally, the company shall provide a step-by-step description of the approach used to calculate the fair value of such assets.

In addition, when the fair value of complex assets is determined internally, two sensitivity tests should be performed (and the impact on asset adequacy testing results presented):

i. Assume a haircut to the internally derived fair values of 5%;

ii. Assume a haircut to internally derived fair values that the company deems reasonable given the commensurate level of anticipated uncertainty.

G. With respect to privately-originated assets, such as assets originated by the company, within the company’s group, or within an entity closely tied to a company’s group (inclusive of the company’s investment manager), practices to help ensure accurate valuation of those assets should be documented in the actuarial memorandum. Also, assumed net cash flows from assets should be net of all explicit or implicit fees or expenses, such as origination fees, as well as reflective of other asset-related risks including credit risk, illiquidity risk, and other market risks.

In particular, please disclose and detail how the following are appropriately reflected in the net cash flows:

i. Contractual agreements in place between such entities.

ii. Any measures related to the valuation of such privately-originated assets resulting from practices to ensure that the valuation is appropriate and accurate.

iii. Revenue sharing, e.g., performance fees, between the entity responsible for providing investment or other types of services and the insurer, if applicable.

H. Investment expenses, whether paid to an external asset manager or to internal investment management staff, as well as additional expenses that are directly attributable to the specific investments, should be commensurate with the complexity of the assets and reflected in the net yield assumed in asset adequacy testing.

I. In cases where fees are expected to be paid by the insurer, an appropriate amount of future expected fees should be modeled as part of the asset adequacy testing.
J. The actuarial memorandum should contain a detailed description of research and monitoring conducted related to trends impacting risks associated with the insurer’s complex assets or industry-wide or market-wide assets of similar type.

K. In cases where material amounts of reserves are ceded to an entity that does not submit a VM-30 actuarial memorandum or where reinsurance counterparty risk is material, the company shall perform asset adequacy testing on the business that includes the ceded reserves. Depending on the circumstances including risk exposure, simplified asset adequacy testing techniques may be appropriate, as noted in ASOP No. 22. Relevant aspects of ASOP No. 11 not in conflict with this section should be considered in the asset adequacy testing.

L. Please identify if any borrowing is modeled beyond to address very short-term liquidity needs. Also, please verify borrowing and reinvestment rates to ensure that projections are not materially benefiting from arbitrage advantages.

{Drafting note: comments would be appreciated on the inclusion of board of director and senior management responsibilities on the quality of complex asset-related assumptions similar to those stated in VM-G}

5. Constraints, Sensitivity Tests, and Attribution Analysis related to Assumptions on Projected High Net Yield Assets

A. Constraint for year-end 2023 with early testing for year-end 2022

i. For the year-end 2022 VM-30 actuarial memorandum, perform and disclose the asset adequacy testing results from the following sensitivity test. For the sensitivity test, assume individual asset (or asset group when there is asset compression) net yields for both current assets and projected reinvestment assets do not exceed net yields on public non-callable corporate bonds with gross asset spreads and asset default costs by projection year that are consistent with PBR Credit Rating 10, i.e., by using PBR Credit Rating 10 rather than PBR Credit Rating 9 and otherwise following the spread and default calculations for the Investment Grade Net Yield Benchmark.

ii. For reserves reported in the December 31, 2023 and subsequent annual statutory financial statements, assumed individual asset (or asset group when there is asset compression) net yields for both current assets and projected reinvestment assets shall not exceed net yields on public non-callable corporate bonds with gross asset spreads and asset default costs by projection year that are consistent with PBR Credit Rating 10.

{Drafting note: comments would be appreciated on the pros and cons of an individual asset-specific versus aggregate (VM-20-type) constraint and/or sensitivity test}

iii. For the constraint and the early testing, any favorable impact to asset adequacy testing results due to borrowing at a rate lower than the rate at which positive cash flows are reinvested in the same time period, should be removed.

B. Perform an attribution analysis for any current assets or projected reinvestment assets assumed to produce net returns in excess of the Investment Grade Net Yield Benchmark, as follows:

i. Please quantify the assumed excess net returns attributable to the following factors:

   (a) Credit risk (in excess of credit risk on corporate bonds with PBR Credit Rating 9, if not already reflected in the default assumption)

   (b) Illiquidity risk

   (c) Volatility and other risks (please identify and describe these risks in detail)
ii. For each of the factors contributing to assumed net returns in excess of the Investment Grade Net Yield Benchmark, please explain why the factor is not assumed to contribute to additional losses (tail or otherwise) related to the risks.

iii. Where appropriate, apply judgment and provide commentary on the supporting rationale of how the expected excess return is estimated across the various risk components.

iv. Examples of Attribution Analysis:

Example 1:

Current collateralized loan obligation (CLO), attained in the year 2018
Assumed annual net return: 5.7%
Investment Grade Net Yield Benchmark (similar issue date and weighted average life): 4.5%
Assumed excess net return: 1.2%

Attribution:
(a) Excess credit risk (if not already reflected in default cost) 0.2%
(b) Illiquidity risk 0.4%
(c) Volatility and other risks [provide detailed description] 0.6%

Explanation of why each factor is not assumed to contribute to additional losses related to the risks: [provide explanations]

Example 2:

Assumed reinvestment in an asset-backed security
Assumed annual net return: 5.2%
Investment Grade Net Yield Benchmark (similar issue date and weighted average life): 3.3%
Assumed excess net return: 1.9%

Attribution:
(a) Excess credit risk (if not already reflected in default cost) 0.4%
(b) Illiquidity risk 0.5%
(c) Volatility and other risks [provide detailed description] 1.0%

Explanation of why each factor is not assumed to contribute to additional losses related to the risks: [provide explanations]
Brian Bayerle  
Senior Actuary

March 21, 2022

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen  
Chief Life Actuary, Minnesota Department of Commerce

Re: Actuarial Guideline Asset Adequacy Testing

Dear Messrs. Boerner and Andersen:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the proposed Actuarial Guideline on Asset Adequacy Testing (AAT, collectively Guideline).

Executive Summary

ACLI is generally supportive of modernizing AAT regulation. ACLI also supports such modernization being applied to the industry’s use high net yield assets as the use of such assets in an informed, controlled way enables industry to make, support, and critically deliver on policyholder benefits. ACLI supports the legitimate regulatory attention to the projected net yields for such assets and would support the development of further analysis, documentation, disclosures, and sensitivity testing to inform the Appointed Actuary’s opinion and facilitate dialogue with the domestic regulator regarding the use of such assets. We believe these efforts will address regulatory concerns by increasing transparency into AAT assumptions across the industry and enabling further regulator evaluation.

ACLI has significant concerns with this Guideline:

- ACLI does not support the wholesale application of a cap on yields as such a constraint is not actuarially sound, is prescriptive and is unduly limiting.
- ACLI does not support the proposed requirement for reinsurance, as it is potentially disruptive and creates a host of issues that conflict with other reinsurance-related initiatives of state regulators.
- ACLI feels the scope of assets in this Guideline is overly expansive and would impact far more assets than we believe the regulators intended.
In light of these concerns and the additional comments listed below, ACLI does not believe the proposed Guideline would meet the regulators’ stated objectives.

ACLI is committed to working with regulators to address their concerns in a feasible, targeted, and timely way. We support independent and informed assumption setting consistent with the principles of AAT and the applicable ASOPs. We hope that additional engagement and exposures of this Guideline will lead to a holistic analysis of the issues and reasonable guidance for Appointed Actuaries.

We offer the following commentary on the various sections of the Guideline.

Section 1 – Effective Date

ACLI supports making enhancements to the asset assumption disclosures, including adding sensitivities for AAT as part of the December 31, 2022 asset adequacy analysis. Given the intent that “the requirements contained in this Guideline will be incorporated into the NAIC Valuation Manual (VM-30) at a future date”, we strongly encourage the development of a corresponding APF in tandem with future developments of this Guideline. This approach ensures at the end of this process, regulators can adopt changes for the 2024 NAIC Valuation Manual. ACLI also supports an explicit ending effective date for this Guideline corresponding to the effective date of the corresponding NAIC Valuation Manual changes.

Section 2 – Scope

ACLI supports significant restriction of the scope of the Guideline. We think it is critical to establish the appropriate scope of assets in this Guideline. The definition in the current exposure is overly expansive and would impact far more assets than we believe the regulators intended. Through additional dialogue of regulators, industry, and interested parties, an appropriate principles-based scope can be developed.

Clearly defining the scope will take time beyond the exposure period. In concept, validating higher spreads associated with certain assets that otherwise have similar quality and duration to rated public bonds may be appropriate. Such assets may reflect a different risk profile than traditional fixed income assets and justify greater disclosure and explanation in the Actuarial Memorandum. Equities are another example of an asset class that involve a very different kind of risk and may require a different approach when presenting sensitivities and yield disclosure, with potential consideration for publicly traded versus private equity positions.

Section 3 – Definitions

ACLI has two suggestions regarding the proposed definitions.

First, the development of a formal definition of the term “complex assets” would be beneficial.

Second, section 3.A.i mixes purchase/book yield concepts and market yield concepts. Because it may be difficult to obtain accurate historical information, it may be preferable to use a current market view for purposes of identifying high net yield assets. However, any relevant analysis, documentation, disclosures, or sensitivities should then be applied on a book yields basis. For future purchases, ACLI supports the proposed use of long-term spreads.

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Section 4 – Asset Adequacy Considerations for Analysis of Business Supported by Any Projected High Net Yield Assets

ACLI does not support the reinsurance component of the Guideline. On its face, the requirement appears to circumvent broader NAIC initiatives related to reinsurance collateral, including the Covered Agreement and Reciprocal Jurisdictions, which effectively convey confidence in the regulatory regimes of non-U.S. jurisdictions. Further, the material counterparty risk requirement potentially challenges the Actuarial Opinion of the reinsurer that files a VM-30 report.

In addition to those jurisdictional considerations, we note that the use of the term “asset adequacy testing” is ambiguous and therefore leads to different interpretations. If “asset adequacy testing” is intended to mean “asset adequacy analysis,” the requirement is redundant, as the Appointed Actuary is already required to assess the collectability of reinsurance in forming the Actuarial Opinion. However, if “asset adequacy testing” is intended to mean “cash flow testing,” the requirement would create a significant new operational burden and would require extensive use of hypothetical assets and judgmental assumptions that may make it challenging for the Appointed Actuary to gain comfort with the results. It is also unclear how results from the proposed testing would impact net AAT results, reinsurance credit taken, reinsurance reserves held and any action that the regulator expects from or will undertake based on the results of such analysis.

Overall, it is unclear what problem the reinsurance component of the draft Guideline fixes. We believe that this initiative should maintain the focus on the use of high net yield assets rather than expanding the scope to include reinsurance issues. Therefore, the reinsurance component should be removed from the Guideline because it is unrelated to the issues underlying high net yield assets.

Section 5 - Constraints, Sensitivity Tests, and Attribution Analysis related to Assumptions on Projected High Net Yield Assets

ACLI opposes the inclusion of the prescribed constraint on “Projected High Net Yield Assets”. This fundamentally changes the nature of asset adequacy testing and moves cash flow testing away from the “principles-based” framework that has long been the underpinning of such testing. The approach outlined in the Guideline supersedes the professional judgment of the Appointed Actuary to fulfill their responsibilities according to presently accepted ASOPs. NAIC Model 820 already provides regulators with the necessary authority to compel an Appointed Actuary to change an assumption that regulators do not believe is reasonable or appropriate.

Further, there are credible arguments for credit spreads exceeding the benchmark spreads (e.g., liquidity, structure, complexity, size, and expertise). ACLI supports enhanced documentation and support in such instances rather than arbitrary limitations.

Analysis, Documentation, Disclosures, and Sensitivity Testing

ACLI believes that regulatory concerns can be addressed through a package of analysis, documentation, disclosures, and sensitivity testing. Some of the requirements in the Guideline may have merit, but others seem disproportionately burdensome. ACLI requests more time to work with regulators to establish appropriate and value-added provisions to more effectively address the concerns of regulators.
Sensitivities are a valuable tool in understanding the volatility and risk of assumptions on AAT results, which is why we are largely supportive of providing enhanced sensitivities. Sensitivities can also reflect the inherent link between policyholder obligations and the supporting assets. We would like to work with regulators to determine which sensitivities would be most beneficial and appropriate. We ask for more time than the current exposure period allows to develop such a proposal that maintains the requirement that Appointed Actuaries continue to apply professional judgement.

Summary

In summary, ACLI would like to continue to work with regulators to develop appropriate scope, definitions, disclosures, and sensitivities for the proposed Guideline. The constraint on high net yield assets should be removed from the Guideline because it is damaging to the industry and policyholders, and the reinsurance aspects of the Guideline should be removed because they are unrelated to the issues underlying high net yield assets.

ACLI is working on developing specific recommendations to the Guideline reflecting the comments above. We appreciate consideration of those recommendations and questions generated from our work as they are more fully developed.

ACLI is appreciative of your consideration of our comments and looks forward to a future discussion.

Thank you for your consideration,

[Signature]

cc: Reggie Mazyck, NAIC
Utah Insurance Department received the following comments on the proposed guideline from one of the insurers domiciled in the state.

**Section 4E**

--Characterization of all assets that aren’t plain vanilla corporate bonds as “complex” seems a bit broad/shallow; an asset that is privately underwritten and not publicly traded is not necessarily complex.

--The sensitivity testing instructions here are quite vague; incorporating this into an actuarial model would require more clear instruction.

--Implementing a margin means that an insurer with an investment strategy that includes some less traditional assets is automatically penalized, when in fact these investments may have even stronger covenants, protection, and subordination than traditional publicly-traded bonds.

**Section 4F**

Seems very broad and punitive for all private assets; 5% of a material portion of an insurer’s portfolio can be a very large number.

**Section 4K**

Foreign/Alien reinsurers often perform their own versions of AAT that may not conform to VM-30 requirements exactly, but are very similar. These results should be acceptable in place of the ceding company having to perform additional AAT on the same business.

**Section 5A**

We’re happy to include extra sensitivity tests where helpful/illustrative, but including this as a constraint would have drastic negative impacts on probably a lot of insurance companies. As of 12/31/2021, here are the net yields for a 5-year asset calculated per the Investment Grade Net Yield Benchmark.

<table>
<thead>
<tr>
<th>Current Assets</th>
<th>Reinvested Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) 5yr Treasury</td>
<td>1.26%</td>
</tr>
<tr>
<td>2) 5yr Spread, PBR Rating 10</td>
<td>1.40%</td>
</tr>
<tr>
<td>3) 5yr Default Cost, PBR Rating 10</td>
<td>0.77%</td>
</tr>
<tr>
<td><strong>1 + 2 - 3 =</strong></td>
<td><strong>1.89%</strong></td>
</tr>
</tbody>
</table>

Therefore, if this were a constraint of CFT modeling, any insurer that offers a traditional fixed deferred annuity or MYGA with a crediting rate over 2-3% would automatically lose money in the projection. This seems unreasonable and highly punitive towards smaller, younger, and/or lower-rated insurance companies that already have a higher cost of capital than their larger competitors.

**Section 5B**

--This would be extremely labor-intensive to perform for every in-force asset and would pose a big resource issue for a smaller firm that doesn’t have a huge actuarial staff and/or dedicated ALM resources.
--Additionally, some assets are often held for shorter terms (1-2 years or less), which would mean that new assets would have to be documented each year for CFT. This would compound the labor/resource issue.

--If a reasonable form of aggregation of similar assets were allowed, this analysis would be much less onerous.

--A formal definition of ‘volatility risk’ would be helpful. Otherwise, this may be difficult to quantify.
Dear Ms. Brown:

Lombard International Life Assurance Company (Lombard International) appreciates the opportunity to comment on the Life Actuarial (A) Task Force exposure of the Asset Adequacy Testing Actuarial Guideline draft.

Lombard International’s feedback on the draft relates to clarifying the definition of the term *Actuarial Reserves*. Lombard believes that Separate Account reserves ("Green Book" reserves) should not be considered Actuarial Reserves and therefore Separate Account reserves would not be applied to the reserve thresholds laid out in the Scope section of the proposed AAT requirements. Only reserves held in the Insurance Company’s General Account would be applied towards the proposed limits in the new AAT memo.

Separate Account Reserves are held dollar-for-dollar to match the Separate Account Assets of the company. As such there is no “Actuarial” component to calculate the Separate Account Reserves. The insurance company holds these assets for the express benefit of the individual policy owner and does not control the investment decisions of the assets held in the Separate Accounts. Further, these assets cannot be used to satisfy the general obligations of the insurance company. As such the investment return assumptions related to separate account assets would have at best a minimal indirect impact on the ability of the insurer to meet its General Account liability obligations. Reserves held as a result of any secondary guarantees related to the performance of these separate account assets would be held in the General Account and would clearly be included when determining the total Actuarial Reserves of the Company.

Similar to Separate Account Assets and Reserves, Lombard believes that reserves associated with Life Insurance Policy Loans made to policyholders should also be excluded from the calculation of actuarial Reserves. For reporting and reserving purposes, Policy Loans are treated exactly like Separate Account Assets. Therefore, they should receive the same exclusion for the reasons listed above.

If the term Actuarial Reserves was already intended to only incorporate General Account reserves, we suggest updating the Scope to explicitly state this or to add the term “Actuarial Reserves” to the Definitions in Section 3 in order to provide full clarity.

In closing, Lombard once again would like to thank the task force for providing an opportunity to receive industry feedback on the Guideline draft.
Respectfully Submitted,

Scott Hedgepeth
EVP, Chief Actuary & Appointed Actuary
Lombard International Life Assurance Company

Copies to: Steve Boston, Reggie Mazyck
March 23, 2022

To: Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen  
Chief Life Actuary, Minnesota Department of Commerce

From: Catherine Murphy, Deputy Appointed Actuary, Jeff Johnson AVP & Actuary

CC: Marianne Harrison, President and CEO; Rich Harris, VP & US Appointed Actuary;  
Ken Ross VP & Counsel – Government Relations  
Reggie Mazyck, NAIC

Re: John Hancock Comments on Draft Actuarial Guideline for AAT Related to Complex Asset Modeling

Dear Messrs. Boerner and Andersen:

John Hancock1 appreciates the opportunity to comment on the draft actuarial guideline presented for comment at LATF on February 10.

While we are supportive of the letter submitted by the ACLI, we submit this letter with additional, more specific comments for your consideration.

Executive Summary

As presented at LATF on December 8, 2021, insurance regulators have identified the need to better understand risks associated with modeling complex or high yielding assets for Asset Adequacy Testing (AAT). While we understand the concerns that have been articulated, we believe that the exposed proposal could have a number of adverse consequences on how companies conduct business and hence, ultimately, on policyholders. We would like to partner with you to find a solution that addresses the concerns and at the same time mitigates the adverse consequences.

The proposed guideline imposes a “one-solution-fits-all” approach for all asset classes and all companies by setting a constraint on complex/high yielding assets and reinsurance. Reducing all asset returns to the equivalent of a BBB bond is excessively generic and punitive as it ignores the fact that investing in a diverse basket of asset classes represents a valuable risk mitigation strategy when these assets are paired with the liabilities of an insurance company through a robust Asset/Liability management strategy. We, therefore, fully support ACLI’s position that better documentation of the risks and return experience associated with these assets should address regulatory concerns. We’d envision this documentation to be comprehensive, inclusive of data supporting the underlying assumptions and margins along with corresponding rationale for the way in which the assets have been modeled. This reporting could include measures of the variability of results and sensitivities on asset margins.

This more fulsome disclosure would enable the domiciliary regulator to assess the reasonableness of the Appointed Actuary’s assumptions and discuss any concerns individually with a company. Such a focused approach would be much more appropriate from a risk oversight perspective and – unlike the

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1 John Hancock is a unit of Manulife Financial Corporation, a leading international financial services provider that helps people make their decisions easier and lives better by providing financial advice, insurance, and wealth and asset management solutions. Manulife Financial Corporation trades as MFC on the TSX, NYSE, and PSE, and under 945 on the SEHK. One of the largest life insurers in the United States, John Hancock supports more than ten million Americans with a broad range of financial products, including life insurance, long term care and annuities.
framework outlined in the exposed draft - would not impose restrictive constraints across the industry that, being generic, would be arbitrary in nature, much less risk sensitive and which could constrain investment strategies in a manner detrimental to the offerings of our products and their pricing. Setting constraints for Asset Adequacy Testing is not appropriate and could have far reaching consequences. Additionally, as part of the risk framework, the Appointed Actuary could more formally report to the Board, not only on Asset Adequacy but also on risks related to specific asset classes, such as a governance infrastructure covering the aspects of policies, procedures, controls and resources in the context of assumptions and margins.

Increased Disclosure – Relating to Experience

As asset cash flows are projected for Asset Adequacy Testing, the asset assumptions and margins should be based on experience, similar to what may be done for liability assumptions today for the purpose of AAT. For example, when liability cashflows are projected, the Appointed Actuary may leverage the company’s own observed experience for mortality, lapse, etc. in setting the assumptions. A similar approach could be applied to all asset assumptions, including growth/income/yield, expenses, and default, among others. To the extent that a company has extensive experience with data supporting it, the Asset Adequacy Testing assumptions should reflect that experience. Margins should also be set considering uncertainties. ASOP22 already provides guidance to the Appointed Actuary in setting assumptions and margins.

To complement the disclosures on assumption/margin selection, sensitivity analysis could be performed. One way to make the sensitivity relevant to the underlying asset portfolio would be to test asset assumptions by adjusting the margins and report the results.

The Actuarial Opinion Memorandum should include documentation and rationale supporting these assumptions and margins along with results from sensitivity testing. While documentation standards may be considered, a simple approach could be to make sure that there is clear rationale on “why the assumptions/margins were selected”. The documentation could also include Actual/Expected reporting, similar to what may be done on liabilities. For example, the Appointed Actuary could demonstrate the appropriateness of a company’s own assumptions by relating the assumption to the actual experience observed for both assets and liabilities.

Finally, formalizing the AAT corporate governance guidance where the Appointed Actuary expands the reporting to the Board beyond Asset Adequacy results could also help increase transparency in AAT. This reporting could include a description of risks related to governance infrastructure (policies, procedures, controls and resources), assumptions and margins. This approach to more formal governance reporting for Asset Adequacy could be incorporated into VM-G – Corporate Governance for Principle-Based Reserves.

We believe that increased transparency and disclosure would address the regulators’ concerns whilst additionally strengthening Board governance and oversight.

Risk Management

Today, insurance companies leverage the benefits of diversification of asset classes to help mitigate risks and to maintain strong yields during a variety of economic cycles. Portfolio diversification should be a part of any investment strategy to manage Asset/Liability risks and ensure appropriate protection for policyholders. A diversified portfolio allows a company to take on measured risk matched to its liability profile; for example, long tail liabilities are generally supported by assets held for a similar period. Having a diverse mix of public and private investments has a variety of incidental societal and economic benefits, the value of which should not be underestimated (for example through investments in roads and infrastructure, agriculture and real property). Arbitrary constraints could lead companies to adjust their investment strategies, which in turn could negatively impact policyholders, public and

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2 Actuarial Standard or Practice #22 on Asset Adequacy Analysis
private bond issuers and to some extent, the companies we invest in.

Insurance companies already set capital aside to cover losses that could be more than moderately adverse. A constraint on yield as part of AAT would amount to a double charge for certain complex or high yielding assets. This double charge could lead companies to change their investment strategy.

Finally, regulators should consider the role that reinsurance plays as an effective risk mitigation technique that allows companies to distribute risk. The AAT guideline proposes a constraint on reinsurance that could negatively impact insurance companies’ use of reinsurance and therefore could lead to less diversification of risk. An alternative to a reinsurance constraint in AAT could be to ensure that companies have a robust and demonstrated reinsurance management process in place.

An actuarial guideline for AAT that limits yields on assets or requires testing gross of reinsurance could lead a company to take action that may result in more risk or could have negative impact on policyholders through more limited product offerings or higher pricing to cover the higher regulatory requirements. Increased disclosures, sensitivities and an open dialogue between companies and their domestic regulators would provide increased transparency for those assets, mitigating concerns more effectively than broad constraints on returns could ever deliver.

Conclusion

The existing guidance and standards already provide direction to the Appointed Actuary on modeling assets and liabilities, including the selection of assumptions and margins based on the risks. These references also apply to modeling of complex or high yielding assets. Guiding the Appointed Actuaries to increase transparency to regulators and Boards should be sufficient to facilitate more robust discussions with domiciliary regulators and key stakeholders. This increased transparency should include modeling, governance infrastructure, selection of assumptions and margins and discussion of risks. We believe that such an approach would effectively address the concerns raised by LATF members while, at the same time, mitigating the negative impact to policyholders, the industry and the economy, more broadly, as outlined above.

For these reasons, we join ACLI in our opposition to adding rigid and arbitrary constraints in Asset Adequacy Testing for both the asset yield and reinsurance.

We are committed to working with regulators, bilaterally and with ACLI, to help address the concerns raised by better defining documentation standards, proposed sensitivities and strengthening the governance approach.
March 23, 2022

Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen
Chief Life Actuary, Minnesota Department of Commerce

Re: Asset Adequacy Testing Actuarial Guideline

Dear Messrs. Boerner and Andersen:

Western & Southern Financial Group, Inc. appreciates the opportunity to comment on the exposed Actuarial Guideline for Asset Adequacy Testing ("AAT").

Given the timing of the release of the exposure, we are not commenting on all aspects of it. Western & Southern Financial Group would, however, like to specifically comment on the proposed requirements around Documentation, Sensitivity Testing and a Constraint for AAT.

Documentation
We believe that additional asset documentation would be helpful in facilitating AAT conversations between Appointed Actuaries and regulators. It would be particularly helpful for regulators, as they would see the same reporting across all companies. Given our initial review of the exposure and our own assets, we believe that requiring individual asset level documentation would be quite onerous and potentially unhelpful given the amount of data involved. Determining the attribution of all of the various types of spread components over an entire historical portfolio would be difficult and would very likely lead to aggregate simplifications. Due to that likelihood and the cost-benefit considerations at issue, we suggest considering aggregate spread documentation split out by asset classes, which would more quickly and easily convey to regulators how much each spread component drives asset yields by asset class.

Constraint/Sensitivity Testing
Asset Adequacy Testing is a test on the adequacy of reserves and, in our view, one could consider it as a principles based reserve. In other contexts within the Valuation Manual, the NAIC has included asset constraints (e.g., VM-20 asset spreads and asset reinvestment mix) and liability constraints (e.g., VM-21 additional standard projection amount). The exposure of this draft is due to the NAIC observing certain aggressive practices regarding assets backing liabilities and asset modeling practices. Providing a Constraint would be in line with other
Mr. Mike Boerner  
Mr. Fred Andersen  
Page 2

current reserving practices and would provide a consistent approach to avoid overly optimistic assumptions. Western & Southern Financial Group supports the utilization of a Constraint or “guardrail” in connection with AAT.

Due to the use of historical book yields and current market spreads, our understanding of the exposure suggests that more assets are scoped in than previously contemplated (including, e.g., equities and below investment grade fixed income), and note that this approach would result in a very prescriptive asset assumption within AAT. We believe the original intent was to scope in fewer assets, focusing on complex or high-yielding assets with uncertain credit sensitivities and particular liquidity concerns, rather than well-understood asset classes with a long historical performance record. We respectfully submit that a more targeted approach would address regulators’ legitimate concerns while appropriately narrowing the scope of reporting, such that the Constraint would be more of a boundary or guardrail than a prescription. We further believe that providing an initial Sensitivity Test, which would align with the Constraint, would be helpful for regulators to understand how sensitive results are to asset assumptions. Adopting a consistent Sensitivity Test and Constraint across the industry would also help regulators consistently see impacts and potential issues among companies.

Most importantly, we believe that adopting a clear and consistent standard impacting all companies is important, as a consistent standard helps facilitate a high level of assurance that companies are appropriately reserving for their obligations to policyholders.

Regarding the specific drafting notes as requested in the exposure, we would like to provide the following comments for consideration.

{Drafting note: comments would be appreciated on the inclusion of board of director and senior management responsibilities on the quality of complex asset-related assumptions similar to those stated in VM-G}

The Appointed Actuary meets with the Board every year and presents on the results. We believe the current process is an adequate process for Board involvement.

Thank you for the opportunity to comment on the exposure,

Sincerely,

David Todd Henderson, FSA, MAAA, CERA  
SVP Chief Actuary and Chief Risk Officer, Western & Southern Financial Group
March 23, 2022

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)

Mr. Fred Andersen  
Chief Life Actuary, Minnesota Department of Commerce

Attention: Reggie Mazyck (rmazyck@naic.org)

Re: Proposed Actuarial Guideline for Asset Adequacy Testing

Dear Messrs. Boerner and Andersen:

Northwestern Mutual appreciates the opportunity to submit comments on the proposed Actuarial Guideline on Modeling Complex or High Yielding Assets in Asset Adequacy Testing.

We support the development of a guardrail on assumed net investment yields for certain asset types to be used in asset adequacy testing and that testing be applied both to direct reserves and to ceded reserves not tested elsewhere.

Northwestern Mutual supports this ultimately being implemented as a guardrail to be met in testing rather than only a disclosure. This ensures that asset adequacy results are not based on net yields relative to the risks that may be excessive for these hard-to-model assets and allows for comparability across companies. This also provides more predictable guidance to the appointed actuary doing the testing. However, we believe more time should be taken to ensure that the guardrail is appropriate for all assets currently in scope. Examples of areas of possible refinement include the treatment of equities under the guardrail (since the characteristics of the risk are different than fixed income assets) and the introduction of an appropriate illiquidity premium for private asset classes. As such, beginning the guardrail as a disclosure and sensitivity test while additional refinements are made is a prudent approach.

We also believe that ceded reserves that are not asset adequacy tested should be addressed. Without this change, it is difficult to ensure that the primary insurer’s liabilities to policyholders are being supported by reserves (whether held by the primary insurer or a reinsurer) that meet the moderately adverse standard. We believe the choice of reinsuring business should not be a reason why testing would not be performed.
Re: Proposed Actuarial Guideline for Asset Adequacy Testing

In addition, more work needs to be done to better understand the practical limitations for the appointed actuary in testing ceded reserves and if other simplified approaches can ensure that reserves meet the moderately adverse standard. Similar to implementing guardrails for direct business, it may also be prudent to implement this first as a disclosure.

Sincerely,

Jason T. Klawonn, FSA, MAAA
Vice-President & Chief Actuary
EQUITABLE

DATE: March 23, 2022

FROM: Aaron Sarfatti, Chief Risk Officer; Steve Tizzoni, Head of Actuarial Regulatory Affairs


Equitable appreciates the opportunity to further comment on the concept of developing an Actuarial Guideline on the modeling of complex or high-yielding assets in Asset Adequacy Testing (AAT).

As noted in our December 2021 and January 2022 letters, Equitable continues to support establishing a credit spread guardrail within AAT. Equitable believes an AAT credit spread guardrail: (1) is consistent with current principles-based reserving approaches, (2) prevents gross abuses within the statutory reserve and capital framework that regulators are rightly concerned about, (3) aids the appointed actuary in determining asset adequacy and (4) is easier to implement and monitor than robust but voluminous documentation.

Further, while compressed development timelines may not support guardrail implementation for YE2022 filings, we encourage the NAIC to underscore its intent to establish a guardrail applicable to both retained business and ceded reinsurance. We observe few other viable paths for the NAIC to maintain confidence in reserve integrity amid rising scrutiny of offshore reinsurance from stakeholders ranging from industry insiders, media outlets, trade publications, the NAIC itself, the Federal Reserve and, most recently, the US Senate.

The remainder of this letter is organized to outline the basis of this support and recommend paths forward:

1) Executive summary – To outline principal arguments and positions
2) Recommendations on guardrail design
3) Recommendations on application to ceded reinsurance
I. Executive Summary

Equitable supports the creation of a guardrail inclusive of both direct and ceded liabilities. Our primary reasons for support include the following:

A. Guardrails are justified empirically by the observed excessive net yields assumed

B. Guardrails are conceptually consistent with Principles-Based Reserve methodologies and do not represent “prescription”

C. Guardrails are more practical and effective than disclosure alone

D. The efficacy of the proposed guardrail design would be enhanced by targeted changes

E. The application to ceded reinsurance is a pragmatic and necessary step to ensure resilience of entities who ceded business to jurisdictions without analogous guardrails

F. The mechanics of the guardrail application to ceded insurance require clarification

G. Regulators should consider phase-ins for ceded businesses given its profound impact on companies with significant offshore reinsurance

A. **Guardrails are justified empirically by the observed excessive net yields assumed**

The NAIC survey-based observations indicating median net yields of 7+% projected in perpetuity for certain classes of widely held securities that went unchecked by appointed actuaries and regulators is *prima facie* evidence of the need for a guardrail. Such optimism in assumptions for unearned spreads can degrade reserves supported by such assets by 40+%

B. **Guardrails are conceptually consistent with Principles-Based Reserves (PBR) methodologies and are not “prescription”**

Including a credit spread guardrail in AAT is consistent with existing statutory reserving approaches. As noted in our previous letters, VM-20, VM-21, and the NY Special Considerations Letter (NY SCL) all require some form of a spread cap as a guardrail to ensure reasonable asset spread assumptions in reserve calculations. For those products governed under prior valuation rules, AAT is the *de facto* reserve in the current rate environment and including a spread guardrail in AAT would be consistent with current industry practices regarding principle-based reserves.

Further, a guardrail safeguards the integrity of principles-based reserves. A guardrail represents boundary setting and not the parameters specification associated with prescription. Guardrails ultimately further PBR adoption by preventing abuses by a minority of companies that undermine confidence in the overall PBR framework.

C. **Guardrails are more practical and effective than disclosure alone**

As noted in our previous letters, a constraint is less burdensome for regulators to monitor, as it reduces the reliance on the regulator to identify and challenge overly optimistic assumptions of spread recognition in complex and high-yielding assets. While documentation of assumptions can enhance regulator understanding of the regulated entity’s basis for spread recognition, it neither (a) ensures uniform regulator treatment across states nor (b) reliably protects the integrity of the total asset requirement in the face of questionable judgment or lax oversight. This is especially true given regulator resource constraints and in light of the proposed robust disclosures that, while valuable, may be of limited effectiveness due to their sheer volume.
Moreover, the guardrail aids the Appointed Actuary in determining asset adequacy for assets that are new or where there is either limited internal or external knowledge or data. A guardrail ensures that actuaries who may not be familiar with certain emerging high-yielding assets classes are using appropriate asset assumptions within AAT.

**D. The efficacy of the proposed guardrail design would be enhanced with targeted changes**

Recommended enhancements are detailed below, but highlights include:

- Use of market yields to concentrate the guardrail only on assumed unearned spread
- Changing the ratings index to A- from BBB- to align better with market practice
- Adding a modest illiquidity premium to reflect enhanced earnings potential for less liquid, non-public assets – while also giving companies the “benefit of the doubt” in gray areas
- Application as an aggregate yield cap, not a security-specific cap, so as not to punish companies with bar-belled net yield profiles and to establish a total budget for assumed unearned spread per projection year

**E. The application to ceded reinsurance is a pragmatic and necessary step to ensure resilience of entities who ceded business to jurisdictions without analogous guardrails**

A common feature of reinsurance transactions is the use of offshore entities that lack guardrails analogous to the current proposal. The application of such guardrails to ceded reinsurance is the most pragmatic and effective way to safeguard offshore reserve integrity against the same excessive spreads that motivated the proposed AAT guardrail. Absent this provision, we anticipate even greater migration of reserves to offshore jurisdictions that readily permit such lenience and, in turn, further exposure of onshore entities to lax offshore reserve standards. Moreover, the use of AAT is more practical and expedient than other mitigation paths such as re-opening jurisdictional reciprocity and prohibiting the use of lower quality letters of credit to fund any onshore reserve deficiencies.

**F. The mechanics of the guardrail application to ceded insurance require clarification**

As detailed in Section III, we think the mechanics of the guardrail application to ceded reinsurance require clarification, particularly with respect to the treatment of trust assets and the allocation of any entity-wide deficiencies to specific treaties.

**G. Regulators should consider phase-ins for ceded businesses given its profound impact on companies with significant offshore reinsurance**

Our understanding is that the offshore reserves for many offshore companies reflect aggregate earned spreads of c.100bps or more than the proposed guardrail. In this circumstance, a liability with a typical 10-year duration would experience a reserve deficiency of c.10+. The management teams of companies who ceded such liabilities (many recently transacted) will require considerable time and effort to restructure their balance sheets, perhaps more time than the present deadline allows. If this were the concern, regulators could also consider enforcing the proposed reinsurance constraints only for transactions effective after a defined date in order to limit the growth of future reinsurance transactions that rely on lenient offshore requirements.
II. **Recommended Enhancements to Current Spread Constraint Design**

We believe an aggregate spread cap based on Single-A corporate spreads plus a modest illiquidity premium applied on a market value basis remains the most effective and appropriate design for an AAT spread guardrail. As such, we offer the following suggestions and associated rationale for the currently proposed spread guardrail. Our key recommendation is that the guardrail be applied based on a market value basis.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendation</th>
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<tr>
<td><strong>Key Recommendation: Spread Guardrail Definition – Market Value vs. Book Value</strong></td>
<td>• Define the spread cap based on market value, instead of book value.</td>
<td>• Market value spread is superior to book value in incorporating market information about risk to cash flows. • Market value is sufficiently audited to be reliable. • The book-value based constraint as currently formulated will have the unintended consequence of reducing spreads on highly rated corporate bonds purchased in periods of compressed spreads. • Market value approach is the same approach utilized by the NY SCL.</td>
</tr>
<tr>
<td><strong>Level of Aggregation for Spread Guardrail</strong></td>
<td>• Formulate credit spread guardrail or cap in the aggregate, rather than at the individual asset level.</td>
<td>An Aggregate Guardrail would: • Allow for some diversification across assets and asset categories while also being easier and more effective to implement. • Allow some reflection of legitimate excess spread unique to certain assets to the extent other, higher-grade assets are below the constraint. • Ameliorate concerns regarding the one-size fits all approach taken by the current proposal.</td>
</tr>
<tr>
<td><strong>Inclusion of Equities in the Actuarial Guideline</strong></td>
<td>• If aggregate guardrail is adopted: Apply the spread guardrail to equities and equity-like investments backing general account liabilities. • If aggregate guardrail is not pursued: Exclude GA equity investments from the guardrail but govern by other measures, such as the immediate shock and subsequent cap on net returns utilized in the NY SCL.</td>
<td>• Additional investment risk should not reduce reserves beyond what is prudent. • Lack of a guardrail on any one asset class (equities) could have unintended consequence of increasing investment in that asset class.</td>
</tr>
<tr>
<td><strong>Reflection of Illiquidity Premium</strong></td>
<td>• Include a modest illiquidity premium within the spread guardrail.</td>
<td>Including a modest illiquidity premium within the constraint will: • Acknowledge the ability of insurers to reliably realize an illiquidity premium given the long-dated nature of their liabilities and ability to invest in private markets.</td>
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Maintain the industry’s ability to compete based on differentiated investment strategies while still addressing the excessive optimism in projected asset yields that regulators are rightly concerned about.

**Level of Guardrail**
- Set the appropriate level for the proposed guardrail dependent on whether the guardrail is applied in aggregate or restricted to high yield assets.
  - **If the guardrail is applied in aggregate:** Set the spread cap on slightly higher credit ratings, such as A or A-, plus a modest illiquidity premium.
  - **If the guardrail is applied solely to high yielding assets:** Maintaining the BBB-spread proposed is not unreasonable. However, if and when C1 reforms for structured securities are enacted, use the same models at a confidence level like CTE70 to calibrate guardrails for assets with bespoke C1 charges.
- Single A curve is recognized in the industry as an appropriate measure of fair value and is the emergent standard for spread recognition in other public accounting regimes (FASB, IAIS, VM-22)
- As of 12/31/21, the proposed BBB-spread (net of default costs) is actually c. 10bps more conservative than a spread cap based on A-, BBB+ or BBB rated bonds.
- This is the result of the significant default costs associated with BBB- bonds and the low spread environment as of 12/31/21. Formulating the guardrail as BBB+ or BBB plus an illiquidity premium would result in a more reliable and less volatile spread cap.
- For assets with bespoke C1 charges, setting the guardrail consistent with the C1 capital modeling ensures consistency in spread recognition between reserves and capital.

**Reinvestment Spreads vs. Current Spreads**
- Harmonize guardrail for existing and reinvestment assets, as currently the reinvestment yields are materially less restrictive than for currently held assets.
- Address via grading from current spreads to long term reinvestment spreads over the period of several years, consistent with current VM-21 and VM-22 frameworks.
- Significant disconnects between existing and reinvestment assets could encourage modeling practices that project significant asset turnover in early years to realize the immediately higher reinvestment spreads, which we do not believe is the intent of the guideline.
- We would, however, guard against situations when current spreads are elevated and above long-term spreads. In those situations, history suggests swift mean reversion of those elevated spreads over a period of no more than 1 year.

**III. Recommendations on Application to Ceded Reinsurance**

The current language requires that a company perform asset adequacy testing on business that includes a ceded reserve if the reinsurer does not file a VM-30 report. While we support the intent of the guidance as noted above, there are practical considerations that must be clarified.

There is limited guidance for how gross asset adequacy testing is defined and should be performed – especially when the insurer has minimal information about the reinsurance assets that are backing the ceded reserves. Key questions include: (i) what assets should be used in the gross AAT calculation when there are no trust assets supporting the ceded reserves and (ii) in the
event there are no trust assets and the assuming reinsurer has an entity wide AAT deficiency, how such asset deficiency is assigned to different treaties.

Additional guidance regarding how the results of the proposed testing would impact net AAT results, gross reserves, and reserve credits taken at the ceding company is also necessary. For example, if the results of testing indicated that reinsurance assets for a particular treaty were insufficient, guidance must be provided whether the ceding insurer should (1) compel the reinsurer to increase collateral, (2) reduce reinsurance reserve credit taken, (3) reduce overall AAT margins to reflect the insufficiency or (4) some combination of the above.

We do believe that with these additional clarifications, the proposed application of AAT to ceded reinsurance is a pragmatic and effective way to ensure the resilience of entities that have ceded significant amounts of business offshore.

* * * * * * * *

Equitable appreciates the opportunity to comment on this exposed proposal and looks forward to working with regulators to reach an appropriate framework for modeling of high yielding assets within the Asset Adequacy Testing framework. We are available to discuss our comments further as desired.

Sincerely,

Aaron Sarfatti, ASA
Chief Risk Officer, Equitable

Head of Actuarial Methodology and Regulatory Affairs, Equitable
March 23, 2022

Mr. Mike Boerner
Chair, NAIC Life Actuarial (A) Task Force

Mr. Fred Anderson
Chief Life Actuary, Minnesota Department of Commerce

Attention: Reggie Mazyck (rmazyck@naic.org)

Re: Proposed Actuarial Guideline for Asset Adequacy Testing (AAT)

Dear Messrs. Boerner and Anderson,

New York Life Insurance Company (NYL) appreciates the opportunity to comment on the draft Actuarial Guideline for Asset Adequacy Testing (AAT). We strongly support the ongoing efforts of the NAIC to develop an actuarial guideline focused on the appropriate modeling of complex or high-yielding assets. We believe it is important for the Appointed Actuary to reflect, and regulators to understand, the risks associated with these assets in AAT. Given the increased use of these complex assets, an actuarial guideline would improve consistency in their modeling, offer greater transparency and enhance the quantification of risks associated with these asset classes. It is our view that this guideline would significantly strengthen the solvency of the life insurance industry and protect consumers by ensuring the ability of companies to meet current and future policyholder obligations.

New York Life Insurance Company, a Fortune 100 company founded in 1845, is the largest mutual life insurance company in the United States\(^1\) and one of the largest life insurers in the world. New York Life has the highest financial strength ratings currently awarded to any U.S. life insurer from all four of the major credit rating agencies\(^2\). Headquartered in New York City, New York Life’s family of companies offers life insurance, retirement income, investments and long-term care insurance.

**Net Yield Guardrails in Asset Adequacy Testing Safeguard Solvency and Promote Consistency**

NYL supports the use of guardrails in AAT as a practical way to ensure that the net yield of assets used to back statutory reserves receive regulatory focus commensurate with the

\(^1\) Based on revenue as reported by "Fortune 500 ranked within Industries, Insurance: Life, Health (Mutual),” Fortune magazine, 6/2/2021. For methodology, please see [http://fortune.com/fortune500/](http://fortune.com/fortune500/).

\(^2\) Individual independent rating agency commentary as of 9/30/2021: A.M. Best (A+++), Fitch (AAA), Moody’s Investors Service (Aaa), Standard & Poor’s (AA+).
importance that regulators have accorded to this risk area while bringing greater discipline to AAT.

The emergence and increased usage of complex and high yielding assets have improved the assumed earnings rate on invested cash flows. Given this, we believe it is critical that the risk associated with these assets be appropriately reflected in reserving and accounting standards. Regulators have observed that the assumed net yields on these asset classes reflect favorable spreads without necessarily adding an adequate provision to account for increased risk. If insurers’ reliance on the sustained outperformance of these assets when setting reserves is not addressed, this growing trend may pose a potential solvency risk for the life insurance industry. The life insurance industry has been resilient through various financial and other crises, and this is in large part due to the strong solvency protections afforded by the state regulatory system. We believe that the use of guardrails in setting the net yields for complex and high yielding assets is not only appropriate but critical to ensuring that strong solvency protections continue.

In addition, the increasing dependence on high yielding assets to support long duration liabilities has, in turn, increased the degree of reliance counted upon by Appointed Actuaries to set assumptions for the risks underlying these assets and has potentially created increased pressure to rely on aggressive assumptions for their net yields. This may result in inconsistency in assumed net yields for similarly rated assets among different companies despite having a similar level of risk.

It has been suggested that relying solely on additional disclosure requirements and sensitivity testing would provide satisfactory insight into the assumptions used with respect to these asset classes. We disagree and believe that such an approach is too weak to effectively address regulatory concerns. Relying solely on sensitivity testing and documentation for these complex and high yielding assets will potentially expand and exacerbate the questionable modeling practices that regulators have begun to observe. In contrast, establishing guardrails around the modeling of complex and high yielding assets will ensure that AAT appropriately reflects the risks inherent in these assets and therefore enhance both transparency and consistency across insurers, allowing regulators to better understand the underlying risks.

While NYL is supportive of guardrails, we acknowledge that the specific guardrail definitions in the draft Actuarial Guideline will require further development and refinement. Consequently, we support the draft’s measured approach to introduce the guardrails as sensitivity tests for year-end 2022 with the goal of transitioning to guardrails the following year and thereby allowing more time to vet and develop appropriately conservative guardrails.

**Net Yield Guardrails do not Diminish the Role of the Appointed Actuary, and are Entirely Consistent with the Discretion Accorded to the Appointed Actuary under the Standard Valuation Law**

AAT is by definition a judgement-based exercise that relies on the expertise, integrity and discretion of the Appointed Actuary. We believe that regulators should take great care not to impinge on the judgement and discretion of the Appointed Actuary. However, we do not believe adding guardrails for complex and high yielding assets impinges upon Appointed Actuary discretion.
Under the Standard Valuation Law, the Appointed Actuary must form “an opinion ... as to whether the reserves and related actuarial items held in support of the policies and contracts ... when considered in light of the assets held by the company with respect to the reserves and related actuarial items ... make adequate provision for the company’s obligations under the policies and contracts...”3 Any proposed guardrails will have no impact on this requirement, nor on the Appointed Actuary’s use of discretion and judgement in forming such opinion.

In fact, Appointed Actuaries do not rely on their own judgment in setting all critical assumptions, particularly in areas where they lack sufficient expertise. In these situations, Appointed Actuaries instead rely on others, and obtain reliance statements.4 In particular, Appointed Actuaries often rely on others to set investment-related assumptions, particularly spread and default assumptions, with respect to which the Appointed Actuary may have limited expertise. This does not limit the Appointed Actuary’s judgment or discretion, but instead facilitates appropriate assumption setting and analysis. Similarly, establishing guardrails on certain asset-related assumptions is entirely appropriate and does not impede the role of the Appointed Actuary.

Greater Transparency into Reinsured Liabilities and Supporting Assets

The use of offshore reinsurance transactions, sidecars and similar structures has increased in recent years and the NAIC has rightfully identified this as one area of concern that needs to be understood:

“Insurers’ use of offshore reinsurers (including captives) and complex affiliated sidecar vehicles to maximize capital efficiency, reduce reserves, increase investment risk, and introduce complexities into the group structure.”5

We support the NAIC’s continued efforts to explore this and related issues. In addition, in the interim, we support efforts to bring greater transparency and consistency to these transactions and therefore support the proposed requirement to include certain ceded reserves (and the related assets) in AAT. While we appreciate the practical challenges associated with this proposal, we believe there is significant value in providing regulators with a view into reinsured liabilities. Given this, we would suggest including additional guidance to help companies navigate the practical challenges (e.g., sourcing appropriate asset data).

* * *

3 Standard Valuation Law, NAIC Model 820, Section 3.B(2). See also Section 3.A(2)(a).

4 Section 3.A.1.d of Section 30 of the Valuation Manual specifically contemplates this sort of reliance: “A reliance section (see Section 3.A.6) describing those areas, if any, where the appointed actuary has relied upon other experts for data, assumptions, projections or analysis (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios), supported by a statement of each such expert in the form prescribed by Section 3.A.12.”

We are grateful for your time and attention to our comments. Please let us know if you need any additional information or if you would like to discuss this letter with us.

Sincerely,

Elizabeth K. Brill
Senior Vice President & Chief Actuary
New York Life Insurance Company
March 23, 2022

The Honorable Cassie Brown
Texas Insurance Commissioner
Chair, NAIC Life Actuarial (A) Task Force
via email to rmazyck@naic.org

The Honorable Commissioner Scott White
Virginia Insurance Commissioner
Vice-chair, Life Actuarial (A) Task Force
via email to rmazyck@naic.org

Mr. Fred Anderson
Chief Life Actuary, Minnesota Department of Commerce
via email to rmazyck@naic.org

Dana Popish Severinghaus
Director, Illinois Department of Insurance
via email to Dana.Severinghaus@illinois.gov

Bruce Sartain
Deputy Director, Illinois Department of Insurance
via email to Bruce.Sartain@illinois.gov

RE: Proposed Actuarial Guideline Asset Adequacy Testing ("AAT")

Everlake has the following commentary on the proposed AAT Actuarial Guideline (AAT AG).

The AAT AG is a significant proposal requiring additional study and input to ensure that:

- the regulatory solvency framework supports the diverse assets that stand behind insurance products, including retirement services, long term care and other long-term liabilities,
- regulatory concerns are addressed through the appropriate mechanism, and
- the strengths of the current solvency framework are considered.

Everlake supports enhancements to the regulatory solvency framework that would improve AAT documentation and transparency as described below. We encourage the Task Force to consider the recommendations in this letter, and the adverse impact the AAT AG will have on the insurance market.

While we agree that the regulatory concern on the increased use of higher yielding assets is appropriate and needs to be addressed, we have significant concerns with several aspects of the proposal. We share your concern that additional documentation, disclosure and sensitivities are warranted, and we would like to work with regulators to develop these requirements to adequately address regulatory concerns. However, we do not support the constraint on spreads for reasons outlined below. We also believe the reinsurance requirement does not belong in this AG and should be removed.
Overview and Background

Over the last decade, the insurance industry has implemented substantial, healthy, and necessary innovation with respect to assets and risk management. Core aspects of that innovation have involved expanding and optimizing the asset classes used to back liabilities and improving asset and liability modeling techniques that consider expected liquidity requirements and policyholder behavior. At the same time, developments in the capital markets, such as ultra-low and even negative interest rates, have forced responsible companies to question the efficacy of continuing to purchase such instruments under the premise of conservatism. Consumers have benefited by expanding the pool of assets available to support long-term liabilities and diversifying asset risk. This has been achieved while increasing crediting rates and reducing costs for the same premium. Adding certain growth-oriented assets may increase short term volatility but can also substantially reduce the risk of failing short of satisfying one’s liabilities over the long term by utilizing diversification as a risk mitigator. Higher yielding assets have been integral to the innovations in the insurance industry. Insurance products have evolved to be an effective and efficient means to meet this macroeconomic consumer need.

At the same time, we recognize challenges that regulators face; needing the tools to validate whether the asset innovation is truly in the best interests of policyholders and assuring that insurance companies are taking and managing risk appropriately, in part through how particular assets are aligned with appropriate liabilities.

We maintain that:

- regulations should foster asset diversification that allows insurers to meet the growing need for affordable insurance products;
- in addition to reserves, asset risk is addressed through established measurements and processes including Risk Based Capital and Enterprise Risk Management ("ERM") Frameworks; and
- the current AAT framework is strong, with decades of successful field testing through multiple economic cycles.

The overall asset requirements of insurance companies have grown, and over the next decade is expected to grow substantially. Moreover, the contribution to overall enterprise risk from adding higher yielding assets will not be the same for each company; it crucially depends on the interdependence of such risk factors with other portfolio assets, the amount of capital held, and with the characteristics of individual company liability factors as well. Assets must be evaluated in the context of the liabilities they support.

We’ve outlined below our concerns with the proposal and have included an early view on potential solutions to these concerns.

Elimination of the cap on net investment returns

Higher net returns are not just a function of the credit rating of the asset. Other characteristics of the assets that can lead to higher returns including illiquidity premiums, underwriting complexity and skill required to price assets. Illiquidity is addressed by the liquidity risk of the liabilities supported by the assets. Underwriting assets is addressed by the skilled professionals and risk management programs employed by the industry. Cashflow timing variability also contributes to greater yields but can be
diversified away in the asset portfolio or by supporting long duration liabilities not dependent on early period cash flows.

Over the past decade (including periods of market dislocation), many higher yielding investment grade asset classes have performed more favorably (from a yield and default standpoint) than similarly rated traditional corporate bonds. For example, the charts here compare the spread over risk free rate and historical realized defaults for A and BBB rated CLOs with comparably rated corporate bonds. This data illustrates that the higher spread achieved with investment grade CLOs are not associated with higher realized defaults. In fact, the opposite is true: CLOs have lower realized defaults than similarly rated corporate bonds.

**Our Concern:** Imposing a cap on returns that is based solely on the credit risk of a comparable corporate bond ignores other characteristics that generate higher yield. Moreover, a diversified portfolio that includes higher yielding investment grade assets can provide higher net returns on a risk-adjusted basis than a non-diversified portfolio that is limited to lower returning assets.

**Potential Solution:** Yields in excess of the credit risk associated with the asset, specifically asset illiquidity, cash flow timing variability, or recovery, is typically addressed in ERM Frameworks, integrating risk management governance, including the liability consideration, can give comfort to external stakeholders that yields can be achieved under moderately adverse conditions. The analysis supporting the current C1 charges clearly shows that equity markets recover, and long-term excess returns are achieved. Similar analysis could be prepared in consideration of a company’s liabilities to show that illiquidity premium is an appropriate source of return when investing to fund illiquid long term liabilities.
Potential Solution: The concern over high returns can also be addressed by increased disclosure of the liabilities supported and the matching of the assets and liabilities, namely through projected cash flow reports and sensitivities exhibited through these cash flow reports. Disclosure and documentation of return assumptions can be supported by the data and rationale for spread assumptions.

Our Concern: Companies manage shortfall risk as well as credit, market and liquidity risks. The punitive nature of caps will bias the industry to overinvesting in traditional fixed income assets replacing credit and liquidity risk with shortfall risk.

Strength of the Current Frameworks: The current AAT framework has decades of successful field testing through multiple economic cycles that models the actual risk/return characteristics of the currently held assets. Further, the projections provide statistically calibrated forward looking views on the performance of the portfolio under moderately adverse conditions. The current framework maintains a consistent approach across all relevant assumptions, including actuarial, policyholder behavior, expense, and asset assumptions. Appointed Actuaries are accountable to understand the business and they are best equipped to develop a moderately adverse set of assumptions. This approach has provided useful information to regulators and management to assess asset adequacy throughout a range of market stress and interest rate environments. This framework has worked well for the industry and has advanced and informed many companies’ Asset Liability Matching (“ALM”) and investment strategies. Additionally, regulators have engaged sophisticated actuarial and investment firms to review and opine on the Appointed Actuary reports. These reviews are both productive and insightful for both the company and the regulator.

Our Concern: Under the proposed framework, all yields are capped at a level achievable with public non-callable BBB bonds. There is no “one size fits all” solution for assessing risk and setting reserves, and we are concerned that this yield constraint is counterproductive for the industry and regulators. A single cap on an assumption is a major paradigm shift from the principles based framework, and this overrides the informed analysis by professionals who are fully integrated into a company’s risks and reserves. Creating an artificial constraint on investment modeling will diminish the informational value of the asset adequacy exercise and does not support regulators or companies in developing thoughtful and informed views on asset adequacy, ALM and risk and return. The proposed reserve requirements are also based on an arbitrary investment constraint, representing a portfolio with no diversification and no prudent, informed risk vs. return asset selection for policyholders. The proposed framework will likely cause insurers to hold artificially higher, excess reserve levels that are not aligned with economic reality. These costly additional reserves may ultimately harm policyholders via rate changes and impacts to non-guaranteed element management.

The industry conducts businesses that span the spectrum of liability profiles. We specialize in different kinds of products across a broad spectrum that range from liabilities that mimic traditional fixed income assets, to liabilities that are exceedingly long and illiquid, to liabilities that are short, to liabilities that are asset intensive, etc. To provide this diverse range of products, the industry must have the flexibility to make asset/liability decisions that support our own unique blocks of business.

Our Concern: The proposed AAT AG discourages asset diversification by requiring a cap on returns. It could lead to structural disincentives to higher yielding asset portfolios by creating unfair reserve increases and, in turn, creating shortfall risk. This would have significant public policy implications given that insurers rely upon higher yielding assets to satisfy their long-term obligations to policyholders.
Scoping of Assets for Additional Disclosure

An important step is proper scoping of assets for which more disclosure is necessary.

**Concern:** As currently drafted, the guideline is excessively broad and would include assets of a very straightforward and well understood nature.

**Potential Solution:** A consideration would be to focus on projected market yields compared to similarly rated and similar weighted average life ("WAL") corporate bonds, but with a margin for deviation due to typical market conditions (spread variance within a rating class), as well as recognition of illiquidity premium. This would more appropriately define the scope of assets warranting further disclosure.

We support additional disclosure and sensitivity testing

**Strength of the Current Frameworks:** Regulators today have existing authority to require individual insurance companies to provide additional information and sensitivities related to their specific books of business. In many cases, regulators have used that authority to gain additional company specific insight and can engage in dialogue with the appointed actuary to ensure proper modeling and reasonableness of assumptions considering the liabilities being supported.

We support constructive improvements to the framework and agree that disclosures should be enhanced to address the growing usage of higher-yielding assets and facilitate regulatory and insurer dialogue.

Targeted refinements to the proven existing frameworks, expanded AAT disclosures and regulators’ existing authority to require individual companies to provide supplemental data addresses the concern over individual companies taking potentially excessive risk. **Everlake believes that the best path forward is for regulators to take additional time to gather industry input to develop broadly informed and vetted solutions to their concerns.**

Elimination of the new reinsurance requirement on ceded reserves

The reinsurance proposal is not a good fit within the proposed actuarial guideline. The AAT AG addresses concerns over higher yielding assets, not the treatment of reinsurance.

**Concern:** The reinsurance requirement replaces dialogue between regulator and Appointed Actuaries and should be removed from the AAT AG. This topic can be addressed as a separate discussion between Appointed Actuaries and Regulators.

**Concern:** Perhaps the most significant concern with the reinsurance requirement is that it appears to conflict with broader NAIC initiatives regarding the regulation of reinsurance collateral required from reinsurers from qualified and reciprocal jurisdictions. This could be viewed as circumventing credit for reinsurance rules and the existing Covered Agreements.

**Potential Solution:** If regulators are concerned with the credit for reinsurance or the impact of reinsurance on the cash flow testing results for a specific company, the regulator should discuss the concern directly with the company, and make appropriate adjustments as needed, rather than imposing “one size fits all” reinsurance requirement on all companies.
Conclusion

Higher yielding assets are critical to the long-term success of the insurance industry and should not be discouraged if the exposure and assumptions are accurately disclosed, and the risks are appropriately understood and modeled. Everlake is committed to appropriate ALM to ensure obligations to policyholders are satisfied, and in that spirit, we support efforts of regulators to ensure AAT procedures are serving their intended purpose.

However, we believe the proposed AAT AG is too restrictive which over the long run will be harmful to policyholders by disincentivizing companies from achieving the overall best risk-adjusted investment results for the benefit of their policyholders. While we support regulatory efforts to improve disclosure and sensitivity analysis to ensure matching of assets and liabilities properly takes into account complexities and riskiness of supporting assets, constraints without reference to economic analysis, such as artificial limits on yields, should not be adopted.

The constraint should be removed as it is damaging to the industry and policyholders and discriminates against companies that can demonstrate higher credit spreads. It creates an arbitrary benchmark that is not equitable across companies and not consistent with liability assumption margins.

We are supportive of additional disclosure, transparency and sensitivities, which should go a long way in remediating regulator concerns around higher yielding assets in AAT.

Reinsurance does not belong in the AAT AG and should be removed.

We stand ready to engage with you to address regulatory concerns, with a view towards ensuring our industry as a whole can continue to deliver on its promise of providing policyholders with insurance products supported by solid well performing asset portfolios.

Thank you for the opportunity to comment on the proposed AAT AG. We look forward to continuing the dialogue and jointly developing solutions that address the concerns raised by regulators.

Doney Largey
Doney Largey (Mar 31, 2022 10:38 CDT)
Doney Largey
Chief Executive Officer
Everlake Life Insurance Company

Ted Johnson
Ted Johnson (Mar 31, 2022 10:33 CDT)
Ted Johnson
Chief Financial Officer
Everlake Life Insurance Company
Theresa M. Resnick  
Senior Vice President and Chief Actuary  
Everlake Life Insurance Company
March 21, 2022

Mr. Mike Boerner,
Chair
Life Actuarial (A) Task Force (LATF)
National Association of Insurance Commissioners

Re: Comments on the exposed draft Actuarial Guideline on Asset Adequacy Testing

Dear Mr. Boerner,

The Asset Modeling and Reporting Task Force of the American Academy of Actuaries (“the Task Force”) is pleased to provide the following comments on the draft Actuarial Guideline (AG) on Asset Adequacy Testing (AAT) which was exposed during LATF’s February 10 meeting.

The Task Force appreciates the need to provide guidance in this area and believes that appointed actuaries should be able to explain the drivers of asset performance and how they’ve reflected the asset risks in their AAT. We support the principle-based guidance and required disclosures in the AG which will help facilitate consistent practice by appointed actuaries and understanding by regulators. However, the Task Force believes the constraints in the AG (e.g., arbitrary yield caps) are at odds with the independence and judgment appointed actuaries need to perform AAT given the wide variety of products and risk profiles of insurers. We strongly recommend the AG focus on principle-based guidance and required disclosures instead of prescribing non-principle-based constraints which could hamper the appointed actuary’s ability to assess the risks affecting an insurer’s specific mix of assets and liabilities, and how to best reflect those risks in AAT.

Regarding the AG’s scope, the Task Force believes company-wide exclusions from the AG should be based on a company’s current and future asset portfolio, not an arbitrary company size threshold (whether measured on a gross or net basis). For example, exclusions could be allowed based on a defined maximum weighted average assumed spread in AAT or defined criteria on the mix of assets a company uses for asset adequacy testing, e.g., considering the quality, volatility, and liquidity characteristics of those assets.

Regarding the AG’s method of identifying high risk assets based solely on asset ratings, we note that due to limitations of and potential inconsistencies among ratings of complex assets, the asset rating alone does not always provide sufficient information regarding an asset’s risk profile. Therefore, we suggest using principle-based approaches to identify assets with high risk relative to their yield, rather than basing their identification solely on asset ratings.

Regarding reinsurance, we note that U.S. actuaries are required to follow ASOP 11, Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports, which has recently been revised (with an effective date of December 1, 2022). Our task force believes that the judgment of the appointed actuary, following actuarial standards of practice in revised ASOP 11, is preferable to prescribing certain situations when AAT must be performed on a gross basis.
Regarding the treatment of equities in the AG, we believe it will be difficult to apply some of the requirements in the exposed AG to equities and suggest considering the development of separate guidance that is specific to the treatment of equities.

The exposure specifically asked for comments on the pros and cons of an individual asset-specific versus aggregate sensitivity test as required in Section 5.A of the AG. The Task Force believes that many companies would perform 5.A’s sensitivity test at the individual asset (or asset group when there is asset compression) level, however we recommend leaving this decision up to the appointed actuary since some companies may need or want to perform this sensitivity test at more aggregate levels for practical reasons, e.g., when portfolios are managed to an aggregate mix of assets. Also, in line with our comments regarding constraints above, the Task Force believes it is appropriate that the sensitivity test in Section 5.A remain a disclosed sensitivity test, rather than becoming a prescribed constraint in 2023 as is currently the case in the AG.

The exposure specifically asked for comments on the inclusion of board of director and senior management responsibilities on the quality of complex asset-related assumptions like those stated in the Valuation Manual’s Governance section (VM-G). Our task force believes that the inclusion of such responsibilities would be beneficial. If additional such responsibilities are added to VM-G we recommend materiality be a consideration.

The Task Force is concerned the amount of work required to comply with the AG by year-end 2022 will be a challenge for some appointed actuaries. In particular, the seriatim attribution analysis required in Section 5.B requires extensive effort, and judgment on how elements are attributed, so we suggest considering alternatives such as limiting the analysis to a handful of assets, postponing the analysis to year-end 2023, doing the analysis at a more aggregate level, or relying on the other required disclosures in Section 4. In addition, if a company is required to make certain model enhancements per Section 4.E, implementing those enhancements in a well-governed and controlled environment by year-end 2022 may be challenging.

Finally, the Task Force appreciates the urgency on this issue however we would prefer the requirements in the AG be implemented directly through the Valuation Manual’s section on the Actuarial Opinion and Memorandum (VM-30) rather than first being implemented as an Actuarial Guideline to accomplish an earlier effective date for the requirements.

Thank you for your consideration of these comments. Please contact the Academy’s deputy director for public policy Devin Boerm (boerm@actuary.org), with any questions.

Sincerely,

Jason Kehrberg, MAAA, FSA
Chairperson
Asset Modeling and Reporting Task Force
American Academy of Actuaries
Agenda

1. Review Summary of Recommended ESG Models for Field Testing
2. Discuss Key Differences between the GEMS® and AIRG Equity Models
   a. Expected Mean Return and Standard Deviation
   b. Link between Equity and Treasury Model
   c. Equity Model Jump Process
3. Questions and Comments
Summary of Recommended ESG Models for Field Testing

<table>
<thead>
<tr>
<th>Model</th>
<th>Field Test Recommendation</th>
</tr>
</thead>
</table>
| Treasury | 1. Field test two GEMS® Treasury model candidates  
| | a. Conning Calibration and Generalized Fractional Floor  
| | b. Alternative Calibration and Shadow Floor  
| | i. Note: The Alternative Calibration will be adjusted ahead of field testing  |
| Equity | 2. Utilize the existing GEMS® equity model with equity-Treasury linkage based on the short Treasury rate for field testing. Additionally, apply the following calibration updates:  
| | a. Update the equity model calibration to account for changes made to the Treasury model  
| | b. Apply a Sharpe-ratio approach with a 5% corridor to set the expected returns for the diversified international equity, aggressive international equity, and US aggressive equity indices  |
| Corporate | 3. Include GEMS® corporate model in initial field testing with the calibration updated for consistency with other generated returns on a risk/reward basis.  |

Key Differences between the GEMS® and AIRG Equity Models

- Model office testing presented by the American Academy of Actuaries has shown that the scenario sets proposed for field testing resulted in significant impacts to reserves and capital for the Variable Annuity (VA) model office as compared to the results produced with scenarios from the prescribed generator.
- Today’s presentation will focus on some of the potential drivers of reserve and capital differences resulting from moving to the GEMS® Equity Model from the ESG prescribed in VM-20 and VM-21. The discussion will also provide some information on a recalibrated version of the GEMS® Equity Model with lower volatility.
Expected Mean Return and Standard Deviation

- The AIRG Equity Model is calibrated using historical data generally from 1955 - 2003* to set the expected mean return and volatility. The GEMS® Equity Model uses historical data back 25 years, but also considers the expected returns and volatility of other domestic and international equity funds to ensure alignment on a risk/reward basis.
- The GEMS® Equity Model has higher volatility than the AIRG in the steady state - which could be a significant source of differences in reserves between the GEMS® and AIRG scenarios. The GEMS® higher volatility leads to returns that are both higher and lower across the scenarios in each period. Over time and across scenarios, those higher and lower returns compound to produce a wider distribution of cumulative equity returns, or wealth ratios, in both tails of the scenario distribution.
- The GEMS® Equity model has similar returns to the AIRG in the steady state, but lower expected returns in the earlier projection period due to the Equity-Treasury linkage and low interest rate environment. Lower mean returns shift the entire distribution of returns lower.

<table>
<thead>
<tr>
<th>ESG Model</th>
<th>Year 1 Mean</th>
<th>Year 1 St. Dev.</th>
<th>Steady State Mean</th>
<th>Steady State St. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRG</td>
<td>8.8%</td>
<td>16.4%</td>
<td>8.6%</td>
<td>16.1%</td>
</tr>
<tr>
<td>GEMS®</td>
<td>5.2%</td>
<td>13.7%</td>
<td>8.6%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

*Source: CONSTRUCTION AND USE OF PRE-PACKAGED SCENARIOS TO SUPPORT THE DETERMINATION OF REGULATORY RISK-BASED CAPITAL REQUIREMENTS FOR VARIABLE ANNUITIES AND SIMILAR PRODUCTS, Revised 2006, AAA C-3 Phase II Working Group

Expected Mean Return and Standard Deviation

Model Results vs. Select Historical Time Periods

Model Results

<table>
<thead>
<tr>
<th>ESG Model</th>
<th>Steady State Mean</th>
<th>Steady State St. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRG</td>
<td>8.6%</td>
<td>16.1%</td>
</tr>
<tr>
<td>GEMS®</td>
<td>8.6%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

Historical United States Large Cap Stock Returns

<table>
<thead>
<tr>
<th>Historical Period</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900-2003</td>
<td>11.8%</td>
<td>21.1%</td>
</tr>
<tr>
<td>3/1957-2003</td>
<td>11.9%</td>
<td>16.5%</td>
</tr>
<tr>
<td>1900-2021</td>
<td>11.8%</td>
<td>20.4%</td>
</tr>
<tr>
<td>3/1957-2021</td>
<td>12%</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

- Both GEMS® and the AIRG have long-term expected returns (8.6%) that are lower than historical returns. The historical periods below show similar average returns (11.8%-12%) that are significantly higher.
- The volatility in the AIRG aligns with the historical data since 1957 (the start of the S&P 500).
- Volatility in the GEMS® ESG is higher than the historical volatility since 1957, but lower than the volatility that considers data back to 1900.
- The inclusion of data after 2003 does not dramatically change the mean but would reduce the volatility slightly.
Historical Prolonged Periods of Negative Cumulative Returns

- After a recession or depression, there have been some extended periods of equity market recovery. This is important to reflect in the scenarios due to the long-term nature of some insurance liabilities.
- The graph on the right illustrates a time period from the late 1920s to the mid 1940s where an investor in the S&P index would not have been able to recoup the original investment value upon sale.

![Historical S&P Index Cumulative Total Returns 1929-1945](image)


Modeled Prolonged Periods of Negative Cumulative Returns

- Both the AAA ESG and GEMS® can produce equity scenarios that exhibit low returns over an extended period of time. This is largely driven by volatility and the expected return. If there is enough volatility or if there are low enough expected returns, low for long equity scenarios will be produced.
- As of 12/30/20, GEMS® produced 12 scenarios with cumulative negative returns over a 30-year projection compared to 3 scenarios for the AAA ESG out of 10,000 scenario projections.
- Reserves and capital are driven by scenarios in the tail. The extreme scenarios illustrated on the right represent significant risks to companies that issue guarantees on separate equity fund allocations.

![Conning Calibration and Generalized Fractional Floor 12/31/20 Equity Scenarios with Negative Cumulative Returns over First 30 Years](image)

GEMS® Equity Model Returns and Gross Wealth Factors when Recalibrated with Lower Volatility

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Year 1</th>
<th>Year 30</th>
<th>Year 30 GWF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>-28.6%</td>
<td>-33.8%</td>
<td>39.1%</td>
</tr>
<tr>
<td>5%</td>
<td>-18.0%</td>
<td>-20.2%</td>
<td>95.9%</td>
</tr>
<tr>
<td>25%</td>
<td>-3.4%</td>
<td>-2.0%</td>
<td>295.1%</td>
</tr>
<tr>
<td>50%</td>
<td>5.9%</td>
<td>8.9%</td>
<td>588.2%</td>
</tr>
<tr>
<td>75%</td>
<td>14.4%</td>
<td>18.2%</td>
<td>1140.7%</td>
</tr>
<tr>
<td>95%</td>
<td>26.4%</td>
<td>36.3%</td>
<td>3214.5%</td>
</tr>
<tr>
<td>99%</td>
<td>35.3%</td>
<td>55.6%</td>
<td>6896.9%</td>
</tr>
<tr>
<td>Mean</td>
<td>5.2%</td>
<td>8.6%</td>
<td>1015.3%</td>
</tr>
<tr>
<td>St Dev</td>
<td>13.7%</td>
<td>17.3%</td>
<td>1599.2%</td>
</tr>
</tbody>
</table>

GEMS Recalibrated to Target Lower AIRG Volatility

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Year 1</th>
<th>Year 30</th>
<th>Year 30 GWF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>-28.1%</td>
<td>-30.1%</td>
<td>55.3%</td>
</tr>
<tr>
<td>5%</td>
<td>-17.7%</td>
<td>-18.3%</td>
<td>118.7%</td>
</tr>
<tr>
<td>25%</td>
<td>-3.5%</td>
<td>-1.7%</td>
<td>317.7%</td>
</tr>
<tr>
<td>50%</td>
<td>5.8%</td>
<td>8.7%</td>
<td>610.3%</td>
</tr>
<tr>
<td>75%</td>
<td>14.4%</td>
<td>18.1%</td>
<td>1149.7%</td>
</tr>
<tr>
<td>95%</td>
<td>26.2%</td>
<td>34.3%</td>
<td>3063.7%</td>
</tr>
<tr>
<td>99%</td>
<td>34.8%</td>
<td>51.6%</td>
<td>6679.6%</td>
</tr>
<tr>
<td>Mean</td>
<td>5.2%</td>
<td>8.4%</td>
<td>1013.1%</td>
</tr>
<tr>
<td>St Dev</td>
<td>13.4%</td>
<td>16.2%</td>
<td>1496.7%</td>
</tr>
</tbody>
</table>

VA model office testing shows a large increase to reserves and capital for the recommended field test model candidates. To help understand the extent to which equity model volatility impacts the results, Conning adjusted the volatility parameters of the model so that the resulting steady state standard deviation was in-line with the current AIRG model (i.e. 16.1% vs the GEMS® Baseline of 17.3%). The chart below shows the material impact that this change can have on long-term, cumulative equity returns, especially at the lower percentiles. For example, the 1st percentile of the Gross Wealth Factor at the end of the 30th projection year is up from a little over 39% to a little over 55%.

If regulators would like to pursue changes to the GEMS® Equity Model volatility, a next step would be to determine the desired level of volatility.

Additionally, if a change is made to the volatility in the U.S. Diversified Large Cap fund, other funds will need to be adjusted to ensure alignment on a risk/reward basis across funds.

Link between Equity and Treasury Model

It is difficult to see strong relationships between equities and Treasuries because the equity market is so volatile. However, investors typically demand equity returns in excess of those offered by risk-free assets to compensate for bearing risk. Today’s low yields imply lower equity returns.

The graph on the right illustrates how changing the initial Treasury levels can influence the distribution of equity returns at the end of the 12th month of the projection. Increases to interest rate levels will shift the equity distribution upwards, and vice-versa.

Several commenters have noted that the equity-Treasury linkage could cause reserve and capital volatility from period to period.

*Impact of Changing Initial Treasury Yield
S&P 500 Total Return, 12 Month Projections with 9/30/20 Start


*Illustrative results only, these charts have not been updated for the latest calibration
Equity Model Jump Process

The graph on the right depicts quarterly total returns from the S&P 500 equity scenarios generated by the AIRG and GEMS® models as compared to the actual Q1 2020 S&P 500 quarterly total return. While both ESGs failed to capture the severe downside Q1 2020 actual return, the jump process in the GEMS® equity model included scenarios with larger negative quarterly returns.

*Actual vs. Projected Q1 2020 S&P 500 Total Returns

Prepared by Conning. Sources: Academy Interest Rate Generator v 7.1.201905 and GEMS® Economic Scenario Generator scenarios

*Illustrative results only, these charts have not been updated for the latest calibration

Equity Model Jump Process, continued

For Q2 2020, both ESGs again missed the large Q2 2020 S&P 500 quarterly total return, but the jump process in the GEMS® equity model produced scenarios with higher quarterly S&P 500 returns. Some commenters have suggested that the large up and down equity market movements produced from ESG models with a jump process may “wash out” over the long term. However, the potential impacts of large equity market movements on hedging programs that are rebalanced periodically or GMXB in-the-moneyness warrant inclusion in field testing.

*Actual vs. Projected Q2 2020 S&P 500 Total Returns

Prepared by Conning. Sources: Academy Interest Rate Generator v 7.1.201905 and GEMS® Economic Scenario Generator scenarios

*Illustrative results only, these charts have not been updated for the latest calibration

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Responses to questions on Academy’s 3-17-2022 model office results presentation to the Life Actuarial Task Force (LATF)

Please note that when we refer to “the new/Conning scenarios” we are referring to the version (i.e., calibration) we tested and presented model office results for on the 3/17/22 LATF call.

1. From Ted Chang:
   a. While the scenario reserves are increased as we all expect, the magnitude of their increase is kind of alarming and makes me wonder whether the new scenarios are too severe or the AIRG amounts are way too inadequate.

   Take into consideration, these are limited model office results which are based on simplified products and investment strategies and only consider time zero reserves on a single cell. There is also a fair amount of judgment involved as to whether the new scenarios are too severe or the AIRG scenarios are too inadequate.

   Regarding interest rates, we know the AIRG scenarios fall short of the NAIC’s new low-for-long interest rate criteria, but some actuaries may think the new interest rate scenarios are a bit severe.

   Regarding equity returns, the new equity scenarios have fatter and more severe tails than the AIRG equity scenarios, with many more equity scenarios losing a more significant portion of their value by the time guaranteed withdrawal benefits are elected (e.g., 30% to 60%+ reduction in cumulative equity returns). Also, unlike the AIRG equity scenarios which are independent of interest rate returns, the new equity scenarios assume a constant mean equity risk premium over interest rates. This makes equity scenarios produced by the new ESG dependent on the starting yield curve which might introduce some procyclical volatility to reserve and capital levels from one valuation date to the next.

   b. Would it be helpful/meaningful to calculate and compare with their respective deterministic reserves, if readily doable, for the purpose of assessing the appropriateness of those SR amounts?

   Before calculating/comparing Deterministic Reserve (DR) levels, we suggest revisiting new methodology that has been proposed for determining the DR scenario. When applied to the new 12/31/2019 scenarios the new methodology resulted in a severe DR scenario with interest rates going down to negative levels and staying there. We have developed an alternative methodology for determining the DR scenario which we look forward to presenting and discussing with LATF on a future call.

   c. What makes the last discount rate 3.75% as shown on Slide 29 out of line while the corresponding one on Slide 30 with low reserve is pretty much in line with others?

   This is due to differences in the two scenario’s interest rates which impact the yield on purchased reinvestment assets. The chart below illustrates how scenario 8025’s interest rates are significantly higher starting in projection year 27, which is why the cumulative annualized Net Asset Earn Rates (NAERs) shown on the upper right of slides 29 and 30 start to diverge after 30 years. Note that the NAERs will differ some from the weighted average interest rates in the chart below because the cash flows...
the NAERs are based on also impacted by spreads, defaults, and investment expenses.

![Weighted average annualized UST rates used for reinvestment by projection year]

2. Is it possible to isolate the impacts for both/either of the models from the following scenario features?
   a. Inversions
   b. Negative Interest Rates
   c. Very High Interest Rates

   It is difficult to isolate the impacts of such features in a given set of economic scenarios because there is no simple and objective method for “turning off” such features in order to directly evaluate their impact. Instead, metrics quantify the prevalence of such features in a given set of economic scenarios. Those metrics can then be compared between scenario sets to get an indication of the degree to which the features signified by those metrics may be impacting results.

   The Universal Life with Secondary Guarantees (ULSG) model office results are largely driven by low/negative interest rates, as can be seen in ULSG results for the unfloored scenario set. However, it is important to note that the ULSG model office uses a rather simple investment/reinvestment strategy (50/50 mix of A/AA 20-year corporate bonds) and single new business cell. Results for actual ULSG inforce blocks with more complicated reinvestment strategies could be more sensitive to inversions and very high interest rates. Even with the field test, it may be difficult to pinpoint how scenario features impact ULSG reserves, which is why it is important to evaluate the economic scenarios independently of the reserves, e.g., by developing robust acceptance criteria that are consistent with economic history while still reflecting regulatory targets.

   Given its liability and asset assumptions, the Variable Annuity (VA) model office results are driven more by equity returns than interest rates. Similar to the ULSG model office, the VA model office uses a single new business cell and
invests/reinvests general account assets into a 50/50 mix of A/AA corporate bonds, but it is slightly more complex in that it reinvests into bonds across the maturity spectrum (not just 20-year). Attributing VA impacts between equity returns and interest rates can be challenging, not to mention attributing VA impacts to different features seen within the equity return scenarios and interest rate scenarios. We suggest contemplating a consistent approach in the field test to help attribute impacts to various scenario features. We also note that criteria on Gross Wealth Factors (GWFs) are especially useful because they describe the cumulative impact of scenario rates which many insurance products (especially VA) are sensitive to.

3. Both models provided results for newly issued business.
   a. Is it possible that due to the smaller size of reserves/TAR for newly issued business as compared to inforce business that the resulting differences between each ESG model are magnified? For example, for ULSG we would expect to see a humped shape reserve pattern as the modeled policies age and get closer to claim payment before dropping off due to decrements.
      Yes, it is possible. But it is also possible that relative impacts could be larger on inforce business. The field test may be able to provide additional insight into this.
   b. How would the reserve/TAR differences between the ESG models look for an inforce product?
      Given the simple nature of our model offices we would expect them to produce directionally similar results if the same products were modeled on an inforce basis. But it is important to note that reserve/TAR differences (whether on new business or inforce) could vary significantly depending on company specific product features, in-the-moneyness of guarantees, type and extent of market dependence in assumptions, investment/hedging strategy, etc. The field test should provide insight into the impacts on inforce business.

4. ULSG Model Specific Questions
   a. How much do the results change if you change the discount rate to be 105% of the 1-year UST if positive and 95% of the 1-year UST when the 1-year UST is negative?
      We have not performed this calculation but would not expect a modest change like this to have a significant impact on results. We also do not understand the rationale behind such a change to the discount rate methodology.
   b. What do the results look like with 10,000 scenarios?
      We would expect them to be similar on our rather simple ULSG model office, so we ran with 1,000 scenarios to save time.
   c. Why do the results on slide 7 look so similar for the Conning GFF, Alternative Shadow, and Reference model?
      Those results are similar because reserves on this ULSG product and reinvestment strategy are primarily driven by low interest rates and all three of those models are calibrated to the same NAIC low-for-long interest rate criteria. Results may not be as similar for other, more complicated, ULSG products and reinvestment strategies.

5. VA Model Specific Questions
   a. For the “3 hybrid” results on slides 32 and 33:
      - What bond fund scenarios were utilized – Conning or AIRG?
        Conning bond fund returns were used. Only the equity scenarios were replaced.
      - Can you provide more insight into why the reserves and TAR were less than those for the “1 AIRG” run?
This is likely due to the level of bond fund returns from the Conning scenarios, and how those scenarios were paired with equity returns from the AIRG scenarios to produce the “hybrid” scenarios we used for our analysis. We are performing analysis to see if we can provide additional information that could help quantify the impact due to the level of bond fund returns in the Conning scenarios versus the impact of pairing those Conning bond fund returns with AIRG equity returns.

b. On slide 32, would it be possible to also show the Guaranteed Benefit Reserve along with a % change from the “1 AIRG” run?
   We added this information to the table in Appendix A on the next page.

c. Can you provide more information on the drivers of the reserve increase?
   The primary drivers are the equity returns and bond fund returns in the first 10 to 20 years of the projection that drive the separate account fund value (80/20 mix). A secondary driver is the impact of interest rates on any reinvestment into general account assets.
### Appendix A – New information provided pursuant to Question 5.b

#### Reserves (gen. acct. resv is excess over CSV) vs. Ratio to CSV

<table>
<thead>
<tr>
<th>Scenario Set (used full 10,000)</th>
<th>12/31/2020</th>
<th>Ratio to CSV</th>
<th>12/31/2020</th>
<th>Ratio to CSV</th>
<th>12/31/2020</th>
<th>Ratio to CSV</th>
<th>new requested info</th>
<th>new requested info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy Interest Rate Generator</td>
<td>95,854</td>
<td>103.3%</td>
<td>98,491</td>
<td>106.1%</td>
<td>100.30%</td>
<td>100.0%</td>
<td>109.5%</td>
<td>100.4%</td>
</tr>
<tr>
<td>ACLI Reference Model V1.0</td>
<td>96,146</td>
<td>103.6%</td>
<td>98,515</td>
<td>106.2%</td>
<td>105.54%</td>
<td>109.51%</td>
<td>274.0%</td>
<td>264.6%</td>
</tr>
<tr>
<td>Conning with Generalized Fractional Floor</td>
<td>101,167</td>
<td>109.0%</td>
<td>107,860</td>
<td>116.2%</td>
<td>110.64%</td>
<td>112.72%</td>
<td>284.1%</td>
<td>316.7%</td>
</tr>
<tr>
<td>Strommen with Shadow Rate Model Floor</td>
<td>TBD</td>
<td></td>
<td>108,971</td>
<td>117.4%</td>
<td>99.88%</td>
<td>98.90%</td>
<td>96.3%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Conning Oct21 Calibration (Unfloored)</td>
<td>TBD</td>
<td></td>
<td>110,825</td>
<td>119.4%</td>
<td>112.32%</td>
<td>112.73%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Reserves (gen. acct. resv is excess over CSV) vs. Ratio to CSV (C3P2 TAR)

<table>
<thead>
<tr>
<th>Scenario Set (used full 10,000)</th>
<th>C3P2 TAR</th>
<th>Ratio to CSV</th>
<th>C3P2 TAR</th>
<th>Ratio to CSV</th>
<th>C3P2 TAR</th>
<th>Ratio to CSV</th>
<th>new requested info</th>
<th>new requested info</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy Interest Rate Generator</td>
<td>69,768</td>
<td>107.0%</td>
<td>103,780</td>
<td>111.1%</td>
<td>100.30%</td>
<td>100.12%</td>
<td>107.00%</td>
<td>110.08%</td>
</tr>
<tr>
<td>ACLI Reference Model V1.0</td>
<td>99,769</td>
<td>107.5%</td>
<td>103,202</td>
<td>111.2%</td>
<td>110.81%</td>
<td>112.73%</td>
<td>100.02%</td>
<td>98.77%</td>
</tr>
<tr>
<td>Conning with Generalized Fractional Floor</td>
<td>106,221</td>
<td>114.5%</td>
<td>113,470</td>
<td>122.3%</td>
<td>112.73%</td>
<td>112.73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strommen with Shadow Rate Model Floor</td>
<td>TBD</td>
<td></td>
<td>114,226</td>
<td>123.1%</td>
<td>112.73%</td>
<td>112.73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conning Oct21 Calibration (Unfloored)</td>
<td>TBD</td>
<td></td>
<td>116,209</td>
<td>125.2%</td>
<td>112.73%</td>
<td>112.73%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hybrid scenario results are a simplistic initial rough test to get an initial feel for the impact of removing the equity risk premium linkage to scenario short term overnight US rates.
UPDATE ON MODEL OFFICE ECONOMIC SCENARIO GENERATOR (ESG) TESTING

Presentation to Life Actuarial Task Force - March 31, 2022

Update on VA/VM-21 ESG Model Office Testing

Additional scenario testing results
Agenda for VA Model Office Update

1. Changes since 3/17/22 – new scenario sets added
2. Summary of results
3. Scenario reserve distributions
4. Fund value exhaust year statistics
5. Equity scenario gross wealth factor and cumulative annualized total return comparisons
6. Preliminary conclusions
7. Caveats

VM-21 Model Office – Changes Since 3/17/22

- New model office testing was done for scenario sets recently added:
  1. Conning GEMS with Generalized Fractional Floor (GEMS GFF) as of 12/31/2019 valuation date
  2. An alternative version of the GEMS GFF 12/31/2019 and 12/31/2020 U.S. large cap equity scenarios using a lower equity volatility assumption
  3. No other changes – same product specs, assumptions and investment strategy (1-30 year bonds, no hedging) as 3/17/22 presentation.
Summary of Results – All Scenario Sets

The next slide summarizes the:

- Stochastic CTE70 reserves and
- C3 Phase 2 RBC after-tax Total Assets Required (TAR)
  - both expressed as a percentage of the initial Cash Surrender Value
  - CSV is 100% in the separate account;
  - excess over 100% CSV is the general account portion of reserve (i.e., the CTE70 GPVAD) and TAR

For the following scenario sets tested (yellow highlighted new since 3/17/22):

1. AIRG scenarios, 12/31/2019 and 12/31/2020 valuation dates
2. ACLI reference SLV model (version 1), 12/31/2019 and 12/31/2020
3a. Conning GEMS with Generalized Fractional Floor (GFF), 12/31/2019 and 12/31/2020
3b. Same as 3a but using lower equity volatility assumption
4. Strommen with Shadow Rate Floor (version 4B), 12/31/2020 valuation date
5. Conning GEMS unfloored 12/31/2020 valuation date scenarios developed in October 2021

In addition, a “hybrid” set of scenarios was tested for 3a above, by replacing the U.S. large cap equity fund scenarios with the AIRG U.S. large cap equity fund scenarios (as an initial rough test to get a feel for impact of removing the equity risk premium linkage to overnight UST scenario rates).

### Summary of Results

#### VA with GLWB and GMDB

<table>
<thead>
<tr>
<th>Scenario Set (used full 10,000)</th>
<th>Total reserve and C3P2 RBC post-tax TAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(General account portion is excess over 100%, initial CSV $92,800)</td>
</tr>
<tr>
<td></td>
<td>12/31/2019</td>
</tr>
<tr>
<td></td>
<td>CTE70 Reserve/CSV</td>
</tr>
<tr>
<td>1</td>
<td>Academy Interest Rate Generator (AIRG)</td>
</tr>
<tr>
<td>2</td>
<td>ACLI Reference Model V1.0</td>
</tr>
<tr>
<td>3a</td>
<td>Conning with Generalized Fractional Floor (GFF)</td>
</tr>
<tr>
<td>3b</td>
<td>Conning with GFF, lower equity fund volatility</td>
</tr>
<tr>
<td>4</td>
<td>Strommen with Shadow Rate Model Floor</td>
</tr>
<tr>
<td>5</td>
<td>Conning Oct21 Calibration (Unfloored)</td>
</tr>
<tr>
<td>3a hybrid</td>
<td>Conning with GFF, using AIRG equity scens</td>
</tr>
<tr>
<td>4 hybrid</td>
<td>Strommen with SRF, using AIRG equity scens</td>
</tr>
<tr>
<td>5 hybrid</td>
<td>Conning Oct 21 unfil, using AIRG equity scens</td>
</tr>
</tbody>
</table>

Hybrid scenario results are a rough test to get an initial feel for the impact of removing the equity risk premium linkage to scenario short term overnight UST rates. The bond fund returns and UST rates used are from the corresponding non-hybrid scenario sets.
Scenario Reserve Distributions

GEMS GFF 12/31/2019 highest 30% Scenario reserves

GEMS GFF 12/31/2020 highest 30% Scenario reserves

Fund value exhaustion statistics

For this product and 80/20 equity/bond fund allocation, fund values exhaust during years ~10 to 20 for scenarios requiring general account reserve above CSV to fund future expenses and guaranteed benefits.

Fees in all years and GLWB withdrawals in years 11+ decrease fund values in all scenarios.

Cumulative fund returns (wealth ratios) over the first 20 years are a critical driver of reserve and capital amounts for these tests.

<table>
<thead>
<tr>
<th>%-ile</th>
<th>GEMS GFF - year fund value exhausts for highest 3,000 scenario reserves</th>
<th>%-ile</th>
<th>GEMS GFF - scenario reserves/CSV ratio for highest 3,000 scenario reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>min</td>
<td>10.7 10.3 10.5 9.5</td>
<td>max</td>
<td>150.2 156.6 162.8 173.9</td>
</tr>
<tr>
<td>1.0%</td>
<td>12.2 11.7 11.8 11.4</td>
<td>99.0%</td>
<td>139.5 143.6 150.2 152.8</td>
</tr>
<tr>
<td>5.0%</td>
<td>13.7 13.2 13.1 12.6</td>
<td>95.0%</td>
<td>129.6 131.9 139.4 142.0</td>
</tr>
<tr>
<td>10.0%</td>
<td>14.7 14.2 14.0 13.5</td>
<td>90.0%</td>
<td>123.5 126.2 133.1 135.9</td>
</tr>
<tr>
<td>50.0%</td>
<td>18.6 17.9 17.0 16.6</td>
<td>50.0%</td>
<td>102.2 104.4 111.9 113.7</td>
</tr>
<tr>
<td>90.0%</td>
<td>40.0 40.0 20.5 20.3</td>
<td>10.0%</td>
<td>100.0 100.0 100.0 100.5</td>
</tr>
<tr>
<td>95.0%</td>
<td>40.0 40.0 28.6 23.5</td>
<td>5.0%</td>
<td>100.0 100.0 100.0 100.0</td>
</tr>
<tr>
<td>99.0%</td>
<td>40.0 40.0 40.0 40.0</td>
<td>1.0%</td>
<td>100.0 100.0 100.0 100.0</td>
</tr>
<tr>
<td>max</td>
<td>40.0 40.0 40.0 40.0</td>
<td>min</td>
<td>100.0 100.0 100.0 100.0</td>
</tr>
</tbody>
</table>

mean 22.6 21.6 17.9 17.2

mean 107.6 109.0 114.5 116.2

1. Right table reserve amount percentiles not an exact match to left table year of fund value exhaustion percentiles, but line up reasonably well.
### U.S. Large cap Equity scenario gross wealth factors

<table>
<thead>
<tr>
<th>%-ile</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>0.17</td>
<td>0.08</td>
<td>0.09</td>
<td>0.03</td>
</tr>
<tr>
<td>1.0%</td>
<td>0.49</td>
<td>0.39</td>
<td>0.42</td>
<td>0.47</td>
</tr>
<tr>
<td>2.5%</td>
<td>0.60</td>
<td>0.55</td>
<td>0.63</td>
<td>0.72</td>
</tr>
<tr>
<td>5.0%</td>
<td>0.71</td>
<td>0.70</td>
<td>0.84</td>
<td>1.09</td>
</tr>
<tr>
<td>10.0%</td>
<td>0.85</td>
<td>0.92</td>
<td>1.13</td>
<td>1.73</td>
</tr>
<tr>
<td>25.0%</td>
<td>1.10</td>
<td>1.23</td>
<td>2.08</td>
<td>3.45</td>
</tr>
<tr>
<td>50.0%</td>
<td>1.29</td>
<td>1.90</td>
<td>3.57</td>
<td>7.02</td>
</tr>
</tbody>
</table>

Gross wealth factors for a scenario are the accumulation of $1 over the number of years stated based on scenario gross total returns.

### U.S. Large cap Equity scenario gross wealth factors

<table>
<thead>
<tr>
<th>%-ile</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>0.37</td>
<td>0.06</td>
<td>0.04</td>
<td>0.05</td>
</tr>
<tr>
<td>1.0%</td>
<td>0.46</td>
<td>0.36</td>
<td>0.39</td>
<td>0.39</td>
</tr>
<tr>
<td>2.5%</td>
<td>0.58</td>
<td>0.48</td>
<td>0.54</td>
<td>0.66</td>
</tr>
<tr>
<td>5.0%</td>
<td>0.68</td>
<td>0.64</td>
<td>0.74</td>
<td>0.96</td>
</tr>
<tr>
<td>10.0%</td>
<td>0.81</td>
<td>0.83</td>
<td>1.05</td>
<td>1.50</td>
</tr>
<tr>
<td>25.0%</td>
<td>1.03</td>
<td>1.21</td>
<td>1.80</td>
<td>2.95</td>
</tr>
<tr>
<td>50.0%</td>
<td>1.29</td>
<td>1.70</td>
<td>3.10</td>
<td>5.88</td>
</tr>
</tbody>
</table>

Gross wealth factors for a scenario are the accumulation of $1 over the number of years stated based on scenario gross total returns.

<table>
<thead>
<tr>
<th>%-ile</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>0.22</td>
<td>0.13</td>
<td>0.15</td>
<td>0.11</td>
</tr>
<tr>
<td>1.0%</td>
<td>0.54</td>
<td>0.46</td>
<td>0.51</td>
<td>0.62</td>
</tr>
<tr>
<td>2.5%</td>
<td>0.64</td>
<td>0.61</td>
<td>0.74</td>
<td>0.95</td>
</tr>
<tr>
<td>5.0%</td>
<td>0.75</td>
<td>0.77</td>
<td>0.99</td>
<td>1.36</td>
</tr>
<tr>
<td>10.0%</td>
<td>0.88</td>
<td>0.96</td>
<td>1.34</td>
<td>2.02</td>
</tr>
<tr>
<td>25.0%</td>
<td>1.11</td>
<td>1.37</td>
<td>2.19</td>
<td>3.73</td>
</tr>
<tr>
<td>50.0%</td>
<td>1.33</td>
<td>1.91</td>
<td>3.67</td>
<td>7.29</td>
</tr>
</tbody>
</table>

**Ratio of GEMS to IAIRG wealth factors shows very different equity distributions and changes by year** - the question should be whether that makes economic sense for the purpose.

---

© 2022 National Association of Insurance Commissioners
### Equity Scenario cumulative annualized total returns

<table>
<thead>
<tr>
<th>%-ile</th>
<th>GEMS GFF new vol 12/31/2019</th>
<th>AIRG 12/31/2019</th>
<th>Difference GEMS minus AIRG</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
<th>5 Yr</th>
<th>10 Yr</th>
<th>20 Yr</th>
<th>30 Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
<td>-26.32%</td>
<td>-18.15%</td>
<td>-9.07%</td>
<td>-7.17%</td>
<td>-17.82%</td>
<td>-9.59%</td>
<td>-4.43%</td>
<td>-2.49%</td>
<td>-8.50%</td>
<td>-8.56%</td>
<td>-4.64%</td>
<td>-4.68%</td>
<td>-2.30%</td>
<td>-3.53%</td>
<td>-2.71%</td>
</tr>
<tr>
<td><strong>1.0%</strong></td>
<td>-11.70%</td>
<td>-7.55%</td>
<td>-3.17%</td>
<td>-1.60%</td>
<td>-9.40%</td>
<td>-4.01%</td>
<td>-0.56%</td>
<td>0.69%</td>
<td>-1.82%</td>
<td>-2.05%</td>
<td>-0.24%</td>
<td>-0.18%</td>
<td>-1.16%</td>
<td>-1.70%</td>
<td>-1.81%</td>
</tr>
<tr>
<td><strong>2.5%</strong></td>
<td>-8.56%</td>
<td>-4.83%</td>
<td>-1.46%</td>
<td>-0.17%</td>
<td>-6.74%</td>
<td>-2.34%</td>
<td>0.58%</td>
<td>1.82%</td>
<td>-0.98%</td>
<td>-1.51%</td>
<td>-0.16%</td>
<td>-0.14%</td>
<td>-2.82%</td>
<td>-1.02%</td>
<td>-1.22%</td>
</tr>
<tr>
<td><strong>5.0%</strong></td>
<td>-5.50%</td>
<td>-2.57%</td>
<td>-0.07%</td>
<td>1.03%</td>
<td>-4.35%</td>
<td>-0.87%</td>
<td>1.74%</td>
<td>2.81%</td>
<td>-0.88%</td>
<td>-1.06%</td>
<td>-0.94%</td>
<td>-0.75%</td>
<td>-2.48%</td>
<td>-2.28%</td>
<td>-1.94%</td>
</tr>
<tr>
<td><strong>10.0%</strong></td>
<td>-2.50%</td>
<td>-0.39%</td>
<td>1.47%</td>
<td>2.85%</td>
<td>-1.53%</td>
<td>1.12%</td>
<td>2.98%</td>
<td>3.84%</td>
<td>-2.57%</td>
<td>0.24%</td>
<td>1.36%</td>
<td>0.88%</td>
<td>-2.37%</td>
<td>-2.69%</td>
<td>-2.43%</td>
</tr>
<tr>
<td><strong>25.0%</strong></td>
<td>2.15%</td>
<td>3.21%</td>
<td>3.99%</td>
<td>4.49%</td>
<td>2.97%</td>
<td>4.23%</td>
<td>5.22%</td>
<td>5.68%</td>
<td>-2.28%</td>
<td>-2.14%</td>
<td>-1.97%</td>
<td>-1.75%</td>
<td>-4.41%</td>
<td>1.52%</td>
<td>1.13%</td>
</tr>
<tr>
<td><strong>50.0%</strong></td>
<td>6.82%</td>
<td>6.69%</td>
<td>6.72%</td>
<td>6.84%</td>
<td>7.70%</td>
<td>7.75%</td>
<td>7.66%</td>
<td>7.59%</td>
<td>-2.48%</td>
<td>-2.18%</td>
<td>-1.74%</td>
<td>-1.37%</td>
<td>-4.22%</td>
<td>1.07%</td>
<td>1.13%</td>
</tr>
</tbody>
</table>

These are annual effective rates that accumulate over the given period to the gross wealth ratios on prior slides. GEMS cumulative annualized equity returns lower than AIRG, driving higher reserves, which are most sensitive to cumulative returns over 20 years (returns after 20 years not as relevant for this product and fund allocation due to fund value exhaustion).

Differences significantly more negative for 12/31/2020, increasing reserves relative to 12/31/2019.
Preliminary Conclusions

- AAA equity scenario ESG compared to GEMS:
  - AIRG ESG has no formulaic linkage between the equity returns and Treasury yields.
    - There is an implicit expected equity risk premium in the long term / steady state if you consider expected equity returns vs. the mean reversion interest rate parameter
    - The AIRG was calibrated to specific targets, and given its structure and inputs, it will continue to meet those targets at all future points in time
    - Equity scenario distribution does not change based on initial market conditions
  - GEMS links expected equity return to current short Treasury Yield. Initially and at every node, the expected equity return is the overnight rate plus a fixed equity risk premium.
    - Therefore the short-term expected equity return is constantly changing based on changes in the simulated overnight rate, produces different expected equity returns across start dates, and makes the equity returns impacted by Treasury model’s mean reversion.
    - Actual scenario total returns also impacted by structural model differences and calibration parameter choices (i.e., the choice made to not update certain Conning Standard Calibration equity parameters and instead accept left tail returns that are significantly lower)
    - GEMS equity return wealth ratios are more volatile and pro-cyclical, and these model office results for this product design and fund allocation indicate this translates to reserves and capital being more volatile and pro-cyclical (at least for unhedged results).

Preliminary Conclusions (continued)

- For this product design and fund allocation, the impact to reserves is very large under the 3 Conning ESG scenario sets tested (GFF, Strommen SRF, GEMS unfloored) relative to current AIRG or ACLI reference model
  - Ratios of reserves and TAR to CSV are significantly higher - general account reserves are more than double the AIRG & ACLI reserves for GEMS GFF and Strommen SRF, and more than triple using the GEMS unfloored set
  - Primary driver is more severe (lower) cumulative equity return distributions in the first ~20 years for the GEMS scenario sets (though this is in part driven by the form of the linkage to interest rates).
  - Secondary driver is the “low for long” interest rate requirements, which are not present in the current AIRG. More work in process to understand these drivers.
  - At 12/31/2020 the short term rates more than 100bp lower than at 12/31/2020, producing higher reserves.
  - Form of linkage of expected equity returns to short term interest rates may drive artificial volatility in reserves and capital.
  - May cause non-intuitive risk management decisions/hedging (e.g., suggests that companies may need to hedge more overnight rates or hold more capital for the stat volatility for changes in overnight rates even if the liabilities and assets do not have an inherent dependence on overnight rates).
  - The “hybrid” scenario results shown (using Conning GEMS GFF interest rate and LT corporate bond fund returns but using AIRG equity returns) have reserve and TAR amounts that are very similar to the AIRG and ACLI reference model results.
Caveats

- Intended as an illustrative single data point (single representative model point issued on valuation date; no future sales; not an in-force block) for assessing materiality and relative impact to reserve levels and volatility from a change to the scenarios
  - No hedging reflected in results – company results may vary depending on hedging strategy.
  - Companies should consider testing their own products using their own models.

- Not intended to:
  - Cover wide variety of products available on the market
  - Reflect a full distribution of issue ages / genders within the given product
  - Reflect different starting in-force block conditions (guaranteed benefit moneyness, etc.)
  - Thoroughly test all the underlying assumptions
  - Be used as a basis for assessing appropriateness of an Economic Scenario Generator

Questions?

- Please contact Devin Boerm at boerm@actuary.org
SOCIETY OF ACTUARIES
RESEARCH UPDATE TO
LATF
March 31, 2022
R. DALE HALL, FSA, MAAA, CERA, CFA
Managing Director of Research

SOA, Academy, ACLI, NAIC
Communication Group
SOA, Academy, LATF, ACLI, NAIC Communication Group

- Replaces Preferred Mortality Project Oversight Group (PM POG)
- Purpose
  - Monthly calls with entities involved in valuation table/assumption development
  - Covers all life and annuity valuation needs
  - Provide status updates on current valuation efforts
  - Discuss anticipated future efforts
  - Coordinate resources
  - Charter, in development, to clarify purpose/roles/membership term
- Membership
  - SOA, Academy, LATF, ACLI & NAIC representatives
  - Valuation/assumption work group leaders

Preliminary 2015-2018 Group Annuity Mortality
Preliminary 2015-2018 Group Annuity Mortality

- Current study indicates higher A/E ratios on a lives basis, lower A/E ratios on an income basis compared to 2011-2014 study

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By Lives</td>
<td>By Income</td>
</tr>
<tr>
<td>1983 GAM</td>
<td>89.0%</td>
<td>81.6%</td>
</tr>
<tr>
<td>1994 GAM Basic with Projection</td>
<td>103.5%</td>
<td>97.2%</td>
</tr>
<tr>
<td>1994 GAR</td>
<td>111.2%</td>
<td>104.5%</td>
</tr>
<tr>
<td>Pri-2012 Projected with MP-2020 to Experience Year</td>
<td>102.7%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Pri-2012 Projected with MP-2020 to Study Midpoint</td>
<td>102.6%</td>
<td>97.2%</td>
</tr>
</tbody>
</table>

Preliminary 2015-2018 Group Annuity Mortality

- Mortality improvement in 2015-2018 study data
  - 0.3% slower than Scale AA during 2015-2018 on both a lives and income basis
  - Roughly the same as Scale MP-2020 on a lives basis, 0.1% faster on an income basis
  - For the 2007-2014 study, improvement was 2.0% faster than Scale AA by lives and 0.9% faster by income
  - Pri-2012 annuitant table produces smoother A/E ratio pattern by age at younger retiree ages
    - GAM 1994 developed as a blend of experience for active and retiree lives, so there is a spike in A/E ratios under age 65.
U.S. Population Mortality Observations: Updated with 2020 Experience

2020 Overall U.S. Population Historical Mortality Rates

- 2020 Mortality Rate = 895.4/100,000 (0.9%)
- First time in U.S. history over 3 millions deaths in one year
- 91.3 deaths/100,000 due to COVID
- 16.8% increase over 2019
- Highest increase on record (1918: +11.7%)
- 2020 highest rate since 2003
- Without COVID, increase over 2019 = 4.9% (last highest 1936: +5.6%)
2020 U.S. Population Mortality Rates by Age

- Mortality rates were lower in 2020 than 2019 for ages under 5
- Younger adults, aged 15-44, saw most of their increase from non-COVID CODs
- Older ages were impacted by COVID much more than non-COVID CODs

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Change in Mortality Rates 2019-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All CODs</td>
</tr>
<tr>
<td>Less than 1</td>
<td>-5.2%</td>
</tr>
<tr>
<td>1-4</td>
<td>-2.6%</td>
</tr>
<tr>
<td>5-14</td>
<td>2.3%</td>
</tr>
<tr>
<td>15-24</td>
<td>20.7%</td>
</tr>
<tr>
<td>25-34</td>
<td>23.8%</td>
</tr>
<tr>
<td>35-44</td>
<td>24.5%</td>
</tr>
<tr>
<td>45-54</td>
<td>20.7%</td>
</tr>
<tr>
<td>55-64</td>
<td>17.6%</td>
</tr>
<tr>
<td>65-74</td>
<td>17.4%</td>
</tr>
<tr>
<td>74-84</td>
<td>16.0%</td>
</tr>
<tr>
<td>85+</td>
<td>15.0%</td>
</tr>
<tr>
<td>All Ages</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

2020 U.S. Population Mortality Rates by Cause of Death

- Heart disease had 4.2% increase – largest increase in 20 years
- Cancer continued its steady improvement
- Accidents, diabetes, liver, hypertension, assaults had very large increases
- Deaths from suicides down but story varies by age group

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Deaths</th>
<th>%</th>
<th>Change in Age-Adjusted Mortality Rates 2019-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>696,962</td>
<td>20.6%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Cancer</td>
<td>602,350</td>
<td>17.8%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>COVID</td>
<td>350,831</td>
<td>10.4%</td>
<td>n/a</td>
</tr>
<tr>
<td>Alzheimer's/Dementia</td>
<td>259,200</td>
<td>7.7%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Accidents</td>
<td>200,955</td>
<td>5.9%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Stroke</td>
<td>160,264</td>
<td>4.7%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>152,657</td>
<td>4.5%</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>102,188</td>
<td>3.0%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Flu &amp; Pneumonia</td>
<td>53,544</td>
<td>1.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Liver</td>
<td>51,642</td>
<td>1.5%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Suicide</td>
<td>45,979</td>
<td>1.4%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>41,907</td>
<td>1.2%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Assault</td>
<td>24,576</td>
<td>0.7%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Other</td>
<td>640,674</td>
<td>18.9%</td>
<td>6.2%</td>
</tr>
<tr>
<td>All COD</td>
<td>3,383,729</td>
<td>100.0%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>
Heart Disease – Historical Annual Death Rates

- Steady decrease until 2012; relatively flat thereafter
- 2015 and 2020 only years with an increase
- Heart Disease is #1 cause of death and key driver of historical overall improvement in mortality

*Age-adjusted

Diabetes – Historical Annual Death Rates

- 2005-2009 saw decreasing mortality rates
- Fairly level rates over 2009-2019
- 2020 mortality rate at 2005 levels

*Age-adjusted
Opioid Deaths – Historical Annual Death Rates

- Steady increase, excluding 2018
- 2018 was only year with improvement
- Big portion of accidental death increase
  - Accidental deaths increased 16.3%
  - Accidents w/o Opioid increased 6.8%

*Age-adjusted

Suicides

- Suicides saw improvement of 3.5% over all ages
- Younger age groups saw an increase in mortality
U.S. Population Mortality Observations: Updated with 2020 Experience

www.soa.org/resources/research-reports/2022/us-population-mortality/

Group Life COVID-19 Mortality Study
Group Life COVID Mortality Study

- Updated through September 2021

**COUNT-BASED INCURRED INCIDENCE RESULTS RELATIVE TO 2017-2019 BASELINE PERIOD**

<table>
<thead>
<tr>
<th>Count-Based</th>
<th>2Q20</th>
<th>3Q20</th>
<th>4Q20</th>
<th>1Q21</th>
<th>2Q21</th>
<th>3Q21</th>
<th>4/20-9/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total / Baseline</td>
<td>115.4%</td>
<td>115.1%</td>
<td>128.1%</td>
<td>122.0%</td>
<td>106.9%</td>
<td>137.7%</td>
<td>120.8%</td>
</tr>
<tr>
<td>COVID-19 Claims</td>
<td>12.97%</td>
<td>9.82%</td>
<td>23.55%</td>
<td>24.44%</td>
<td>6.68%</td>
<td>18.62%</td>
<td>96.27%</td>
</tr>
<tr>
<td>COVID / Baseline</td>
<td>12.4%</td>
<td>9.6%</td>
<td>21.7%</td>
<td>21.8%</td>
<td>6.6%</td>
<td>18.7%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Non-COVID / Baseline</td>
<td>103.0%</td>
<td>105.5%</td>
<td>106.4%</td>
<td>100.2%</td>
<td>100.3%</td>
<td>119.0%</td>
<td>105.7%</td>
</tr>
</tbody>
</table>

GROUP LIFE AND U.S. POPULATION EXCESS MORTALITY PERCENTAGES BY QUARTER

<table>
<thead>
<tr>
<th>Age</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
<th>Q1 2021</th>
<th>Q2 2021</th>
<th>Q3 2021</th>
<th>Q4 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Life</td>
<td>15%</td>
<td>15%</td>
<td>28%</td>
<td>22%</td>
<td>7%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>U.S. Population</td>
<td>20%</td>
<td>16%</td>
<td>21%</td>
<td>17%</td>
<td>5%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>-5%</td>
<td>-1%</td>
<td>7%</td>
<td>5%</td>
<td>2%</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>


---

Group Life COVID Mortality Study

- Updated through September 2021

**EXCESS MORTALITY BY DETAILED AGE BAND**

<table>
<thead>
<tr>
<th>Age</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
<th>Q1 2021</th>
<th>Q2 2021</th>
<th>Q3 2021</th>
<th>4/20-9/21</th>
<th>% COVID</th>
<th>% Non-COVID</th>
<th>% Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-24</td>
<td>119%</td>
<td>127%</td>
<td>108%</td>
<td>102%</td>
<td>121%</td>
<td>129%</td>
<td>118%</td>
<td>2.7%</td>
<td>15.2%</td>
<td>2%</td>
</tr>
<tr>
<td>25-34</td>
<td>129%</td>
<td>135%</td>
<td>124%</td>
<td>120%</td>
<td>131%</td>
<td>181%</td>
<td>136%</td>
<td>11.4%</td>
<td>25.1%</td>
<td>2%</td>
</tr>
<tr>
<td>35-44</td>
<td>124%</td>
<td>136%</td>
<td>129%</td>
<td>129%</td>
<td>132%</td>
<td>217%</td>
<td>144%</td>
<td>19.8%</td>
<td>24.7%</td>
<td>4%</td>
</tr>
<tr>
<td>45-54</td>
<td>123%</td>
<td>127%</td>
<td>130%</td>
<td>133%</td>
<td>121%</td>
<td>208%</td>
<td>140%</td>
<td>23.8%</td>
<td>16.5%</td>
<td>10%</td>
</tr>
<tr>
<td>55-64</td>
<td>117%</td>
<td>123%</td>
<td>130%</td>
<td>129%</td>
<td>116%</td>
<td>170%</td>
<td>131%</td>
<td>21.0%</td>
<td>10.0%</td>
<td>18%</td>
</tr>
<tr>
<td>65-74</td>
<td>116%</td>
<td>115%</td>
<td>133%</td>
<td>130%</td>
<td>108%</td>
<td>133%</td>
<td>122%</td>
<td>16.8%</td>
<td>5.6%</td>
<td>17%</td>
</tr>
<tr>
<td>75-84</td>
<td>113%</td>
<td>113%</td>
<td>132%</td>
<td>122%</td>
<td>105%</td>
<td>116%</td>
<td>117%</td>
<td>13.3%</td>
<td>3.7%</td>
<td>20%</td>
</tr>
<tr>
<td>85+</td>
<td>111%</td>
<td>102%</td>
<td>123%</td>
<td>130%</td>
<td>90%</td>
<td>98%</td>
<td>106%</td>
<td>10.4%</td>
<td>-4.6%</td>
<td>27%</td>
</tr>
<tr>
<td>All^a</td>
<td>116%</td>
<td>115%</td>
<td>128%</td>
<td>122%</td>
<td>107%</td>
<td>139%</td>
<td>121%</td>
<td>15.6%</td>
<td>5.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Group Life COVID-19 Mortality Study

www.soa.org/resources/experience-studies/2022/group-life-covid-19-mortality/

U.S. Individual Life COVID-19 Mortality Study
U.S. Individual Life
COVID-19 Reported Claims Analysis
• Updated through 3rd Quarter 2021

Table 1 Reported Claims – Ratio of 2020 and 2021 Claims by Quarter to Historical Average (2017-2019)
By Claim Count and Claim Amount

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Group Life*</th>
<th>Individual Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020 Quarter 1</td>
<td>99%</td>
<td>101%</td>
</tr>
<tr>
<td>2020 Quarter 2</td>
<td>111%</td>
<td>117%</td>
</tr>
<tr>
<td>2020 Quarter 3</td>
<td>114%</td>
<td>117%</td>
</tr>
<tr>
<td>2020 Quarter 4</td>
<td>122%</td>
<td>125%</td>
</tr>
<tr>
<td>2021 Quarter 1</td>
<td>129%</td>
<td>121%</td>
</tr>
<tr>
<td>2021 Quarter 2</td>
<td>110%</td>
<td>102%</td>
</tr>
<tr>
<td>2021 Quarter 3</td>
<td>120%</td>
<td>107%</td>
</tr>
</tbody>
</table>


U.S. Individual Life COVID-19 Mortality Study

www.soa.org/resources/experience-studies/2022/us-ind-life-covid-q1/
Additional Life Research

Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Link/Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality Improvement Survey</td>
<td>Complete a survey to learn how companies are reacting to the slowdown in the level of mortality improvement within the general population.</td>
<td><a href="https://www.soa.org/resources/research-reports/2022/mortality-improvement-survey/">https://www.soa.org/resources/research-reports/2022/mortality-improvement-survey/</a></td>
</tr>
<tr>
<td>Cause of Death Study</td>
<td>Prepare a cause of death study.</td>
<td>3/30/2022</td>
</tr>
<tr>
<td>2009-2015 Individual Life Experience Committee Lapse and Mortality Study</td>
<td>Study mortality and lapse experience in the database of 2009-2015 Individual life experience data and release a report with the findings.</td>
<td>3/30/2022</td>
</tr>
<tr>
<td>COVID-19 Individual Life Mortality Study - Experience Study Report - 2021 Q2</td>
<td>Complete a mortality study assessing the impact of COVID-19 on Individual Life Insurance.</td>
<td>3/30/2022</td>
</tr>
<tr>
<td>Individual Life Waiver of Premium Study</td>
<td>Review mortality and lapse experience where waiver of premium provisions apply.</td>
<td>3/30/2022</td>
</tr>
</tbody>
</table>
### Practice Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Link/Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity Trends and Mortality and Longevity Impacts</td>
<td>Develop an estimate of the impact of obesity in mortality and morbidity costs in the US and Canada.</td>
<td><a href="https://www.soa.org/resources/research-reports/2021-obesity-mortality/">https://www.soa.org/resources/research-reports/2021-obesity-mortality/</a></td>
</tr>
<tr>
<td>US Cause of Death Mortality By Socioeconomic Category</td>
<td>Develop US age-adjusted death rates by cause of death and socioeconomic category from 1982-2018.</td>
<td>4/30/2022</td>
</tr>
<tr>
<td>US Mortality Improvement Company Survey</td>
<td>Update MM-2021 based on user feedback.</td>
<td>4/30/2022</td>
</tr>
<tr>
<td>US Mortality Improvement Trends Analysis</td>
<td>Survey life insurers and annuity companies to see how mortality improvement assumptions have changed in light of COVID.</td>
<td>5/2/2022</td>
</tr>
<tr>
<td>ALM Practices</td>
<td>Conducts a survey of current ALM practices focused on various life insurance company products with attention paid to issues such as general account vs. separate account product distinctions.</td>
<td>3/30/2022</td>
</tr>
<tr>
<td>Expert Opinion on Impact of COVID-19 on Future Mortality</td>
<td>Survey panel of experts on short and mid term thoughts on future population and insured mortality.</td>
<td>3/30/2022</td>
</tr>
<tr>
<td>Mortality Improvement Trends Analysis</td>
<td>Identify how mortality improvement varies by driver.</td>
<td>3/30/2022</td>
</tr>
</tbody>
</table>

### Presentation Disclaimer

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Life Practice Council Update

Ben Slutsker, MAAA, FSA
Vice President, Life Practice Council

Agenda

- Webinars and Events
- Recent and Ongoing Activities
- Life Experience Committee
- Professionalism

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Webinars and Events

Recent
- Winter 2022 Life Policy Update Webinar (January)

Upcoming
- ASOP No. 2 Webinar, on Nonguaranteed Elements—*The Revised ASOP No. 2: What You Need to Know* (April 5)
- ASOP No. 11, *Treatment of Reinsurance or Similar Risk Transfer Programs Involving Life Insurance, Annuities, or Health Benefit Plans in Financial Reports*—Webinar (May 12)
- Life Policy Update Webinar (May 2022)
- Webinar on VM-31 PBR Actuarial Report Reviews (Fall 2022)

Recent Activity

- Presented potential Academy model office testing for the National Association of Insurance Commissioners (NAIC) economic scenario generator proposals

- Proposed an amendment proposal form to LATF on transitioning from LIBOR to SOFR (APF 2022-04)

- Presented recommendations on updated C-2 mortality factors to the NAIC’s Life Risk-Based Capital (E) Working Group
Recent Activity (continued)

- Submitted comments to LATF on high yielding asset actuarial guideline for asset adequacy analysis
- Provided comments to LATF related to the Actuarial Guideline 49 exposure
- Shared a comment letter with the Index-Linked Variable Annuity (A) Subgroup on the nonforfeiture interim value actuarial guideline exposure

Recent Activity (continued)

- Published an updated version of the VM-21 Variable Annuity Practice Note
- Submitted comments to the NAIC Life Risk-Based Capital (E) Working Group on the Pension Risk Transfer in light of C-2 longevity risk charges
- Submitted comments to Accelerated Underwriting (A) Working Group
- Submitted comments on APF 2020-12, hedging strategies, to LATF
Ongoing Activities

- Developing fixed annuity principle-based approach joint field study for non-variable annuities in coordination with the NAIC and ACLI
- Providing input on economic scenario generator transition and field study
- Continue providing comments and ideas related to active LATF issues: high-yielding asset actuarial guideline, nonforfeiture, and Actuarial Guideline 49

Life Experience Committee

- Assist practicing actuaries and regulators with respect to assumptions regarding life insurance and annuity products
- First goal: Addressing mortality questions such as:
  - How COVID-19 should be reflected in PBR/asset adequacy/RBC calculations
  - Modeling a product where mortality improvement is both a positive and a negative
  - Changes to be made to reflect accelerated underwriting
- Other projects
  - Review other assumptions, such as lapse, benefit utilizations
Life Experience Committee (continued)

☐ Work with the SOA, which does the experience studies and develops the CSO Tables
  - Interface with LATF with respect to any changes needed to the Valuation Manual, Actuarial Guidelines and RBC
  - Write practice notes to assist the practicing actuary who works with mortality and other assumptions
  - Interface with the Actuarial Standards Board with respect to any changes needed to actuarial standards of practice

Professionalism

☐ The Actuarial Standards Board (ASB) adopted revisions to the following actuarial standards of practice (ASOPs):
  - ASOP No. 2, Nonguaranteed Elements for Life Insurance and Annuity Products (Effective June 2022)
  - ASOP No. 22, Statements of Actuarial Opinion Based on Asset Adequacy Analysis for Life Insurance, Annuity, or Health Insurance Reserves and Other Liabilities (Effective June 2022)
  - ASOP No. 38, Catastrophe Modeling (Effective Dec. 2021)
Professionalism (continued)

- The ASB is currently working on the following ASOPs:
  - ASOP No. 7, Analysis of Life, Health, or Property/Casualty Insurer Cash Flows
  - ASOP No. 10, Methods and Assumptions for Use in Life Insurance Company Financial Statements Prepared in Accordance with U.S. GAAP
  - ASOP No. 12, Risk Classification
  - ASOP No. 24, Compliance with the NAIC Life Insurance Illustrations Model Regulation
  - ASOP No. 40, Compliance with the NAIC Valuation of Life Insurance Policies Model Regulation with Respect to Deficiency Reserve Mortality
  - ASOP No. 41, Actuarial Communications
  - New ASOPs on reinsurance pricing and actuarial opinions without asset adequacy analysis

Thank You

- Questions?
- For more information, please contact the Academy’s deputy director for public policy, Devin Boerm, at boerm@actuary.org.
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee April 7, 2022, Minutes ........................................................ 6-2
Consumer Information (B) Subgroup March 22, 2022, Minutes (Attachment One).................................................... 6-5
   Federal No Surprises Act (NSA) Presentation Handout (Attachment One-A) .......................................................... 6-8
Health Innovations (B) Working Group April 4, 2022, Minutes (Attachment Two) ...................................................... 6-12
The Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Glen Mulready, Chair (OK); Troy Downing, Co-Vice Chair (MT); Russell Toal Co-Vice Chair (NM); Lori K. Wing-Heier (AK); Michael Conway (CO); John F. King represented by Steve Manders (GA); Amy L. Beard (IN); Anita G. Fox (MI); Grace Arnold (MN); Chris Nicolopoulos (NH); Andrew R. Stolfi (OR); Michael Humphreys (PA); Jon Pike (UT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Karima M. Woods (DC); Dana Popish Severinghaus (IL); Vicki Schmidt (KS); and Edward M. Deleon Guerrero (NMI).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner McVey made a motion, seconded by Director Wing-Heier, to adopt the Committee’s Dec. 15, 2021, minutes (see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee). The motion passed unanimously.

2. **Adopted its Subgroup, Working Group, and Task Force Reports**

Commissioner Stolfi made a motion, seconded by Commissioner McVey, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its March 22 minutes (Attachment One); 2) the Health Innovations (B) Working Group, including its April 4 minutes (Attachment Two); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

3. **Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work**

Commissioner Arnold provided an update to the Committee on Workstream Five’s work to date as the new Workstream co-chair for 2022. She said that along with Commissioner Birrane, the other Workstream Five co-chair for 2022, she met with the Workstream’s 2021 co-chairs, Commissioner Ricardo Lara (CA) and former Commissioner Jessica K. Altman (PA), to discuss the Workstream’s 2021 work and potential 2022 work. She said that following this meeting, the Workstream met in a regulator-to-regulator session to discuss its focus and work plan for 2022.

Commissioner Arnold said the Workstream discussed and agreed its focus should center on: 1) identifying demographic-based barriers to the acquisition and use of health insurance and creating strategies for mitigating or removing such barriers; and 2) understanding the role health insurance can play in addressing inequities in health outcomes and social determinates of health. She said the Workstream also agreed on a framework for executing on those objectives, including the specific topics it will cover this year.

With respect to the first objective, Commissioner Arnold said the Workstream decided that the topics it will focus on this year will be: 1) benefit design, which includes examining provider network design and benefit structures; and 2) consumer empowerment and engagement. She said the first topic is foundational because it is critically important that products are inclusive in design and that carriers consider the actual health needs of certain communities. She provided examples of what the Workstream would be examining: “Are prescription drug formularies designed to assure that medications that treat conditions more prevalent among Black or Brown people are offered with no or minimal co-pays?” and “What do preventative services look like, and how are wellness programs designed and promoted?” She said the use of scales and Fitbits in wellness programs may be a great incentive for some people to focus on their health, but nutritional support and transportation may be far

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more important for people whose health is affected by their environment. Similarly, the Workstream will be
considering, with respect to benefit design, what the network looks like, not only in the traditional sense of the
availability of appointments, but also looking at the impact of the kinds of providers and the cultural competency
of providers on the willingness and ability of people to use services.

Commissioner Arnold said that with respect to the second topic, consumer engagement and empowerment, the
Workstream will be looking at successful strategies for enrollments and for facilitating consumer understanding
of how to access care through insurance and how to navigate claim issues.

Commissioner Arnold said the Workstream also discussed what its end work product should be. She said the
Workstream is considering developing a guide for state insurance regulators that compiles information about
barriers and presents potential tools and strategies for state insurance regulators to use to address them. She said
the Workstream is mapping out a schedule for completing its work before the end of the year. The Workstream
hopes to meet at least monthly to hear from various stakeholders—such as consumer groups, academics, and
industry—on the topics it has identified as its focus for this year: benefit design and consumer empowerment.

Commissioner Arnold said that with respect to the second objective, the Workstream also discussed holding
listening sessions, potentially in conjunction with Zone member meetings, with community-based individuals and
organizations who work with racially disadvantaged and historically underserved and underrepresented
populations to facilitate a ground zero understanding of the determinants of health and how insurance can affect
that.

4. Heard an Update from the CCIIO on NSA Implementation

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) provided an update on the
steps the federal Centers for Medicare & Medicaid Services (CMS) has taken to date in implementing the federal
No Surprises Act (NSA) since its launch Jan. 1.

Mr. Wu said the CMS created a No Surprises Help Desk, which consumers and providers can call to ask questions
or file complaints. Consumers and providers can also file a complaint online. He said the CMS created a consumer
web form and a provider web form to assist in submitting online complaints. He said the CMS also has created a
document providing helpful tips on how to complete a complaint form. The CMS also has developed several sets
of frequently asked questions (FAQ)—provider FAQ, good faith estimates FAQ, and independent dispute
resolution (IDR) updates FAQ.

Mr. Wu discussed the CMS’ NSA outreach and education efforts targeted at consumers and providers. He also said
the CMS also has specifically conducted lots of outreach to consumers and providers related to the good faith
estimates for uninsured or self-pay individuals provision. He said the CMS is leveraging its contacts with
organizations such as the Kaiser Family Foundation (KFF), the federal Consumer Financial Protection Bureau
(CFPB), and the Commonwealth Fund to assist it in these education efforts.

Mr. Wu discussed NSA enforcement and its interaction with state law. He reiterated that the states are the primary
enforcers of the NSA. Under the statute, the CMS will only enforce a provision with respect to the applicable
regulated parties if the CMS determines that a state is not substantially enforcing a provision. He said that the
CCIIO recognizes that the states are in different positions as far as NSA enforcement is concerned and that it is
committed to working with the states to address any implementation and enforcement issues. He explained that
the CCIIO has held meetings with the states to discuss NSA enforcement and recently published a series of
Consolidated Appropriations Act of 2021 (CAA) enforcement letters that outline the CMS’ understanding of the
federal Public Health Service Act (PHSA) provisions, as extended or added by the CAA, that each state is enforcing
directly or through a collaborative enforcement agreement and the provisions the CMS will enforce. These letters
also communicate whether the federal IDR process and federal patient-provider dispute resolution process apply in each state and in what circumstances.

Commissioner Mulready asked about the status of, and timeline for resolving, the Texas Medical Association (TMA) v. United States Department of Health and Human Services (HHS) case, which challenged the Biden administration’s Sept. 30, 2021, interim final rule that directed arbiters under the IDR process to presume that the median in-network rate is the appropriate out-of-network rate and limit when and how other statutory factors come into play. The U.S. District Court for the Eastern District of Texas, Tyler Division, ruled Feb. 23 that the NSA unambiguously establishes the framework for deciding payment disputes and concluded that the interim final rule conflicted with the statutory text and must be set aside under the federal Administrative Procedure Act (APA). The court also ruled that the HHS improperly bypassed the APA’s notice and comment requirements, and thus the interim final rule must be set aside for this additional reason. Mr. Wu said the HHS has no idea when there could be a final resolution of the case, but meanwhile, the CMS is moving forward with implementing the NSA provisions, including the IDR process provisions.

Commissioner Mulready asked about the nature of the calls the CMS has received through the No Surprises Help Desk. Mr. Wu said the calls received have changed over time. He said that Initially, the calls involved general questions about the NSA. He said that currently the Help Desk is receiving more specific questions about the NSA’s provisions and complaints, which are mostly complaints about billing and related issues.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned into regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Statement on Open Meetings.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met March 22, 2022. The following Subgroup members participated: Mary Kwei, Chair, and Joy Hatchette (MD); Debra Judy, Vice Chair, and Jill Mullen (CO); Yada Horace and Anthony L. Williams (AL); Kathy McGill and Randy Pipal (ID); Patrice Dzire (IL); Jenifer Groth and Alex Peck (IN); LeAnn Crow and Brenda Johnson (KS); Judith Watters (ME); Gregory Maus and Sherri Mortensen-Brown (MN); Camille Anderson-Weddle, Carrie Couch, Amy Hoyt, and Michelle Vickers (MO); Charlette C. Borja (MP); Robert Croom and Kathy Shortt (NC); Michael Anderson, Laura Arp, and Jordan Blades (NE); Donna Dorr, Cuc Nguyen, Kelli Price, Mike Rhoads, and Rebecca Ross (OK); David Buono (PA); Gretchen Brodkorb, Candy Holbrook, and Jill Kruger (SD); Brian Hoffmeister and Scott McAnally (TN); Heidi Clausen, Ryan Jubber, and Shelley Wiseman (UT); Jane Beyer (WA); and Barbara Belling, Diane Dambach, Monica Hale, and Darcy Paskey (WI). Also participating was: Jana Jarret (OH).

1. Discussed Potential Work Products for the Year

Ms. Kwei asked the Subgroup to think through projects it could take on for the year. She reviewed projects from 2021, including an addendum to the Frequently Asked Questions on Health Care Reform (FAQ) document, five consumer guides on the claims process, updates to the main body of the FAQ document, and a consumer alert on the federal No Surprises Act (NSA).

Ms. Kwei asked for ideas for new projects. She said the consumer alert on the NSA focused on the basics, but there is a lot more in the law. She said good faith estimates and continuity of care provisions were two topics the Subgroup may want to address this year.

Ms. Judy said the two provisions would be helpful, but there is uncertainty on timing because of the lack of federal rules, as well as what consumer guidance federal officials may release on these topics.

Ms. Kruger said the presentation from Brenda J. Cude (University of Georgia) and Lisa Groshong (Center for Insurance Policy and Research—CIPR) could inform the Subgroup’s choice of projects for the year.

Harry Ting (Health Consumer Advocate) said the Subgroup should consider strategies to encourage consumers to consult more often with departments of insurance (DOIs). He suggested efforts to quantify consumer contacts with DOIs to identify which states are especially effective in engaging consumers. He said this could be done through a survey of states. Ms. Judy said she would appreciate knowing which states do consumer engagement well. Ms. Shortt and Ms. Kruger agreed that this would be valuable information.

Dr. Ting said Subgroup members should think about what the best way is to measure these issues. Ms. Arp said states may not track web access to materials, which is likely the most common way consumers access information from DOIs. She said reaching out to the provider community could also be useful because they are important stakeholders in balance billing protections.

Dr. Cude suggested collecting information about the barriers to measuring impact, such as why states cannot track website usage. Eric Ellsworth (Consumers Checkbook) said much previous work has focused on helping consumers
understand the current system, not in making the system easier to navigate for consumers. He said DOIs should seek to close gaps on behalf of consumers. Ms. Kwei said such work may exceed the charge of the Subgroup. Mr. Ellsworth asked what group at the NAIC would be more appropriate for work to simplify consumer processes. Ms. Kwei said she would follow up to suggest other groups.

Ms. Kwei asked for volunteers to work on a draft survey of states to collect information on their consumer engagement practices. Ms. Shortt, Ms. Judy, Mr. Williams, Holly Blanchard (Regulatory Insurance Advisors LLC), and Dr. Ting said they would be happy to work on a survey. Dr. Cude said she would be interested in reviewing initial ideas from the volunteers.

Ms. Kwei said the survey work would be the Subgroup’s initial priority, and the Subgroup could look at other topics under the NSA once there is more clarity on federal actions. She said the Subgroup would consider updates to the FAQ document later in the year.

2. **Heard a Presentation on Consumer Understanding of Surprise Bills and Balance Bills**

Ms. Kwei said Dr. Cude and Ms. Groshong collaborated on a survey of consumers and asked to share results with the Subgroup.

Dr. Cude said a handout (Attachment One-A) has the key information from the presentation. She said surprise billing is harmful to consumers, and $88 billion in medical bills appears on consumer credit reports. Ms. Groshong said the CIPR provides data and research on insurance topics, and she works on consumer issues and understanding. She said a survey collected information from more than 2,000 adults in 2020; it included questions on health insurance and specifically surprise billing. She said consumers have reasonable knowledge of basic insurance terms like co-pay and deductible. However, they generally were not able to define surprise medical bills in the way the term is used in the NSA.

Ms. Groshong said respondents were provided with the formal definition of surprise (out-of-network) medical bills. She said about 40% said they received a surprise bill under this definition, and 15% were unsure. She said media coverage of surprise billing may have increased since the survey was fielded and added to consumer understanding. She said both the NSA and state legislation addresses surprise billing, but there is still a need for more consumer education on the topic.

Ms. Groshong said she and Dr. Cude identified several states that have worked to educate consumers on surprise bills. Dr. Cude said state DOI websites may confuse consumers with different headlines for surprise bill sections. She said it is useful for states to provide a definition of surprise bills at the outset so consumers understand the circumstances covered by state or federal law protections. She said consumers will use their own definition if they are not provided with the correct one. She said they may believe they are protected against any bill that is a surprise. She encouraged states to use 8th or 9th grade level writing to ease understanding. She said the Subgroup’s 2021 document on the NSA may be somewhat confusing because it begins by discussing balance billing rather than surprise billing.

Ms. Groshong said there are ways to educate consumers by using plain language and clear definitions. Dr. Cude said there is no common understanding without a clear definition.

Ms. Kwei asked about the most useful way to present a definition. Dr. Cude said state insurance regulators should use any and all ways to reach consumers (e.g., social media and website users may be different audiences). Ms.
Groshong said the most effective way can be to use storytelling about consumers who have received surprise bills. She said myth-and-fact sheets are not effective because they reinforce myths as well as facts. Dr. Cude said many state DOI websites are not using the Subgroup’s consumer guide on the NSA.

Mr. Ellsworth asked what evidence is available on how consumers understand explanations of benefits and other insurance documents. Dr. Cude said studies that ask consumers to apply knowledge from documents would be more helpful in addressing that question than the 2020 consumer survey. She said consumers’ estimation of themselves as a financial manager is more important than their knowledge as measured by a multiple-choice survey.

Ms. Groshong said further research could investigate consumers’ understanding of issues beyond surprise billing.

Having no further business, the Consumer Information (B) Subgroup adjourned.
Surprise Billing Presentation
to NAIC’s Consumer Information (B) Subgroup

March 22, 2022

Brenda J. Cude, PhD, NAIC Consumer Representative and Professor Emeritus, University of Georgia;
bcuda@uga.edu

Lisa Groshong, PhD, Communication Research Scientist, NAIC’s Center for Insurance Policy and Research; lgroshong@naic.org

Surprise medical billing hurts consumers

Surprise medical bills are a major source of financial hardships for patients (Cooper et al., 2018). According to a Kaiser Family Foundation survey, one-third of the large troubling medical bills received by insured, working-age adults are charges from out-of-network providers (Hamel et al., 2016). Unexpected medical bills harm consumers; 37% of adult Americans could not cover an unexpected $400 expense without borrowing or selling assets (Board of Governors of the Federal Reserve System, 2020).

CIPR surprise billing survey

NAIC’s Center for Insurance Policy and Research is the research group within NAIC that provides data and analysis about insurance issues and topics, including a recent overview of the No Surprises Act.

In July 2020, CIPR surveyed about 2,000 people about their health insurance knowledge and experience, using SurveyMonkey’s Audience Panel.

**About 70% of survey respondents correctly answered questions about health insurance concepts.**

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<tr>
<th>Concept</th>
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<td>1267</td>
<td>535</td>
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<tr>
<td>Define deductible</td>
<td>1256</td>
<td>546</td>
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<td>Pre-existing/A CA</td>
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<td>496</td>
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<td>Preventive care/A CA</td>
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The majority of respondents correctly answered questions about health insurance concepts, including the definitions of deductibles and copay. And they knew that insurance must cover pre-existing conditions and preventive care under the Affordable Care Act.
But only about one in five respondents chose the correct definition of “surprise medical bill” (a bill for the charges when you use a provider who is outside your health insurance network, even if you didn’t choose the outside provider) from among four choices. In fact, the correct definition ranked third among the four options. The other answer choices were A bill for charges you think your insurance company has already paid, A bill for services or medications that you don’t think you ever received, and A bill for services or medications that the insurance company said it would pay but now it won’t (the most popular choice).

**Surprise bill receipt**

After we asked respondents to try to define the term, we provided our definition. We then asked if respondents or their family members had ever received a surprise out-of-network medical bill. Forty percent reported that they or a family member had; another 15% weren’t sure.

In our further analysis, we used a subsample of people who had health insurance through an employer. In that group, respondents ages 45 to 60 were more likely to report having received a surprise medical bill than those ages 18 to 29. Given that 40% of medical procedures at hospitals and surgery centers are performed on patients aged 45-64, it makes sense that people in this age group are more likely to encounter surprise billing (Hall et al., 2017).

**Legislation**

We fielded our survey in 2020, well before the federal No Surprises Act went into effect in January 2022. Under the act, providers and health plans treat many out-of-network services as if they were in-network in terms of patient cost-sharing, except related to ground transportation. Unlike existing state legislation, the federal law protects consumers with employer-sponsored health plans.

We don’t know how consumers would respond to our survey today, but we suspect that news coverage has increased general awareness of surprise billing. But we’re still uncertain how well people will
understand what’s meant by surprise billing given the general lack of understanding we saw in the survey.

**Consumer outreach**

Rules about surprise billing are now being enforced through both state and federal legislation. This may result in ongoing consumer confusion. Further, a lack of uniform understanding of the term indicates a need for more consumer information and education efforts related to surprise medical billing.

The next section highlights some useful examples of surprise billing consumer outreach, both as models to emulate and cautionary examples to avoid.

The Alabama Department of Insurance uses a **straightforward definition**:

Surprise billing occurs when a patient receives a balance bill after unknowingly receiving care from an out-of-network provider or an out-of-network facility, such as a hospital. This can occur in emergency and non-emergency situations.

Montana’s department offered a **concise yet detailed overview** of the federal legislation:

On January 1\textsuperscript{st} of this year, the No Surprises Act (NSA) went into effect protecting individuals with private health insurance from surprise medical bills. In other words, if you are insured from a company that is not Medicare or Medicaid and receive emergency medical care or a scheduled procedure at an in-network facility then, in most circumstances, you will not be billed at ‘out of network’ rates.

New Mexico also offers a straightforward **definition**:

A surprise bill is when a person, through no fault of their own, unknowingly or unavoidably receives health care services from providers outside their insurance company’s network and then is billed directly for that care.

Messages should be crafted carefully to ensure they are easy for consumers to interpret. For example, this description of the legislation could easily be misinterpreted:

Effective January 1, 2022, the federal No Surprises Act provides new protections for unexpected or excessive medical bills consumers may receive from health care providers, including hospitals, physicians, ambulances, and other medical professionals.

This example provides valuable information—but is written at about a 20th grade reading level, far above the 8th grade level that readability experts recommend:
The law protects patients from receiving and paying surprise medical bills above the patient’s in-network rate from health care providers for emergency care or, in certain circumstances, unanticipated out-of-network care, such as at an in-network health care facility from an out-of-network provider and including lab/pathology services. Cost sharing amounts, which include coinsurance, copayments, and deductibles, are limited to the patient’s lower in-network amounts.

NAIC Consumer Information Subgroup Resource

In 2020, the NAIC Consumer Information Subgroup created New Protections from Surprise Medical Bills, a two-page document plus two pages of examples of surprise medical billing. This document includes clear and concise language about surprise medical billing. In hindsight and with the insights gained from this survey, Brenda Cude would now recommend flipping the first two sections (What is balance billing? What is surprise billing?) to discuss surprise billing first.

Readability resources

Microsoft Word includes a tool that will display readability scores with documents. Instructions are here. Resources for writing in plain language to a wide range of readers are available at the Centers for Disease Control and Prevention’s health literacy website.

The digital publication The Pudding has an interesting resource about writing in plain language.

References


The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 4, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Anthony Williams (AL); Sarah Bailey (AK); Doug Ommen and Andria Seip (IA); Julie Holmes (KS); Cynthia Amman (MO); John Arnold (ND); Maureen Belanger (NH); Nancy Clark and Chris Herrick (TX); Tanji Northrup (UT); Molly Nollette (WA); and Erin Hunter (WV). Also participating were: Weston Trexler (ID); and Katie Merritt (PA).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner Houdek made a motion, seconded by Ms. Nollette, to adopt the Working Group’s Dec. 11, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee, Attachment Five*). The motion passed unanimously.

2. **Heard Presentations on Coverage Changes Associated with the End of the Covid-19 PHE**

Commissioner Stolfi said state Medicaid programs have been limiting redeterminations during the pandemic, but this pause will end after the Covid-19 public health emergency (PHE) ends. He said maintaining coverage for individuals who leave Medicaid will take coordination between federal officials, states, and health plans as well as public education. He said a recent report from State Health and Value Strategies outlines steps state insurance regulators can take to aid in this transition.

Anne Marie Costello (federal Centers for Medicare & Medicaid Services—CMS, federal Center for Medicaid and Children Health Insurance Program—CHIP Services) presented on planning the CMS has performed to prepare for the resumption of redeterminations and resources available for states. She said the CMS is committed to assuring individuals remain covered as the public health emergency ends. She said states received enhanced federal match for Medicaid if they paused redeterminations. She said states will have 12 months to renew eligibility for all enrollees once the PHE ends. She said 15 million individuals will be at risk for Medicaid coverage terminations, about half for procedural reasons. She said it may have been 2-3 years since state Medicaid agencies had been in contact with some enrollees. She said states have prepared communications strategies, they but are waiting for the PHE to end before launching public communications. She said CMS has gathered toolkits for states and other guidance at the website Medicaid.gov/unwinding. She said preparing for the end of the PHE is the highest priority for the CMS.

Jeff Grant (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented on strategies for making Marketplace coverage accessible for individuals who leave Medicaid. He said the CMS is working to smooth transitions when appropriate, including implementing policy and operational flexibilities. He said the CCIIO has paused certain data matching issues and special enrollment period verifications to prevent unnecessarily blocking people from getting coverage. He said the Administration supports extending subsidies currently in place under the federal American Rescue Plan Act (ARPA). He said CCIIO is examining its data capabilities to keep track of coverage transitions and perform targeted outreach. He said the CMS Office of Communications is pursuing a chase campaign to encourage individuals to enroll. He said state-regulated plans are important partners, particularly those that offer Medicaid managed care plans as well as Marketplace plans.
He said the CMS is asking such plans to coordinate across their lines of business and to make a commitment to year-round enrollment. He said issuers should be aware of all the guidance the CMS is putting out.

Commissioner Stolfi asked if the CMS has identified what states can do beyond a communications and outreach campaign and how much flexibility would be available under a waiver. Ms. Costello said states are doing a lot in addition to communications, such as planning systems changes, making process improvements, working to improve renewal rates, and enhancing staff capacity. She said fair hearing processes are also being improved and streamlined. She said there are a number of suggestions for steps states can take as well as waiver authorities outlined in a recent State Health Official letter. Mr. Grant said time is of the essence, so states should approach the CMS early if they want to do something different. He said some states with state-based exchanges are exploring streamlined applications and enrollment, which may be called auto-enrollment in some states. He said states would receive 60 days warning before the PHE ends, so the current assumption is that the current deadline of April 16 would be extended, likely until July.

Jeremy Vandehey (Oregon Health Authority—OHA) presented on his agency’s preparations for the end of the PHE. He said every state is facing this issue. He said Oregon has 300,000 more Medicaid enrollees since before the PHE and is likely to lose a similar number once eligibility determinations resume. He said state survey data show Oregon has the lowest uninsured rate ever, largely due to the policy of pausing redeterminations, with disproportionate improvement among Black residents. He said Oregon saw gains in what had been called the “churn population,” those who transition off and on Medicaid, sometimes moving to federal Affordable Care Act (ACA) marketplace eligibility. He said the Oregon legislature passed a bill to provide flexibility and direct OHA to develop a new program to provide more continuous coverage to the churn population with income just over Medicaid eligibility. He said the Oregon legislature’s goal is to maintain coverage as much as possible, rather than the prior practice of frequent coverage changes. He said Oregon will perform redeterminations first on those who are likely to remain eligible and only later address those at higher risk for coverage loss. He said the legislation also calls for a bridge plan that would be developed in a waiver application, either a basic health plan under the ACA or a state innovation waiver. He said most individuals go between Medicaid and no insurance, not Medicaid and Marketplace coverage. He said the bridge plan would allow them to continue to have coverage through their Medicaid managed care plan by allowing them to continue coverage even when an individual’s income rises to 200% of the federal poverty level. He said this approach could be a pathway for other states in the future. He said the end of the PHE is an opportunity for Medicaid and other coverage sources to work together in ways they have not in the past. Commissioner Stolfi said the Oregon’s plan would address not only the end of the PHE, but the problem of churn in coverage that pre-dated it.

Marissa Woltmann (Massachusetts Health Connector—Connector) gave a presentation on how the Massachusetts state-based marketplace is working to maintain coverage for individuals who leave Medicaid after the end of the PHE. She said both federal and state subsidies are available through the Connector. She said Connector enrollment has dropped as individuals who move to Medicaid have stayed there over the last two years. She said the Connector expects about 100,000 people to enroll after leaving Medicaid. She said the expiration of enhanced federal subsidies would complicate the transition to the individual market for many enrollees. She said the Connector has worked to reduce administrative burden, establish automatic special enrollment periods for those losing Medicaid, and support individuals who need to use paper documents. She said the Connector is adding an option for automatic enrollment for those with $0 premiums and is looking to maintain continuity of care for those who transition. She said clear messaging will be critical in reaching individuals who need to transition coverage. She said the transition is a high stakes project that requires collaboration across many entities. Commissioner Stolfi asked about how health insurance premium rates might be affected by the influx of enrollees from Medicaid. Ms. Woltmann said projections have not yet been developed, but because several Medicaid managed care plans also participate in the state’s individual market, they likely have good data on the
expected cost of these enrollees. Commissioner Stolfi said Oregon expects more enrollees from Medicaid could lead to a better risk pool in the individual market.

Wayne Turner (National Health Law Program—NHLP) and Karen Seigel (Health Equity Solutions) presented on suggestions for insurance regulators to address the end of the PHE. Mr. Turner said consumer representatives have met over the last two months to develop recommendations for regulators. He said large coverage losses are possible. He said some individuals will transition coverage, but others will be unlawfully terminated from Medicaid and maintaining coverage for them as they go through the process is important. He said some consumers may not know they have lost coverage until they need a service and are denied coverage and these may be the ones who come to state insurance regulators. Ms. Seigel said people of color have less access to employer-sponsored coverage while people with disabilities may have less access to receiving and understanding important information send to them about their coverage. She said working with community-based organizations can help assist individuals who experience these challenges. She said FAQs and other messaging should be clear and community organizations can help workshop messaging. She said consumers will need assistance both in enrolling in plans and in using their coverage. Mr. Turner said transitions are often not smooth, so there will be disruptions to care. He referenced the Health Benefit Plan Network Access and Adequacy Model Act (H#74) and its provisions on continuity of care provisions, which have been adopted in some state laws. He said Departments of Insurance should link consumers to other resources, including Medicaid, the Marketplace, state prescription drug assistance programs, and others. He encouraged regulators to examine health insurers’ payment of commissions for ACA marketplace products and network adequacy.

Jackson Williams (Dialysis Patient Citizens—DPC) urged regulators to consider the ongoing care needs of individuals with chronic diseases, not just continuity of care for patients who are in the middle of an acute care episode.

3. Received an Update on Research into Health Disparities

Kelly Edmiston (NAIC) presented an update on research he conducted with the Center for Insurance Policy and Research (CIPR) colleagues on the health disparities impacts of the rise in telehealth services and the move to alternative payment models. He said the end of the PHE has some implications for telehealth policy as some restrictions on telehealth use were relaxed during the PHE.

Mr. Edmiston said the CIPR’s overall assessment on telehealth is that it provides a significant opportunity to increase access to care and reduce disparities, but at the same time it creates the possibility for a new disparity among vulnerable populations who lack access to the digital tools or to culturally competent care.

Mr. Edmiston said alternative payment models can be vulnerable to opportunist behavior from providers, so the models should be adjusted to account for this challenge. He said different alternative payment models all have features that may create incentives to treat vulnerable populations differently and inequitably. He said value-based payments have pros and cons regarding health disparities. He said the highest cost patients have the greatest opportunity to reduce costs and there are incentives for care coordination in value-based payments. He said that risk adjustment mechanisms in value-based care are not sophisticated enough to remove incentives to avoid high-risk patients.

Mr. Edmiston said the CIPR could help in developing ideas for how the Working Group could present evaluation findings in response to its charges from the Special (EX) Committee on Race and Insurance. Commissioner Stolfi said the Working Group would solicit feedback from members and interested parties, then he would work with
the CIPR and the Working Group vice chairs and support staff to write an evaluation or recommendations for the Special (EX) Committee on Race and Insurance.

Having no further business, the Health Innovations (B) Working Group adjourned.
HEALTH ACTUARIAL (B) TASK FORCE

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Health Actuarial (B) Task Force
Virtual Meeting (in lieu of meeting at the 2022 Spring National Meeting)
March 29, 2022

The Health Actuarial (B) Task Force met March 29, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, and Julie Weinberg (NM); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Lan Brown (CA); Michael Conway represented by Eric Unger (CO); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Jeff Ji (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng and Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Michael Humphreys represented by Jim Laverty (PA); Raymond G. Farmer represented by Andrew Dvorine (SC); Cassie Brown represented by Aaron Hodges (TX); and Mike Kreidler represented by Lichiou Lee (WA).

1. **Adopted its March 2 and Feb. 1 Minutes**

The Task Force met March 2 and Feb. 1. During these meetings, the Task Force took the following action:

1) adopted a proposal to revise the instructions for the health Statement of Actuarial Opinion (SAO);

2) discussed a proposal to revise the instructions for the health SAO.

Mr. Toal made a motion, seconded by Mr. Leung, to adopt the Task Force’s March 2 (Attachment One) and Feb. 1 (Attachment Two) minutes. The motion passed unanimously.

2. **Adopted the Report of the Long-Term Care Actuarial (B) Working Group, Including its March 9 Minutes**

Mr. Lombardo said the Working Group met March 9 to discuss the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s final *Long-Term Care Insurance Mortality and Lapse Study*.

Mr. Schallhorn made a motion, seconded by Mr. Unger, to adopt the report of the Long-Term Care Actuarial (B) Working Group (Attachment Three). The motion passed unanimously.

3. **Heard an Update from the CCIIO on URRT Submissions via SERFF**

Megan Mason (federal Center for Consumer Information and Insurance Oversight—CCIIO) and Brandy Woltkamp (NAIC) gave an update on Uniform Rate Review Template (URRT) submissions via the System for Electronic Rates & Forms Filing (SERFF).

Ms. Woltkamp said in the first quarter of 2022, the SERFF team undertook a process change for effective rate review states. All URRT and supporting documents for rate changes for qualified health plans (QHPs) and non-QHPs in a single risk pool will now be submitted within SERFF. She said new web services were created to validate the URRT and to submit those documents to the federal Centers for Medicare & Medicaid Services (CMS) at the same time the documents are submitted to the state within a SERFF filing. She said the web services will be updated if the items are updated post submission as well. Ms. Woltkamp said the final piece of the new web services is the ability for the states to submit their determination within SERFF. She said the creation of the new web services removes duplicate work for issuers and states by submitting documentation in SERFF and the Health Actuarial (B) Task Force.
Insurance Oversight System (HIOS) URRT module. She said if there are questions regarding the rate review process, please contact ratereview@cms.hhs.gov, and if there are questions regarding the new SERFF process, please contact serffhelp@naic.org.

4. **Heard an Update on SOA Research**

Dale Hall (SOA) gave an update on SOA research activities (Attachment Four).

5. **Heard an Update from the Academy Health Practice Council**

Barbara Klever (Blue Cross Blue Shield Association—BCBSA) gave an update on Academy Health Practice Council activities (Attachment Five).

6. **Discussed a Referral Letter from the Health Risk-Based Capital (E) Working Group**

Mr. Lombardo introduced a referral letter (Attachment Six) from the Health Risk-Based Capital (E) Group asking the Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that would indicate that regardless of the blank an insurer files, asset adequacy testing is required if the criteria for mandatory AG 51 filing are met.

Mr. Andersen said the Long-Term Care Valuation (B) Subgroup will consider and discuss the referral during its next meeting.

Having no further business, the Health Actuarial (B) Task Force adjourned.
The Health Actuarial (B) Task Force met March 2, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Lan Brown (CA); Michael Conway represented by Eric Unger (CO); Doug Ommen represented by Klete Geren (IA); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Brrane represented by Jeff Ji (MD); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Glen Mulreadly represented by Andrew Schallhorn (OK); Cassie Brown represented by Aaron Hodges (TX); Mike Kreidler represented by Lichiou Lee (WA); and Allan L. McVey represented by Joylynn Fix (WV).

1. **Adopted its Proposal to Revise Instructions for the Health Annual Statement SAO**

Mr. Lombardo presented the Task Force’s proposal as exposed for public comment (Attachment One-A) to revise the language in Section 4, Section 5, Section 7, and Section 9 of the instructions for the health Statement of Actuarial Opinion (SAO) and comments received from the New York State Department of Financial Services (Attachment One-B), the Pennsylvania Insurance Department (Attachment One-C), the Washington State Office of the Insurance Commissioner (Attachment One-D), and UnitedHealth Group (UHG) (Attachment One-E).

The Task Force agreed to not delete “under the terms of its contracts and agreements” from Section 7E as suggested by comments from the Washington State Office of the Insurance Commissioner.

Mr. Dyke made a motion, seconded by Mr. Leung, to adopt the proposal as revised during the meeting. The motion passed unanimously. Mr. Lombardo said the proposal will be forwarded to the Blanks (E) Working Group for its consideration.

Having no further business, the Health Actuarial (B) Task Force adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON: Eric King</th>
<th>DATE: March 2, 2022</th>
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<tbody>
<tr>
<td>TELEPHONE: 816-708-7982</td>
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<tr>
<td>EMAIL ADDRESS: <a href="mailto:eking@naic.org">eking@naic.org</a></td>
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<tr>
<td>ON BEHALF OF: ASOP 28 Task Force, ASB</td>
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<tr>
<td>NAME: Annette James, Chair, ASOP 28 Task Force</td>
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<td>TITLE:</td>
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FOR NAIC USE ONLY

Agenda Item #
Year
Changes to Existing Reporting [ ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) 

BLANK(S) TO WHICH PROPOSAL APPLIES

<table>
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Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

See the following page for details of proposed changes.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to revise the language in sections 4, 5, 7 and 9 of the orange blank annual statement instructions related to the actuarial opinion to ensure that all items (actuarial assets and liabilities) within the scope of the statement of actuarial opinion are treated consistently. Currently, reserves and liabilities are referenced in sections 4, 5, 7 and 9 of the orange blank annual statement instructions. Since actuarial assets are included in the scope of the actuarial opinion, it is important that these instructions provide guidance to appointed actuaries that apply to all actuarial items, assets as well as liabilities, included in the scope of the actuarial opinion.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:__________________________________________________

Other Comments:

** This section must be completed on all forms. Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Instructions to Annual Health Statement Blank, Actuarial Opinion (Actuarial Opinion Instructions):

Modify section 1A. (Definitions), of the actuarial opinion instructions to add definitions of “actuarial asset” and “actuarial liability”.

Modify section 4 (Identification section), section 5 (Scope section), and section 7 (Opinion section) of the actuarial opinion instructions to ensure that the opinion’s prescribed wording clearly indicates that the actuary’s opinion covers actuarial assets as well as actuarial liabilities.

Modify section 9 of the actuarial opinion instructions to ensure that guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities.

Section 1

1A. Definitions

“Insurer” means an entity authorized to write accident and health contracts under the laws of any state and which files on the Health Blank.

“Actuarial Memorandum” means a document or other presentation prepared as a formal means of conveying the appointed actuary’s professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary’s opinion or findings and that documents memorandum is further described in Section 1C.

“Actuarial asset” means an actuarial item presented as an asset in the annual statement and included in the scope of the Statement of Actuarial Opinion.

“Actuarial liability” means an actuarial item presented as a liability in the annual statement and included in the scope of the Statement of Actuarial Opinion.

Section 4

4. The IDENTIFICATION section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary, date of appointment, and should specify that the appointment was made by the Board of Directors, or its equivalent or by a committee of the Board.

A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

Section 5:
5. The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, actuarial assets, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

Section 7:

7. The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and: (Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)

the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state,

or

the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;

E. Make a reasonable provision for all actuarial assets of the organization under the terms of its contracts and agreements;

F. On a combined basis, make a reasonable provision for all actuarial assets and actuarial liabilities of the organization under moderately adverse conditions;

G. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and

H. Include appropriate provision for all actuarial items that ought to be established.

Section 9:

9. If the appointed actuary is able to form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and actuarial liabilities are not good and sufficient, actuarial assets are not reasonable, or the actuarial assets and
actuarial liabilities on a combined basis are not reasonable under moderately adverse conditions. (An adverse opinion does not meet one or more of items D, E, or F of Section 7.)

When, in the actuary’s opinion, the reserves, actuarial liabilities, or actuarial assets included in the scope of the opinion for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated reserve amount makes a good and sufficient provision for the actuarial liabilities associated with the specified reserves; actuarial assets are reasonable; and combined actuarial assets and actuarial liabilities are reasonable under moderately adverse conditions, except for the item or items to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or H of Section 7.)

The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not be reached.
From: Carmello, William (DFS)
To: King, Eric
Subject: FW: Exposure: Health Blank SAO Instructions Proposal
Date: Wednesday, February 9, 2022 12:15:40 PM
Attachments: image001.png, image002.png, image003.png, image004.png, image005.png

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

I think we should look for more consistency with the life actuarial opinion. Life has actuarial assets (deferred premiums are all I can think of right now) and I can’t recall how they are handled in the opinion. I believe the life opinion also uses the phrase “adequate” under moderately adverse conditions which seems more prudent than “reasonable”. We don’t want the tail (actuarial assets) wagging the dog (solvency).

William B. Carmello, Jr., FSA, MAAA
Chief Life Actuary
New York State Department of Financial Services
One Commerce Plaza, Albany, NY 12257
(518) 474-4135 | william.carmello@dfs.ny.gov
www.dfs.ny.gov

From: Thomas, Lia C <LCThomas@naic.org>
Sent: Wednesday, February 9, 2022 11:05 AM
Cc: King, Eric <EKing@naic.org>
Subject: Exposure: Health Blank SAO Instructions Proposal

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To the Health Actuarial (B) Task Force, Interested Regulators, and Interested Parties:

The updated proposal to modify the Health Blank Statement of Actuarial Opinion instructions, as discussed on the Task Force’s February 1 call, is being exposed for comment.

Please submit comments to Eric King by February 24.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/HEALTH%20INS%20and%20MANAGED%20CARE%20B%20COMMITTEE/Health%20Actuarial%20(B)%20TF/Conference%20Calls/3-2%20HATF/NY%20Health%20SAO%20Comments.msg

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Eric,

I believe there may be a typo of an unintended comma before the words "are not good and sufficient" in the second paragraph of Section 9. (Most easily seen when the document is in a "No Markup" status.)

Please feel free to let me know if you need further clarification regarding the location of this likely unintended comma.

Steve Boston
Life Actuary
Pennsylvania Insurance Department

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: February 8, 2022

CONTACT PERSON: Eric King

TELEPHONE: 816-708-7982

EMAIL ADDRESS: eking@naic.org

ON BEHALF OF: ASOP 28 Task Force, ASB

NAME: Annette James, Chair, ASOP 28 Task Force

TITLE: 

AFFILIATION: 

ADDRESS: 

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Agenda Item # ________

Year ________

Changes to Existing Reporting [ ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ ] Received For Public Comment

[ ] Adopted Date

[ ] Rejected Date

[ ] Deferred Date

[ ] Other (Specify) ____________

BLANK(S) TO WHICH PROPOSAL APPLIES

[X] ANNUAL STATEMENT

[X] INSTRUCTIONS

[X] CROSSCHECKS

[ ] QUARTERLY STATEMENT

[ ] SEPARATE ACCOUNTS

[ ] PROTECTED CELL

[ ] TITLE

[ ] LIFE, ACCIDENT & HEALTH/FRATERNAL

[ ] PROPERTY/CASUALTY

[ ] HEALTH

[ ] LIFE (LIFE SUPPLEMENT)

[ ] OTHER ___________________

Anticipated Effective Date: Annual 2022

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NAIC STAFF COMMENTS

Comment on Effective Reporting Date:___________________________

Other Comments:

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“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

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“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, actuarial assets, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

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A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and:
   (Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state,
   or
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;

E. Make a reasonable provision for all actuarial assets of the organization;

F. On a combined basis, make a reasonable provision for all actuarial assets and actuarial liabilities of the organization under moderately adverse conditions;

G. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and

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9. If the appointed actuary is able to form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and actuarial liabilities, are not good and sufficient, actuarial assets are not reasonable, or the actuarial assets and actuarial liabilities on a combined basis are not reasonable under moderately adverse conditions. (An adverse opinion does not meet one or more of items D, E, or F of Section 7.)
When, in the actuary’s opinion, the actuarial liabilities or actuarial assets included in the scope of the opinion for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated amounts make a good and sufficient provision for the actuarial liabilities; whether the stated amounts make a reasonable provision for actuarial assets; and whether the aggregation of actuarial assets and actuarial liabilities makes an appropriate provision for the intended purpose of the opinion. The only exception(s) being for the item or items to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or H of Section 7.)

The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not be reached.
February 24, 2022

Mr. Paul Lombardo, Chair
Health Actuarial (B) Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Via electronic mail to Eric King.

Re: Proposed changes to the Health Annual Statement instructions for the Actuarial Opinion.

Dear Mr. Lombardo:

I am writing on behalf of UnitedHealth Group with regard to the proposed changes to the Health Annual Statement instructions for the Actuarial Opinion, as exposed for comment by your Task Force on February 9, 2022. We appreciate the opportunity to offer our comments.

We have some concerns about the newly added Sections 7.E and 7.F in the proposal. To begin with, we do not believe that the Appointed Actuary should be made to address the provision for assets (7.E) separately from the provision for liabilities (7.D). The Appointed Actuary’s concern should be the “actuarial balance sheet” (i.e., the actuarial assets and liabilities) as a whole; it is all of those items in combination that affect the reporting entity’s capital and surplus. There does not seem to be any valid reason to have the Appointed Actuary attest to various pieces of the actuarial balance sheet in isolation. Furthermore, it is unclear what a “reasonable provision” for the actuarial assets would be, outside of the context of the actuarial liabilities and the desired degree of conservatism in those liabilities. Therefore, we do not believe that the proposed Section 7.E is appropriate.

We have two concerns about Section 7.F. First, we are concerned that the phrase “on a combined basis” does not add clarity as to exactly what the Appointed Actuary is attesting to. Second, as just noted, we do not believe that the actuarial balance sheet should be segmented for purposes of attestation. Adding Section 7.F as proposed would still leave a separate attestation for the liabilities only (7.D).
We suggest, therefore, that the proposed Sections 7.E and 7.F be deleted, and that Section 7.D be revised to address the actuarial balance sheet in its totality. For example, the revised Section 7.D might read:

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements, when the actuarial liabilities are reduced by any overstatement (or increased by any understatement) of the actuarial assets; [added material underlined]

We believe that this would make the nature of the Appointed Actuary’s attestation much more explicit. We note two further points about this suggested language.

- The objection raised on the February 1 call to the word “overstatement” does not apply here. Then, the concern was the amount of overstatement: it would not be reasonable to require an adverse opinion if the overstatement were only $1. Here, that concern would not occur, because reducing the liabilities by $1 would be entirely appropriate, and presumably would not affect the Appointed Actuary’s ability to issue an unqualified opinion.

- We feel it is entirely appropriate to recognize an understatement of the actuarial assets as an additional source of conservatism. We understand that regulators prefer, from a financial reporting perspective, that deficiencies in any one line item should not be made up by excesses in another line item; each line item should be reported appropriately. However, it should not be the Appointed Actuary’s role to police the company’s reporting. That is much better dealt with by the auditors who must sign off on the audited financial statements, and by the insurance department financial analysts and financial examiners who review the financial statements. As we have indicated above, the Statement of Actuarial Opinion should address the actuarial liabilities and assets from an overall perspective, not piecemeal.

We would be happy to discuss these comments with you and the Task Force.

James R. Braue  
Senior Director, Actuarial Services  
UnitedHealth Group

cc: Eric King, NAIC  
     Randi Reichel, UnitedHealth Group
The Health Actuarial (B) Task Force met Feb. 1, 2022. The following Task Force members participated: Andrew N. Mais, Chair, represented by Paul Lombardo (CT); Russel Toal, Vice Chair, represented by Julie Weinberg (NM); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Lan Brown (CA); Michael Conway represented by Eric Unger (CO); Doug Ommen represented by Klete Geren (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Marti Hooper (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by William Leung (MO); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Lilane Fox (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Jim Laverty (PA); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by David Shea (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. Discussed its Proposal to Revise Instructions for the Health Annual Statement SAO

Mr. Lombardo said the Task Force needs to revisit its proposal (Attachment Two-A) to revise the language in Section 4, Section 5, Section 7, and Section 9 of the instructions for the health Statement of Actuarial Opinion (SAO) to ensure all items—actuarial assets and liabilities—within the scope of the SAO are treated consistently and provide a final recommendation to the Blanks (E) Working Group. He said the American Academy of Actuaries (Academy) provided comments on Section 7D that express concern that the proposed language may be too cumbersome, and there is the potential for a different interpretation of the language than expected. He said the Academy suggested the addition of the language, “Do not overstate actuarial assets,” to Section 7E. Mr. Dyke suggested the addition of the language, “Make a reasonable provision for all actuarial assets of the organization under the terms of its contracts and agreements.” Mr. Lombardo said the Task Force will work with the Academy to draft final language for Section 7E and other revisions. He said once a final version has been drafted, it will be exposed for a 15-day public comment period.

Having no further business, the Health Actuarial (B) Task Force adjourned.

https://naiconline.sharepoint.com/:w:/r/sites/NAICSsupportStaffHub/Member%20Meetings/Spring%202022%20National%20Meeting/Task%20Forces/HealthActuarial/Conference%20Calls/2-1%20HATF/02-01-22%20HATF.docx?d=w9e0adbba90174fc9acd8654d8152a6eb&csf=1&web=1&e=p3Vo5r

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**NAIC BLANKS (E) WORKING GROUP**

Blanks Agenda Item Submission Form

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<th>Eric King</th>
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<tbody>
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<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:eking@naic.org">eking@naic.org</a></td>
</tr>
<tr>
<td>ON BEHALF OF:</td>
<td>ASOP 28 Task Force, ASB</td>
</tr>
<tr>
<td>NAME:</td>
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**DATE:** April 23, 2021

**FOR NAIC USE ONLY**

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**BLANK(S) TO WHICH PROPOSAL APPLIES**

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| Property/Casualty | Protected Cell | [ ] |
| Health | Health (Life Supplement) | [ ] |

Anticipated Effective Date: Annual 2021

**IDENTIFICATION OF ITEM(S) TO CHANGE**

See the following page for details of proposed changes.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to revise the language in sections 4, 5, 7 and 9 of the orange blank annual statement instructions related to the actuarial opinion to ensure that all items (actuarial assets and liabilities) within the scope of the statement of actuarial opinion are treated consistently. Currently, reserves and liabilities are referenced in sections 4, 5, 7 and 9 of the orange blank annual statement instructions. Since actuarial assets are included in the scope of the actuarial opinion, it is important that these instructions provide guidance to appointed actuaries that apply to all actuarial items, assets as well as liabilities, included in the scope of the actuarial opinion.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ________________________________

Other Comments: __________________________________

** This section must be completed on all forms. Revised 7/18/2018 **
IDENTIFICATION OF ITEM(S) TO CHANGE

Instructions to Annual Health Statement Blank, Actuarial Opinion (Actuarial Opinion Instructions):

Modify section 1A. (Definitions), of the actuarial opinion instructions to add definitions of “actuarial asset” and “actuarial liability”.

Modify section 4 (Identification section), section 5 (Scope section), and section 7 (Opinion section) of the actuarial opinion instructions to ensure that the opinion’s prescribed wording clearly indicates that the actuary’s opinion covers actuarial assets as well as actuarial liabilities.

Modify section 9 of the actuarial opinion instructions to ensure that guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities.

Section 1

1A. Definitions

“Insurer” means an entity authorized to write accident and health contracts under the laws of any state and which files on the Health Blank.

“Actuarial Memorandum” means a document or other presentation prepared as a formal means of conveying the appointed actuary’s professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary’s opinion or findings and that documents memorandum is further described in Section 1C.

“Actuarial asset” means an actuarial item presented as an asset in the annual statement and included in the scope of the Statement of Actuarial Opinion.

“Actuarial liability” means an actuarial item presented as a liability in the annual statement and included in the scope of the Statement of Actuarial Opinion.

Section 4

4. The IDENTIFICATION section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary, date of appointment, and should specify that the appointment was made by the Board of Directors, or its equivalent or by a committee of the Board. A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”
5. The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, actuarial assets, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

Section 7:

7. The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and:
   (Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state,
   or
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;

E. Make a reasonable provision for all actuarial assets of the organization under the terms of its contracts and agreements;

F. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and

G. Include appropriate provision for all actuarial items that ought to be established.

Section 9:

9. If the appointed actuary is able to form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and liabilities, when considered in combination with any actuarial assets included in the scope of the opinion, are not good and sufficient. (An adverse opinion does not meet item D of Section 7.)

When, in the actuary’s opinion, the reserves or actuarial assets included in the scope of the opinion for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state
whether the stated reserve amount makes a good and sufficient provision for the liabilities associated with the
specified reserves, when considered in combination with any actuarial assets included in the scope of the
opinion, except for the item or items to which the qualification relates. The actuary is not required to issue a
qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be
material. (A qualified opinion does not meet one or more of the items A, B, C or F of Section 7.)

The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information
that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or
limitations in the data, analyses, assumptions or related information, then the actuary should issue an
inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not
be reached.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met March 9, 2022. The following Working Group members participated: Tomasz Serbinowski, Chair (UT); Jennifer Li (AL); Lisa Luo (CA); Paul Lombardo (CT); Lilyan Zhang (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Michael Muldoon (NE); Russel Toal (NM); Bill Carmello (NY); Laura Miller (OH); Andrew Schallhorn (OK); Andrew Dvorine (SC); and Aaron Hodges (TX).

1. **Discussed an LTCI Mortality and Lapse Study**

   Mr. Serbinowski said the American Academy of Actuaries (Academy) and Society of Actuaries (SOA) Research Institute’s Final Long-Term Care Insurance (LTCI) Mortality and Lapse Study (Attachment Three-A) as provided in response to a request (Attachment Three-B) from the Long-Term Care Valuation (B) Subgroup will be reviewed and considered for adoption by the Working Group.

   Warren Jones (Retired) and Bob Yee (PricewaterhouseCoopers) gave an overview of the study. Superintendent Toal asked if the study can be updated with an actual-to-expected analysis using more current experience data. The Working Group agreed to submit a request to the Academy and the SOA with parameters for the actual-to-expected analysis.

   Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
Long-Term Care Insurance Mortality and Lapse Study
November 2021

Developed by the Long-Term Care Valuation Work Group
of the American Academy of Actuaries
and the Society of Actuaries Research Institute

Warren Jones, MAAA, FSA, FCA

Chairperson

Lo Linda Chow, MAAA, FSA
Sivakumar Desai, MAAA, FSA
Noelle Destrampe, MAAA, FSA
Robert Hanes, MAAA, FSA
Peggy Hauser, MAAA, FSA
Laurel Kastrup, MAAA, FSA
Matthew Klaus, MAAA, FSA
Perry Kupferman, MAAA, FSA

Diane Mui, MAAA, ASA
Lisa Parker, MAAA, ASA
Marianne Purushotham, MAAA, FSA
Steven Schoonveld, MAAA, FSA
Bruce Stahl, MAAA, ASA
James Stoltzfus, MAAA, FSA
Robert Yee, MAAA, FSA
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I. INTRODUCTION

On May 5, 2016, the Long-Term Care Valuation (B) Work Group of National Association of Insurance Commissioners’ (NAIC’s) Health Actuarial (B) Task Force’s Long-Term Care Actuarial Working Group (LTCAWG) requested recommendations from the American Academy of Actuaries (Academy)\(^1\) and the Society of Actuaries Research Institute (SOA)\(^2\) to replace the mortality and lapse bases for statutory minimum reserves. A copy of the request is included in Appendix 1 to this report.

The Academy and SOA created a Long-Term Care Valuation Work Group (Work Group) to address the request. The Work Group is chaired by Warren Jones, the Mortality Subgroup is led by Bruce Stahl, and the Lapse Subgroup is led by Bob Yee. The Work Group has provided regular updates to the LTCAWG at national meetings and provided opportunities for the LTCAWG members to ask questions regarding the work in progress.

This report presents the recommended lapse tables in Appendix 3, and recommended mortality tables in Appendix 4, and describes the methodology and process in developing these tables.

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\) Serving as the research arm of the Society of Actuaries, the SOA Research Institute provides objective, data-driven research bringing together tried and true practices and future-focused approaches to address societal challenges and business needs. The Institute provides trusted knowledge, extensive experience and new technologies to actuaries, employers, regulators, research funders and the public, to help them effectively identify, predict and manage risks.
II. BACKGROUND

The minimum statutory reserve basis for long-term care (LTC) insurance is documented in the NAIC Valuation Manual VM-25: Health Insurance Reserves Minimum Reserve Requirements. The mortality table specified for currently new issues is the 1994 Group Annuity Mortality (GAM) Table. The lapse rate specified is the lesser of x% of the voluntary lapse rate used in the calculation of gross premiums and y%, where x and y vary by policy year:

- For policy year one (1), x is 80% and y is 6%.
- For policy years two (2) through four (4), x is 80% and y is 4%.
- For policy years five (5) and later, x is 100% and y is 2%, except for group insurance, for which y is 3%.

Both the mortality and lapse bases for the minimum reserve requirements have been revised over the years with the changes to apply to new issues only. The mortality basis has been that for whole life insurance or payout annuities.

General Approach

Our charge is to develop recommended mortality and lapse tables for valuation on both a total-lives basis and an active-lives basis. This charge dictates the approach we have chosen to develop such tables.

Valuation tables are conservative in nature. A logical method is to develop basic tables based on experience first and then consider the margins to be added. Because the mortality and lapse tables would be used in combination, it is desirable for both tables to be as consistent as possible with respect to the data source and the factors that the tables vary by. The Work Group recognizes the likelihood of the under-reporting of death for healthy policyholders. Thus, the delineation between death and lapse is not always clear. Consistency in both data source and factors can facilitate the assessment of combined deaths and lapses for reasonableness checks.

Source of Data

The Work Group defined the base mortality table to be the 2012 Individual Annuity Mortality Table. Further, development of mortality margins and the lapse assumption is to be based on the recent SOA/LIMRA LTC Voluntary Lapse and Mortality Experience Study (the Study). It is comprised of experience data from 2000 through 2011 for 22 companies. From the aggregate data, we observed trends during the study period, especially for lapse. Accordingly, we selected the observation period 2008-2011 to reflect more recent trends. Furthermore, the Study identified certain participating companies with relatively more accurate data submitted. Data from 10 companies (Definition 2 [DEFN 2] companies) satisfied the following conditions:

1. Deaths are separately identified from lapses,
2. Unknown terminations are less than 25% of total terminations, and
3. Performed matching with Social Security death records within the previous three years from the date of submission.
Apart from some preliminary comparisons between DEFN 2 data and the full dataset, we further restricted our data to these DEFN 2 companies. We compared our tabulated lapse counts and exposures with the published summary data from the SOA. We concluded that our data is reasonably representative of corresponding summary data from the Study. The DEFN 2 companies represent approximately 70% of the industry experience for the exposure period used.

The following table shows the summary statistics of the DEFN 2 subset of data:

<table>
<thead>
<tr>
<th></th>
<th>Total Lives</th>
<th>Active Lives</th>
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<tbody>
<tr>
<td></td>
<td>Counts</td>
<td>Exposure Years</td>
</tr>
<tr>
<td>Mortality—Individual</td>
<td>142,647</td>
<td>9.4MM</td>
</tr>
<tr>
<td>Lapse—Individual</td>
<td>197,000</td>
<td>9.4MM</td>
</tr>
<tr>
<td>Lapse—Group</td>
<td>302,000</td>
<td>4.9MM</td>
</tr>
</tbody>
</table>

3 The mortality was derived using individual mortality and tested using both individual and group data. Also, the figures in this line include 19,599 deaths from “Substandard” and “Unknown” risk classes that do not appear in the “Death Count Totals” table later in this report.

4 The lapse count is the same for Total Lives and Active Lives as the immaterial number of disabled life lapses that were ignored.

5 Ibid.
III. MORTALITY

Purpose and Scope

The Mortality Subgroup worked to identify reasonable mortality tables to be used in setting statutory reserves for individual LTCI policies, either as a particular set of tables or as guidance that the NAIC could expect from insurers.

The Work Group further recognized that the NAIC allows principle-based reserving for life insurance and that, therefore, the NAIC may be interested in guidance for a similar approach with LTCI mortality. Guidance for principle-based reserving may be of particular interest when considering marital status and underwriting risk classes.

When setting mortality assumptions in accordance with actuarial standards of practice (ASOPs) for LTC (e.g., ASOP 186), it is appropriate to consider the effects of both selection and class of applicants on expected mortality experience (section 3.2.2). Consequently, in addition to other potential mortality rate differentiators, the analysis considered risk class and marital status, representing both selection and class of applicants.

Data Quality

Addressing data quality under ASOP 23, Data Quality, the Work Group relied upon the Society of Actuaries’ Intercompany Study from 2015 to make sure the data was “clean” and as uniform as possible for complex and diverse data that came from 10 insurance companies.

The Work Group sought to follow the ASOP on credibility procedures (ASOP 25) in its work. Industry data is more relevant than general population data for two reasons. First, the selection process when issuing LTCI, from both the applicants’ and the insurers’ perspectives, may result in the insured population being a low mortality subset of the general population. Second, a mortality study of this nature requires consideration of numerous cells of data. The number of deaths in a given cell may or may not be credible. Looking at data from multiple insurers increases the number of cells that are credible.

6 Actuarial Standards Board; Actuarial Standard of Practice No. 18, Long-Term Care Insurance; May 2011.
7 Actuarial Standards Board; Actuarial Standard of Practice No. 23, Data Quality; December 2016.
8 Actuarial Standards Board; Actuarial Standard of Practice No. 25, Credibility Procedures; December 2013.
To assess data credibility with respect to rate development, it is a common practice to consider 1,082 or more counts in a particular cell in Tables 2 and 3 below to be fully credible. It is also typical to assign a lower count number to annotate partial credibility for a cell. For example, a minimum count of 271 can be considered as partially credible. Using 271 deaths as a measure, the majority of the cells in Table 2 below can be considered as partially credible.

Table 2. Death Counts (Total Lives) By Sex, Risk Class, Attained Age, and Marital Status

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<th>Attained Age</th>
<th>Female: Preferred Risk</th>
<th>Female: Standard Risk</th>
<th>Male: Preferred Risk</th>
<th>Male: Standard Risk</th>
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<td>Married</td>
<td>Single</td>
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<td>Married</td>
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<td>Under 60</td>
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<td>60-64</td>
<td>393</td>
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<td>85</td>
<td>344</td>
<td>684</td>
<td>1,088</td>
<td>954</td>
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<td>86</td>
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<td>757</td>
<td>1,073</td>
<td>868</td>
</tr>
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<td>87</td>
<td>308</td>
<td>727</td>
<td>1,035</td>
<td>791</td>
</tr>
<tr>
<td>88</td>
<td>258</td>
<td>803</td>
<td>1,061</td>
<td>725</td>
</tr>
<tr>
<td>89</td>
<td>248</td>
<td>745</td>
<td>993</td>
<td>624</td>
</tr>
<tr>
<td>90-94</td>
<td>590</td>
<td>2,605</td>
<td>3,195</td>
<td>1,543</td>
</tr>
<tr>
<td>95 and over</td>
<td>112</td>
<td>914</td>
<td>1,026</td>
<td>266</td>
</tr>
</tbody>
</table>

| Total       | 7,458   | 12,772 | 20,230 | 19,408 | 25,737 | 45,145 | 11,151  | 4,452  | 15,603 | 29,031  | 13,019 | 42,050 |

Full credibility means that there is a 90% probability that the observed rate is within 5% of the true underlying result. Some practitioners would accept as low as 200 data points as minimally credible (approximately 40% partial credibility).

Corresponding to 1,082 as full credibility, 271 counts means that there is a 90% probability that the observed rate is within 10% of the true underlying rate.
Table 3. Active Life Death Counts

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 60</td>
<td>1,029</td>
<td>978</td>
<td>2,007</td>
</tr>
<tr>
<td>60-64</td>
<td>1,829</td>
<td>1,890</td>
<td>3,719</td>
</tr>
<tr>
<td>65-69</td>
<td>3,325</td>
<td>3,460</td>
<td>6,785</td>
</tr>
<tr>
<td>70-74</td>
<td>5,367</td>
<td>6,001</td>
<td>11,368</td>
</tr>
<tr>
<td>75</td>
<td>1,425</td>
<td>1,631</td>
<td>3,056</td>
</tr>
<tr>
<td>76</td>
<td>1,502</td>
<td>1,859</td>
<td>3,361</td>
</tr>
<tr>
<td>77</td>
<td>1,607</td>
<td>1,916</td>
<td>3,523</td>
</tr>
<tr>
<td>78</td>
<td>1,765</td>
<td>2,082</td>
<td>3,847</td>
</tr>
<tr>
<td>79</td>
<td>2,032</td>
<td>2,324</td>
<td>4,356</td>
</tr>
<tr>
<td>80</td>
<td>2,077</td>
<td>2,277</td>
<td>4,354</td>
</tr>
<tr>
<td>81</td>
<td>2,079</td>
<td>2,388</td>
<td>4,467</td>
</tr>
<tr>
<td>82</td>
<td>2,173</td>
<td>2,400</td>
<td>4,573</td>
</tr>
<tr>
<td>83</td>
<td>2,219</td>
<td>2,465</td>
<td>4,684</td>
</tr>
<tr>
<td>84</td>
<td>2,133</td>
<td>2,399</td>
<td>4,532</td>
</tr>
<tr>
<td>85</td>
<td>2,163</td>
<td>2,273</td>
<td>4,436</td>
</tr>
<tr>
<td>86</td>
<td>2,162</td>
<td>2,204</td>
<td>4,366</td>
</tr>
<tr>
<td>87</td>
<td>2,061</td>
<td>2,036</td>
<td>4,097</td>
</tr>
<tr>
<td>88</td>
<td>1,932</td>
<td>1,848</td>
<td>3,780</td>
</tr>
<tr>
<td>89</td>
<td>1,720</td>
<td>1,402</td>
<td>3,122</td>
</tr>
<tr>
<td>90-94</td>
<td>5,052</td>
<td>3,946</td>
<td>8,998</td>
</tr>
<tr>
<td>95 and over</td>
<td>1,336</td>
<td>707</td>
<td>2,043</td>
</tr>
<tr>
<td>Total</td>
<td>46,988</td>
<td>48,486</td>
<td>95,474</td>
</tr>
</tbody>
</table>

As important as using multiple contributors is to enhance credibility, using multiple contributors also compromises the uniformity of the data and, in that sense, reduces the credibility. For example, the study identified marital status based in part on the presence of a spouse discount, and some insurers apply a spouse discount based on the legal status of being married alone, while others require both spouses to apply for coverage, and still others require both spouses to be issued policies. Similarly, the data recorded whether policies were preferred, standard, or substandard risks, but each insurer defines the health

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11 The study variable “marital status” is based on a combination of the data fields “marital status at issue” and “marital discount.” In the case where marital status at issue was provided, that field was used. For approximately 43% of the policies submitted for the study, marital status at issue was not provided. For 37% of the policies, the marital status at issue was not provided but the marital discount was provided (and was used to define the study marital status variable for those policies). For the remaining policies (approximately 20%), neither marital status at issue nor marital discount were provided; these cases were coded as marital status = “unknown.”

12 The SOA study defined the risk class using “Premium Class” as “The class in which the policy was issued relative to the base policy.” If an underwriting discount or load was given, then preferred or substandard was provided by the company. The data provided did not permit aligning across companies.
status of the risk in different ways following its own particular underwriting guidelines. The NAIC may want to address this lack of homogeneity when determining what mortality table standards to set for statutory reserves.

The Work Group also chose to rely on statistical metrics to identify the significance of the variables associated with each policy. The statistical metrics help to identify interactions among the variables, allowing the Work Group to minimize the number of parameters needed for setting mortality tables. They also help to identify which variables the NAIC may want each insurer to consider more closely when setting reserves for LTCI, using the information as guidance.

When setting tables using the statistically identified variables, the Work Group employed smoothing techniques that generated reasonable outcomes. Part of the analysis involved an iterative smoothing process. At younger and older ages where data was sparse, we used the slope of the 2012 Individual Annuity Mortality Basic tables (2012 IAM) as a guide.

Before converting the smoothed tables as guidance for deriving the valuation tables, the Work Group decided to apply mortality improvement to recognize that LTC insured mortality has likely improved since the time of the experience period 2008–2011. A separate section on mortality improvement is provided below.

A valuation table is expected to be conservative; for longevity risks such as with LTCI, “conservative” means using lower mortality than expected. Past annuity tables have essentially used mortality rates that are 90% of the experience, with modifications for very old ages beyond 100. The Work Group recommended using the 90% factor once again and capping the mortality of the valuation table at 0.400, which generally limits the mortality at very old ages. A large majority of insurers’ actual mortality experience exceeded this proposed mortality factor.

The Work Group does not think the NAIC should ignore marital status and risk class because, despite the lack of homogeneity in the definitions, these variables still proved to be influential in the prediction of the actual mortality.

The Work Group does not necessarily think the NAIC should use marital status and risk class without any consideration for specific insurer definitions and practices. As stated previously, insurers treat these differently, and, while these items had a high statistical significance, the effect of these items will likely vary according to the definition followed or practices used by each insurer.

The Work Group did not have the data necessary to identify the specific values for each marital status definition or risk class identification. Therefore, adjusting for these variables may not be practical without the NAIC granting individual companies the ability to justify how their mortality might appropriately vary from the findings identified in this report. If the NAIC allowed individual insurers to justify such differences, each insurer could easily add margin by applying a similar conservative factor of 90% to the mortality rates that it identifies.
Methods

Issue Ages

The data was consistent with measuring age as age last birthday (ALB). No tables are offered to convert the findings to age nearest birthday (ANB).

Exposures

For policyholders who died within a particular period, the Work Group chose to use the full exposure, meaning the count of lives at the beginning of the period being measured; for everyone else, the Work Group chose to use the exact (daily) exposure (for example, a policy that lapsed three months into its policy year was treated as having one-fourth of an exposure year for that particular year). This method of calculating exposure is consistent with the Balducci Hypothesis, which essentially assumes mortality rates decrease during the exposure period. As a reminder, the Balducci assumption may have distortions when the mortality rates are relatively high and credibility is low. Please see “Experience Study Calculations” written by David Atkinson and John McGarry on behalf of the SOA. Please also note that the manner used to derive mortality rates in this study relied heavily on the 2012 IAM slope at very old ages where the lack of credibility is of greatest concern (the method is described later). The 2012 IAM study also used the Balducci method and smoothing.

Predictive Variables

LIMRA developed a statistical Generalized Linear Model and other statistical methods to identify variables that had the greatest significance in explaining the mortality experience and might be most appropriate for use in projecting future experience.

Initially, the analysis recognized nine variables: sex, attained age, policy year, coverage type (whether nursing home only, home health care only, comprehensive, or other), an indicator for the presence of an automatic increasing benefit, an indicator that the policy has had a rate increase, the underwriting risk class (Preferred, Standard, or Substandard), marital status, and an indicator for whether the policy had an unlimited maximum benefit period.

Some factors were represented by multiple indicator variables. For example, Premium Risk Class was represented by three indicators. (For Table 4, we identified the highest Wald Chi-Square value from the group of indicators.)
Table 4 shows a measure of the significance of the variables under a Poisson distribution and is generally representative of other measures. Under other distributions, the factor “Gender” had greater statistical significance yet, even here, we deemed the significance to be strong.

Table 4. Significant Covariates Using Poisson Distribution

<table>
<thead>
<tr>
<th>Significant Covariates</th>
<th>Wald Chi-Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>7,838</td>
</tr>
<tr>
<td>Premium Risk Class</td>
<td>5,508</td>
</tr>
<tr>
<td>Lifetime Maximum (Limited or Unlimited)</td>
<td>3,851</td>
</tr>
<tr>
<td>Coverage Type</td>
<td>2,336</td>
</tr>
<tr>
<td>Marital Status (presence of spouse discount)</td>
<td>1,605</td>
</tr>
<tr>
<td>Premium Rate Increase</td>
<td>276</td>
</tr>
<tr>
<td>Policy Year</td>
<td>110</td>
</tr>
<tr>
<td>Gender</td>
<td>6</td>
</tr>
<tr>
<td>Automatic Increasing Benefit Maximums</td>
<td>0</td>
</tr>
</tbody>
</table>

For example, using the standard Chi-squared test in the Poisson distribution, most of the factors had a probability of being statistically significant at over 0.9999. Gender had a probability of being statistically significant at 0.9884, compared to the Automatic Increasing Benefit Maximum at only 0.2639.

The factors (variables) were selected based on (1) those that had a high rate of responses (some variables had a relatively high number of missing values), (2) those that had a material influence on the mortality (sometimes a variable appeared to be statistically significant but only trivially altered the mortality rate), and (3) those that were not redundant (not statistically correlated with other factors). Such analysis reduced the initial nine to five: sex, age, policy year, underwriting risk class, and marital status. (Age can be identified either at issue age or attained age because the presence of policy year correlates the two age measurements.)

The findings, therefore, provide tables that include the five predictive variables. For two of the variables—underwriting class and marital status—the underlying data is not homogeneous by contributing company because contributing insurers derive or define these differently, and presumably the differences for some insurers could be larger for some than others. The findings provide a set of tables that offer the option to exclude underwriting risk class and marital status. The NAIC may want to consider the optionality of these two variables.
Development of Tables

The Work Group noticed that the selection period in the data appeared to be about 20 years, and that the number of deaths in policy years 21 and over was not very credible. The Work Group, consisting primarily of LTCI actuaries, then relied heavily upon Susan Willeat, an actuary from RGA with many years of experience in deriving mortality tables. She initially identified a set of ultimate tables prior to identifying selection factors. She increased the number of deaths from policy years 15 to 20 to estimate the ultimate mortality, and she did so iteratively in order to find a good fit. Starting with an increase of anywhere between 2% and 4%, she narrowed the annualized increases to an average of 3%. Therefore, the death counts from policy year 15 were increased by a factor of 1.036 in order to identify the number of deaths expected without any value from initial underwriting. She adjusted the death counts for policy years 16 through 20 in a similar manner. For example, she increased death counts from policy year 19 by a factor of 1.032, and from policy year 20 by a factor of 1.03.

Willeat used the ultimate rates for quinquennial age bands to improve credibility. This result required a 1.02 overall “true-up” factor to match the actual experience. The Work Group then identified a trend line by applying Gompertz’s law (mortality increases exponentially) through the Excel GROWTH function. This resulted in a pattern for ages 60 to 89 (in five-year age bands) that the Work Group considered to be materially inconsistent with the actual data, so the Work Group modified the approach to find two suitable trend lines. Then, the Work Group followed through with applying selection factors and calculated final actual to expected factors. The female actual data had only a small departure from ages 75 to 79, while the male actual data had a major departure that the Work Group deemed unusable. The Work Group decided to apply the female ratios to the male data in order to get a better fit.

Next, the Work Group graduated the curves for ages 60 to 89 using the Karup-King six-point graduation technique and then extended the table to younger and older ages using the slope of the 2012 IAM as a guide. Initially, the Work Group tried to set the expected mortality rates at younger ages using 90% of the 2012 IAM, but iteratively found that 100% for males and 120% for females appeared to be a better fit to the actual data. For older ages, the Work Group floored the Karup-King results at 107% of the 2012 IAM for males and 101% for females. See Figures 1 and 2 below.
Figure 1. Male Ultimate Mortality Rates, Age Last Birthday

Figure 2. Female Ultimate Mortality Rates, Age Last Birthday
Applying the Excel "add trendline" options to the issue-age adjusted data, the Work Group found a best fit selection pattern with an R-square value of 0.9967. It was a POWER function in the form $y = 0.1736\times^{0.5775}$. The Work Group modified this slightly to allow policy year 21 to be exactly at 100%, so the equation became $y = 0.175\times^{0.5775}$.

Further review suggested that there was less value from selection at younger issue ages than at older but longer selection periods at younger issue ages than older. For issue ages below 65, the Work Group extended the selection period to 30 years and, for issue ages above 70, reduced the selection period to 10 years. The Work Group graded the selection period between these issue ages.

Then, the Work Group returned to validate the results by determining the actual-to-expected ratios, as shown in Tables 5 and 6.

### Table 5. Males—Actual-to-Expected Ratio

<table>
<thead>
<tr>
<th>Policy Year</th>
<th>&lt;50</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>119.8%</td>
<td>108.3%</td>
<td>113.0%</td>
<td>97.0%</td>
<td>68.6%</td>
<td>136.1%</td>
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</tr>
<tr>
<td>2</td>
<td>37.7%</td>
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<td>104.9%</td>
<td>97.7%</td>
<td>130.0%</td>
<td>79.3%</td>
<td>82.4%</td>
<td>104.7%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>128.9%</td>
<td>81.0%</td>
<td>96.1%</td>
<td>107.4%</td>
<td>123.1%</td>
<td>94.2%</td>
<td>95.1%</td>
<td>93.8%</td>
<td>104.5%</td>
</tr>
<tr>
<td>4</td>
<td>103.1%</td>
<td>107.5%</td>
<td>106.2%</td>
<td>112.5%</td>
<td>116.0%</td>
<td>82.0%</td>
<td>97.4%</td>
<td>102.7%</td>
<td>105.4%</td>
</tr>
<tr>
<td>5</td>
<td>83.1%</td>
<td>103.2%</td>
<td>110.4%</td>
<td>99.1%</td>
<td>110.2%</td>
<td>98.9%</td>
<td>89.0%</td>
<td>97.8%</td>
<td>102.2%</td>
</tr>
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<td>107.9%</td>
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<td>103.2%</td>
<td>96.7%</td>
<td>95.1%</td>
<td>113.4%</td>
<td>101.7%</td>
</tr>
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<td>106.3%</td>
<td>103.1%</td>
<td>89.8%</td>
<td>96.1%</td>
<td>94.2%</td>
<td>113.2%</td>
<td>98.0%</td>
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<tr>
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<td>110.4%</td>
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<td>100.1%</td>
<td>99.2%</td>
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<td>100.7%</td>
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<td>96.1%</td>
<td>108.0%</td>
<td>102.6%</td>
<td>105.6%</td>
<td>101.0%</td>
</tr>
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<td>104.4%</td>
<td>106.2%</td>
<td>110.5%</td>
<td>102.0%</td>
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<td>107.3%</td>
<td>93.2%</td>
<td>104.0%</td>
<td>101.2%</td>
<td>103.3%</td>
<td>101.2%</td>
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</tr>
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<td>101.8%</td>
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<td>104.2%</td>
<td>103.4%</td>
<td>100.8%</td>
</tr>
<tr>
<td>13</td>
<td>113.9%</td>
<td>128.5%</td>
<td>111.1%</td>
<td>98.8%</td>
<td>99.8%</td>
<td>100.7%</td>
<td>98.8%</td>
<td>100.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>14</td>
<td>116.5%</td>
<td>89.6%</td>
<td>95.0%</td>
<td>93.2%</td>
<td>104.1%</td>
<td>101.3%</td>
<td>95.0%</td>
<td>99.9%</td>
<td>102.1%</td>
</tr>
<tr>
<td>15</td>
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<td>101.5%</td>
<td>103.8%</td>
<td>98.0%</td>
<td>102.1%</td>
<td>97.7%</td>
</tr>
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<td>101.0%</td>
<td>97.5%</td>
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<td>101.0%</td>
<td>97.0%</td>
<td>100.0%</td>
</tr>
<tr>
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<td>97.2%</td>
<td>99.0%</td>
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<td>97.0%</td>
<td>99.8%</td>
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<tr>
<td>19</td>
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<td>93.8%</td>
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</tr>
<tr>
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<tr>
<td><strong>Total</strong></td>
<td>97.1%</td>
<td>98.0%</td>
<td>103.8%</td>
<td>97.0%</td>
<td>101.0%</td>
<td>101.9%</td>
<td>102.0%</td>
<td>107.4%</td>
<td>100.9%</td>
</tr>
</tbody>
</table>
Table 6. Females—Actual-to-Expected Ratio

<table>
<thead>
<tr>
<th>Policy Year</th>
<th>&lt;50</th>
<th>50-54</th>
<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>115.6%</td>
<td>81.3%</td>
<td>65.0%</td>
<td>98.8%</td>
<td>85.6%</td>
<td>91.6%</td>
<td>17.6%</td>
<td>83.3%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>291.9%</td>
<td>85.7%</td>
<td>93.3%</td>
<td>103.1%</td>
<td>90.7%</td>
<td>102.7%</td>
<td>116.9%</td>
<td>63.4%</td>
<td>98.1%</td>
</tr>
<tr>
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<td>89.6%</td>
<td>107.5%</td>
<td>106.2%</td>
<td>111.9%</td>
<td>102.9%</td>
<td>58.9%</td>
<td>102.6%</td>
</tr>
<tr>
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<td>104.6%</td>
<td>128.9%</td>
<td>111.4%</td>
<td>103.5%</td>
<td>72.7%</td>
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</tr>
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<td>110.8%</td>
<td>103.6%</td>
<td>100.6%</td>
<td>101.8%</td>
<td>106.1%</td>
<td>104.1%</td>
</tr>
<tr>
<td>6</td>
<td>77.4%</td>
<td>97.7%</td>
<td>91.5%</td>
<td>86.7%</td>
<td>94.0%</td>
<td>99.6%</td>
<td>85.8%</td>
<td>101.9%</td>
<td>92.5%</td>
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<td>7</td>
<td>108.0%</td>
<td>102.3%</td>
<td>94.5%</td>
<td>105.8%</td>
<td>96.4%</td>
<td>83.2%</td>
<td>99.2%</td>
<td>102.7%</td>
<td>96.7%</td>
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<td>96.6%</td>
<td>100.0%</td>
<td>93.5%</td>
<td>102.6%</td>
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<td>100.8%</td>
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<td>9</td>
<td>78.0%</td>
<td>93.5%</td>
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<td>102.7%</td>
<td>102.3%</td>
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<td>91.6%</td>
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<tr>
<td>10</td>
<td>76.4%</td>
<td>91.6%</td>
<td>105.2%</td>
<td>105.5%</td>
<td>101.5%</td>
<td>107.6%</td>
<td>100.1%</td>
<td>98.4%</td>
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</tr>
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<td>11</td>
<td>106.2%</td>
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<td>98.9%</td>
<td>102.1%</td>
<td>105.2%</td>
<td>106.8%</td>
<td>98.2%</td>
<td>102.9%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>81.1%</td>
<td>96.7%</td>
<td>94.2%</td>
<td>105.1%</td>
<td>95.5%</td>
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<td>101.9%</td>
<td>99.8%</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>76.0%</td>
<td>87.5%</td>
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<td>102.0%</td>
<td>99.3%</td>
<td>103.9%</td>
<td>96.8%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>113.1%</td>
<td>90.7%</td>
<td>102.0%</td>
<td>97.6%</td>
<td>98.9%</td>
<td>97.8%</td>
<td>88.7%</td>
<td>97.0%</td>
<td></td>
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<tr>
<td>15</td>
<td>130.7%</td>
<td>126.8%</td>
<td>104.7%</td>
<td>98.6%</td>
<td>95.0%</td>
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<td>99.1%</td>
<td>97.2%</td>
<td></td>
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<tr>
<td>16</td>
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<td>96.9%</td>
<td>98.0%</td>
<td>98.5%</td>
<td>98.1%</td>
<td></td>
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</tr>
<tr>
<td>17</td>
<td>95.1%</td>
<td>125.1%</td>
<td>104.8%</td>
<td>104.9%</td>
<td>100.4%</td>
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<td>102.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>99.2%</td>
<td>120.9%</td>
<td>116.1%</td>
<td>104.0%</td>
<td>98.1%</td>
<td>100.6%</td>
<td>101.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>34.8%</td>
<td>97.4%</td>
<td>111.6%</td>
<td>102.3%</td>
<td>95.2%</td>
<td>102.7%</td>
<td>99.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>67.3%</td>
<td>104.3%</td>
<td>99.2%</td>
<td>101.9%</td>
<td>101.3%</td>
<td>101.7%</td>
<td>101.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95.7%</strong></td>
<td><strong>99.5%</strong></td>
<td><strong>99.1%</strong></td>
<td><strong>101.7%</strong></td>
<td><strong>98.6%</strong></td>
<td><strong>100.9%</strong></td>
<td><strong>98.2%</strong></td>
<td><strong>96.5%</strong></td>
<td><strong>99.7%</strong></td>
</tr>
</tbody>
</table>

The Work Group followed similar methods for deriving tables by adding underwriting risk classes and marital status, both separately and together, and for deriving tables for Active Lives.

Being healthier than the disabled lives, the mortality rates for the Active Lives are smaller than for Total Lives. At very old ages, the mortality of Active Lives is as high as that for Total Lives. Beginning around attained age 90, the ultimate Active Lives mortality begins to converge to that of the Total Lives to the point they are equal at ages above 100.

**Procedures**

The Work Group initially worked in coordination with the Lapse Subgroup to make sure that the findings of the two Subgroups (1) would be consistent and (2) could be used in conjunction with each other. Insurers of LTCI typically know when a policy terminates, but they do not necessarily know the reason. Often deaths and lapses can be misreported or not be identified at all. Comparing the data to the Social Security Database is one way to clarify which of the terminated policies were due to death. This database is not without error, yet the Subgroups believed that using it to adjust the data was more credible than otherwise. Therefore, the two Subgroups agreed to use a restricted number of contributors identified as “Definition 2” (DEFN 2).
Early in the process, the Work Group recognized that few of its members had experience in deriving mortality tables. Therefore, the group relied heavily upon guidance provided by Marianne Purushotham of LIMRA, as well as previous studies performed by the SOA, in order to identify how to calculate the actual mortality rates and how to identify the predictive variables (please see Methods above, particularly “Exposure” and “Predictive Variables”). When the Work Group reached the point of developing mortality tables, it relied heavily upon Susan Willeat.

The study period is the four-year period 2008 to 2011. The central year of the study’s exposure was 2010; to adjust the study to 2020, the Work Group applied the G2 mortality improvement assumptions for 11 years. If subsequent issue years are to have improvement, the same annual improvement figures can be applied. The Work Group applied G2 mortality improvement during the study but did not measure the actual mortality improvement.

Finally, the Work Group chose to follow similar Provisions for Adverse Deviation (PAD) as used by those who had derived mortality tables for annuity valuation tables in the past.

<table>
<thead>
<tr>
<th>Annuity Table</th>
<th>Omega Age</th>
<th>General Adjustment to Age 100</th>
<th>Adjustment Age 100+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983 GAM</td>
<td>110</td>
<td>90% at all ages</td>
<td>90% at all ages</td>
</tr>
<tr>
<td>1994 GAM</td>
<td>120</td>
<td>93% at all ages</td>
<td>Beginning after age 102, graded up from 93% to 100% when mortality was .5000 or greater.</td>
</tr>
<tr>
<td>1996 IAM</td>
<td>115</td>
<td>90% at all ages</td>
<td>Graded from 90% to 100%</td>
</tr>
<tr>
<td>2000 Annuity</td>
<td>115</td>
<td>90% at all ages</td>
<td>Graded from 90% to 100%</td>
</tr>
<tr>
<td>2012 IAM</td>
<td>120</td>
<td>90% at all ages</td>
<td>Minor grading around age 103 that ends due to a capping of the rate at 0.400000</td>
</tr>
</tbody>
</table>

The Work Group tested the number of contributors of data whose mortality would have been higher than the mortality using a similar PAD as used for the 2012 IAM. The grading was performed over the same ages as the 2012 IAM but with slightly different and rounded factors. As shown in Figure 3, seven of the 10 had mortality that was higher overall than identified by the recommended table with this PAD.
Six out of 10 companies had less than or equal to 100% actual deaths to expected deaths based on the fitted table before the application of the margin. (Less than 100% A/E implies that the recommended table is inadequate in reflecting their experience.) The number of companies to have actual-to-expected ratios below 100% may reasonably be expected to be about half of the total unless a small number have an inordinate amount of weight. Six is about half. By lowering the expected deaths by 10%, only three companies remain under 100% A/E. The 70% coverage is adequate as a valuation table provided that the sample of 10 companies is a fair representation of the industry. If the margin were to cover 80% or 90% of the companies, the expected deaths would need to be reduced by 16% or 22%, figures which seem extreme considering that one company’s experience is less credible than the whole, and that other mortality table provisions for adverse deviation are not that high. However, with more data or a more precise explanation of the existing data, an actuary may sufficiently demonstrate that a company has different mortality than the industry. For example, if hypothetically a particular company had a spouse discount only when the married applicant also had a healthy spouse apply for coverage, while most other companies required only that the applicant be married regardless of the status of the spouse, the particular company’s actual-to-expected ratio could be low. Similarly, the reverse could be true. If hypothetically, a particular company had a relatively weak requirement for spouse discounts, then the actual-to-expected ratio could be high.
Disclosures

1. The Work Group relied upon the following reports and parties to perform its work.
   a. SOA Long Term Care Experience Study Committee for the collection of the data.
   b. LIMRA, MIB, and Willis Towers Watson for “cleaning” the data (part of the SOA Long-
      Term Care Experience Study Committee work).
   c. The SOA report titled “Experience Study Calculations” by David Atkinson and John
      McGarry.\textsuperscript{13}
   d. Marianne Purushotham and LIMRA for calculating the exposure and identifying the
      statistical significance of predictive variables.
   e. Susan Willeat of RGA Reinsurance Company for developing the mortality tables.

2. The findings of this study have important limitations as follows.
   a. The data was for traditional, stand-alone LTCI. Mortality for combination or hybrid
      products may differ. Also, what represents provision for adverse experience on
      combination products will likely differ. Similarly, the mortality may differ for other
      products that have some features in common with LTCI (i.e., short-term care products).
   b. The Social Security Database may not be as accurate as expected and, therefore, the
      mortality assignments for terminations may be misleading.
   c. The predictive variables may not be defined consistently among the contributors. This is
      particularly true for marital status and underwriting risk class.
   d. The data for later policy durations and extremely old ages may not be fully credible.
   e. The trend or mortality improvement from 2010 to 2020 based on the 2012 IAM may not
      have represented the LTCI insured population.

3. Recommendations for further study
   a. Update this study when mortality at extremely old ages and later policy durations
      becomes more credible.
   b. While individual insurance companies are not the intended users of the findings from this
      study, they may find value in identifying mortality within their own definitions of marital
      status and underwriting risk class, particularly if they have maintained their definitions
      over the entire population within the data being analyzed. Insurance companies may
      want to compare their own mortality to this study.

\textsuperscript{13} https://www.soa.org/globalassets/assets/Files/Research/2016-10-experience-study-calculations.pdf
Mortality Tables

The mortality tables presented in this report should be used with the full understanding of how they were derived and the purpose for which they were intended.

Basic tables are without margin (they are smoothed and extrapolated actual experience with the ability to apply G2 mortality improvement for a specified period of improvement).

Total or Active Lives may be selected, as well as the following parameters:
- Sex, Issue age, and Policy year
- Sex, Marital status, Issue age, and Policy year
- Sex, Underwriting risk class, Issue age, and Policy year
- Sex, Marital status, Underwriting risk class, Issue age, and Policy year

Valuation tables are derived by multiplying the “Expected” mortality rates by a factor of 0.90 with the margin factor grading to 1.00 at very old ages.

Mortality Improvement

Mortality improvement is observed in the general population and all insured lines of business. Mortality improvement scales are almost always based on Social Security Administration general population data over decades of time.

The Work Group is recommending the G2 Scale developed by the American Academy of Actuaries/Society of Actuaries Payout Annuity Table Team in the development of the 2012 Individual Annuity Reserving Table (2012 IAR). The recommended improvement starts from the midpoint of the observation period for the mortality data, 2008 to 2011 inclusive to the end of 2020 (i.e., 11 years of improvement).

ASOP No. 18, *Long-Term Care Insurance*, 14 section 3.2.8 “Change-over-Time Assumptions” requires the actuary to consider assumptions that change over time. Mortality improvement from the period observed to the period for which the assumption is to be used should be considered. The LTCAWG may consider alternative projection scale(s) to that recommended by the Work Group. The impact of improvement to the ultimate basic (without margin) mortality is illustrated in Table 8 below.

The G2 scale is recommended for improvement from the observation period to the end of 2020 for both total life mortality and active life mortality. The Work Group chose the G2 scale as it is a contemporary mortality improvement scale developed from Social Security Administration’s mortality data. The G2 scale was developed by the 2012 IAR Work Group. We note that the ultimate LTC mortality table developed by the Work Group has a substantially similar shape and level as the 2012 IAM table. The Work Group is not making any recommendations for disabled life mortality as that is outside of the scope of the request from the LTCAWG.

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14 Actuarial Standards Board; Actuarial Standard of Practice No. 18, *Long-Term Care Insurance*, May 2011.
Additionally, an alternative the LTCAWG may consider is improvement of total life mortality and active life mortality beyond 2020, either for all policies for which the recommended mortality would apply (i.e., calendar year), or by issue year with no improvement beyond the issue year.

We used the Actuarial Guideline 51 (AG51) sample cells to show the sensitivity of applying the mortality improvement to 2020 and applying it indefinitely beyond 2020 for policies issued in 2020.

The following reserve amounts in Table 8 are for illustrative purposes only to provide an indication of how the mortality improvement might affect them. The interest rate used for discounting was 3.50%. The decrements are based on the recommendations in this report, assuming a Preferred premium rate class. The underlying incidence rates were based on the SOA 2015 LTC Experience Study’s GLM model #2, without diagnosis. They were increased to account for the impact of the elimination period on the incidence. The claim terminations were calculated using the SOA 2015 LTC Experience Study’s GLM model #2, applying the same continuance assumption during the elimination period as used to adjust the incidence. The recoveries were set at the difference between the total terminations and assumed disabled lives mortality. Mortality could not be higher than total terminations. The utilization was set at 100%.

### Table 8. Sample Active Life Reserves

<table>
<thead>
<tr>
<th>Sample Active Life Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample 1</strong></td>
</tr>
<tr>
<td><strong>Sample 2</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Policy Year Fifteen (15)</th>
<th>Policy Year Thirty (30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserve</td>
<td>Ratio relative to no improvement</td>
<td>Reserve</td>
</tr>
<tr>
<td><strong>Sample 1</strong></td>
<td>No Improvement Scenario</td>
<td>198,960</td>
</tr>
<tr>
<td>No Disabled Lives Mortality Improvement</td>
<td>199,866</td>
<td>100%</td>
</tr>
<tr>
<td>Active Lives Improvement to 2020 Scenario</td>
<td>200,563</td>
<td>101%</td>
</tr>
<tr>
<td>Active Lives Indefinite Improvement Scenario</td>
<td>202,219</td>
<td>102%</td>
</tr>
<tr>
<td>Disabled Lives Mortality Improvement</td>
<td>210,963</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td><strong>Sample 2</strong></td>
<td>No Improvement Scenario</td>
</tr>
<tr>
<td>No Disabled Lives Mortality Improvement</td>
<td>16,081</td>
<td>100%</td>
</tr>
<tr>
<td>Active Lives Improvement to 2020 Scenario</td>
<td>16,138</td>
<td>101%</td>
</tr>
<tr>
<td>Active Lives Indefinite Improvement Scenario</td>
<td>16,084</td>
<td>100%</td>
</tr>
<tr>
<td>Disabled Lives Mortality Improvement</td>
<td>16,142</td>
<td>101%</td>
</tr>
</tbody>
</table>
The Work Group offers the following additional observations with respect to mortality improvement for valuation:

1. There is currently no known industry study on LTC mortality trends. There is evidence of mortality improvement trends in both general and annuitant populations. Because mortality experience for Individual Annuitants and LTC policyholders appear to have similar shapes (see figures 4 and 5, below), it is reasonable to assume that mortality improvement exists in LTC as well.

**Figure 4. Female Ultimate Mortality Rates, Age Last Birthday**

![Figure 4: Female Ultimate Mortality Rates, Age Last Birthday]
2. If no future mortality improvements are assumed in the valuation of liabilities, the valuation tables may be inadequate in the future if there is indeed future improvement and the built-in margin for conservatism is eroded. This may be an acceptable position if industry experience can be monitored in a timely manner.

3. With respect to the choice of G2 scale for LTC, there is a possibility that LTC policyholders have greater improvement than annuitants because they tend to have a higher socioeconomic status. Again, timely industry experience monitoring is necessary.

4. In a first-principle valuation method, active and disabled policyholders are modeled separately (disabled policyholders tend to have materially higher mortality than active policyholders). A decision needs to be made on whether mortality improvement applies to both active and disabled policyholders or to actives only.

   a. There is evidence of disabled lives mortality improvement in Social Security disabled beneficiaries’ data. There is also evidence of improvement in disabled retired persons’ data (RP-2000 and RP-2014 tables). However, the definition of disability varies considerably among disabled populations.

   b. From a comparison of five-year survival rates of disabled samples in the National Long-Term Care Surveys, there is no evidence of mortality improvement.\textsuperscript{15} Comparison of

disabled mortality rates by calendar year using the 2000–2011 SOA LTC Inter-Company Study is inconclusive with respect to mortality improvement trends.

c. Requiring mortality improvement on total lives may be inconsistent with not requiring improvement on disabled lives.

d. For financial projections and valuation under generally accepted accounting principles (GAAP), industry practice has been to assume mortality improvement on active policyholders only.

e. Disabled mortality improvement is an unresolved issue in LTC. A reasonable approach is to allow companies to choose disabled mortality improvement or not. AG51 may consider requiring sensitivity analysis with respect to this assumption.

5. Currently, there is no conclusive indication whether COVID-19 will have a permanent impact on future LTC mortality experience. The coronavirus may subside, and vaccines may be effective so that the impact on mortality is only temporary. On the other hand, herd immunity may be difficult to develop, so the impact may linger. Early data suggests that COVID-19 has a relatively flat excess percentage of mortality across ages above 60. It is, therefore, unclear how COVID-19 may affect future mortality improvement trends. If COVID-19’s impact is permanent, then the recommended tables will likely have additional margins.
IV. LAPSE

Developmental Process

Similar to the mortality tables, the following general steps were taken to derive the recommended lapse tables:

- Check reasonableness of provided data using published SOA summary data.
- Determine predictive factors for lapse tables.
- Develop raw rates.
- Smooth rates.
- Develop factors.
- Calculate expected lapses based on preliminary proposed rates with factors.
- Compare actual lapses to expected lapses.

Study Period

As noted previously, lapse data from the DEFN 2 participating companies for the most recent four-year period (2008–2011) of the 2000–2011 SOA LTC Intercompany Study was used for the lapse tables. As suggested by Figure 6 below, there appears to be a declining trend in lapses, perhaps impacted by improved death coding over the SOA study period from 2000 to 2011, especially at the later policy durations beyond year 13.

Figure 6. Lapse Rates by Policy Duration and Study Period, All Issue Ages, DEFN 2 Companies
Lapse and Exposure Definitions

The recommended lapse tables to be developed pertain to voluntary lapses. Voluntary lapses are defined as policy terminations due to nonpayment of premium, group termination, policy conversion, and other terminations with unknown causes. Terminations due to benefit exhaustion were excluded. However, it is possible that certain companies might have classified benefit exhaustions as other terminations with unknown causes.

Annual lapse rates for the recommended tables are ratios of counts over exposures. Both counts and exposures are tabulated on a policy year basis. During any policy year, a policy contributed to a lapse count if the policy lapsed during the policy year. Because almost all LTC policies waive premiums during claim, we assumed that the lapse counts are the same on both total-lives and active-lives bases.

Exposures are also determined on a policy year basis. A full year of total-lives exposure for lapse (consistency with mortality) is assigned if a policy is in force at the beginning of the policy year and still in force at the end of the policy year or if the policyholder lapsed during the policy year. If the policy terminated for any other reasons, a partial year of exposure is assigned based on the month during which the policy terminated.

For active lives lapse exposures, the policy must not be on claim at the beginning of the policy year. If a policy becomes active during a policy year, partial exposure is assigned from the first month of being active.
Data Credibility

Based on the selected data, Figures 7 and 8 below summarize the lapse counts by issue age group and policy duration with respect to credibility, using 1,082 counts or more as a measure of full credibility.

Figure 7. Minimum of Number of Individual Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration

![Graph showing lapse counts by issue age group and policy duration with 47% partial credibility.]

Figure 8. Minimum of Number of Group Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration

![Graph showing lapse counts by issue age group and policy duration with 55% partial credibility.]

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The graphs indicate that the majority of the developed rates in issue age and duration cells are fully credible, except for certain cells in the later policy durations.

As shown in the graph for individual lapses (Figure 7), lapse counts for policy duration 11 and over for the issue age group Under 55 are only partially credible. Thus, it is inadvisable to split the Under 55 issue age group further. This also holds for group lapses (Figure 8) in the issue age group 60 and over for policy duration beyond the sixth year. Any further subdivision would render the results not credible.

**Predictive Variables**

LIMRA, the statistical agent for the Study, performed a multivariate analysis of the tabulated lapse data. A logistic regression model with forward selection produced the following ranked results of factor significance based on Wald Chi-Square:

<table>
<thead>
<tr>
<th>Significant Covariates (Wald Chi-Square)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor</strong></td>
</tr>
<tr>
<td>Policy Year</td>
</tr>
<tr>
<td>Premium Status</td>
</tr>
<tr>
<td>Attained Age</td>
</tr>
<tr>
<td>Underwriting Type</td>
</tr>
<tr>
<td>Periodic Premium Level</td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td>Premium Mode</td>
</tr>
<tr>
<td>Physician Statement</td>
</tr>
<tr>
<td>Marital Discount</td>
</tr>
<tr>
<td>Rate Increase Indicator</td>
</tr>
</tbody>
</table>

Policy year, attained age, underwriting type, premium level, and marital status appeared to be key factors for table development.

These findings are consistent with the results from the corresponding model for mortality. Accordingly, the Work Group decided that the factors for both mortality and lapse should be as identical as possible. That is, the lapse table will utilize policy year, attained age (in the form of issue age and policy duration), underwriting type, and marital status as factors.

For group LTC business, the vast majority of certificates are guaranteed issue and marital status is typically not known. Therefore, these factors would not apply to group business.
Development of Tables

As shown in Figures 9 and 10, raw individual and group lapse rates for total lives by issue age group and policy duration were determined as ratios of lapse counts over exposures.

**Figure 9. Raw Lapse Rates by Issue Age, Group and Policy Duration, Individual, Total Lives**

With respect to the raw individual lapse rates, we noted that later policy duration lapse rates tended to be increasing, especially at the older issue age groups. This phenomenon can at least be partially attributed to the under-reporting of deaths upon policy termination, which occurs more frequently at
later policy durations and older attained ages. Due to the declining trend by calendar year, the Work Group believes it is prudent to be conservative at the later policy durations. Accordingly, the raw lapse rates were adjusted to be non-increasing by policy duration.

Note that, for group lapse rates, policy durations from year 11 through 15 were aggregated in order to improve data credibility at these durations.

To derive the recommended lapse rates for total lives by issue age group and policy duration, the raw rates were smoothed by fitting them to either a 2-degree polynomial or a power function. A polynomial or power equation was chosen by visualizing the fit in an Excel graph. Figures 11 and 12 below display the recommended lapse rates.

**Figure 11. Smoothed Lapse Rates by Issue Age Group and Policy Duration**
The recommended lapse tables for active lives were developed in a similar fashion by substituting active lives exposures for total lives exposures. The numerators of the ratios, the numbers of active lives lapses, are assumed to be the same as for total lives lapse rates. Because almost all long-term care policies have waiver of premium benefits, very few policies lapsed while the policyholders were on claim.
Underwriting Risk Class and Marital Status Factors for Individual Business

The underwriting risk class and marital factors for total lives individual lapses were determined by policy duration only with the same factors applying to all issue age groups. Lapse rates by policy duration for the three underwriting classes—preferred, standard, and substandard—were first calculated. The factors are the ratios of these lapse rates to the overall durational lapse rates without underwriting distinction. These factors for the three classes were smoothed to arrive at the final proposed factors. A similar process was also performed for marital status. Figures 13 and 14 below show the raw and the smoothed factors.

Figure 13. Raw and Smoothed Factors for Underwriting Class

![Graph showing raw and smoothed factors for underwriting class]

- Preferred: $y = -0.0178x + 1.177$
- Standard: $y = 0.0067x^2 - 0.0542x + 0.9254$
- Substandard: Linear

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Because the lapse rates for active lives are not materially different than those of total lives, the recommended factors derived from total lives lapses can equally apply to active lives lapse rates.

The underwriting risk class and marital status factors are not applicable to the recommended group lapse rates because most of the group business was guaranteed issue and marital status is generally unknown.
Development of Margin Recommendation

The recommended lapse tables and factors represent best estimates of future long-term care lapse events based on past experience. In order to use these tables for valuation purposes, a margin of conservatism should be added to cover a company’s variation from industry experience. The Work Group was able to obtain lapse data from individual participating companies that made up the aggregate data for the recommended lapse table construction. A ratio of actual lapses to expected lapses based on the recommended lapse tables was calculated for each company. The results are shown in Figure 15:

**Figure 15. Actual-to-Expected Lapses, Individual Total Lives, by Company, Without Margins, Policy Years 11 & Over**

One company with an abnormally high actual-to-expected ratio was excluded in the comparison. The actual-to-expected ratio for two out of nine companies was above 100%. However, a 15% margin on the recommended lapse tables would result in six out of nine companies’ actual lapses exceeding the newly expected number of lapses based on the more conservative lapse tables. Accordingly, the Work Group recommends a 15% margin.
Comparison of Recommended Lapse Tables With Actual Experience

In order to assess the reasonableness of the recommended lapse tables relative to past experience, the Work Group performed a series of comparisons.

Figure 16 compares the actual total lives Individual lapses by policy duration to the expected number of lapses based on the recommended lapse tables.

**Figure 16. Actual-to-Expected Lapses, Individual Total Lives, by Policy Duration, With and Without Margins**

The greater-than-100% actual-to-expected ratio beyond the ninth duration is due to the restriction of non-increasing lapse rates by policy duration. The overall actual-to-expected is 106%. With the margin, the overall actual-to-expected is 125%. The Work Group believes the recommended lapse rates by policy durations relative to actual experience are reasonable in light of the declining trends in recent experience years.
The Individual total lives actual lapses to expected by issue age group are shown in Figure 17.

**Figure 17. Actual-to-Expected Lapses, Individual Total Lives, by Issue Age Group, With and Without Margins**

The non-increasing limitation by policy duration has the greatest impact on issue ages 70 and over.
Figure 18 shows the total lives individual actual-to-expected ratios by marital status and underwriting risk class.

The actual-to-expected ratios are relatively close to the overall actual-to-expected without the margin.

The total lives group actual lapses to expected by policy duration are provided in Figure 19:

Figure 19. Actual-to-Expected Lapses, Group Total Lives, by Policy Year, With and Without Margins
Without margin, the actual-to-expected ratios are relatively stable during the first eight policy durations but slightly exceed 100% thereafter. The Work Group believes the slight conservatism is justified due to the significance of the lapse rates at higher durations for valuation purposes.

The total lives group actual lapses to expected by issue age group are shown in Figure 20:

**Figure 20. Actual-to-Expected Lapses, Group Total Lives, by Issue Age Group, With and Without Margins**

The corresponding comparisons for actives lives lapses produced similar results as for total lives lapses. These comparisons are presented in Appendix 2.

**Recommended Lapse Tables**

The recommended lapse tables for total lives and active lives are shown in Appendix 3. The individual lapse rates vary by issue age group, policy duration, marital status and underwriting class. The group lapses rates vary by issue age group and policy duration.
V. TOTAL TERMINATION

A policy may lapse because the policyholder died. Verification of death is not always possible, and results vary from company to company. Accordingly, the delineation between voluntary lapse and death is not precise for long-term care insurance. The Work Group performed a check on total terminations (i.e., combining lapses and deaths) to ensure that the recommended lapse and mortality tables reasonably represent actual combined experience.

The lapse and death components that made up the total lives individual actual-to-expected are shown in Figure 21:

Figure 21. Actual-to-Expected Mortality and Lapse, Individual Total Lives, With and Without Margins

During the study period 2008–2011, there were approximately 79,000 deaths and 200,000 lapses. The slightly aggressive actual-to-expected deaths are more than offset by the conservatism from that for lapses. For terminations that occurred beyond policy year 15, there were 11,000 deaths and only 8,800 lapses.

The individual total lives actual total terminations are slightly greater than the expected with and without margins beyond the 10th policy duration, as seen in Figure 22:
As shown in Figure 23 below, the actual-to-expected is slightly increasing by issue age group:

**Figure 23. Actual-to-Expected Total Terminations, Individual Total Lives, by Issue Age Group, With and Without Margins**
For group business, the actual total terminations are slightly less than the expected without margins beyond the 15th policy year, as shown in Figures 24 and 25 below:

**Figure 24. Actual-to-Expected Mortality and Lapse, Group Total Lives, With and Without Margins**

**Figure 25. Actual-to-Expected Total Terminations, Group Total Lives, by Policy Duration, With and Without Margins**

The actual total terminations are greater than the expected with margins for all policy durations.
By issue age group, the group total lives actual total terminations are equal to or slightly greater than the expected without margins for all issue age groups. As seen in Figure 26, actual total terminations are greater than the expected with margins for all issue age groups.

**Figure 26. Actual-to-Expected Total Terminations, Group Total Lives, by Issue Age Group, With and Without Margins**

The relationship of actual-to-expected total terminations for actives lives is very similar to that for total lives.

In conclusion, the Work Group is satisfied with the recommended tables in that the implied total terminations are consistent with actual experience.
VI. APPENDICES

Appendix 1—LTCAWG Request

5/5/16

The Long-Term Care Valuation (B) Work Group of the NAIC Health Actuarial (B) Task Force’s Long-Term Care Actuarial (B) Working Group requests assistance from the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) with the following:

1) Develop a replacement mortality table for the current statutorily prescribed long-term care (LTC) mortality basis for active life reserves (ALR), the 1994 Group Annuity Mortality Static Table. The replacement mortality table is to be based on the 2012 Individual Annuity Mortality Table, and should vary, where appropriate, by issue age, gender, and individual versus group policy. Consider whether it would be prudent to develop a margin for conservatism to be applied to the table for ALR. Such a margin may be in the form of select and ultimate factors reflective of data studied in the recent SOA/Life Insurance Research Marketing Association (LIMRA) LTC Voluntary Lapse and Mortality Experience Study.

2) Develop a proposal to replace the current statutorily prescribed LTC voluntary lapse parameters. The proposal is to be developed using data from the recent SOA/Life Insurance Research Marketing Association (LIMRA) LTC Voluntary Lapse and Mortality Experience Study, and should vary, where appropriate, by issue age, gender, policy duration, individual versus group policy as well as by the presence of specific benefits features that show evidence of producing different lapse experience historically than others.

3) For both items above, consider whether the required assumptions used for determining ALR should be modified depending upon whether the morbidity tables used in determining ALR are based on an active lives only or an all lives approach.

Please provide updates on progress as, available, and provide final results for mortality and lapses separately if they are completed at different times.

Thank You,

Perry Kupferman, Chair, Long-Term Care Actuarial (B) Working Group
Appendix 2—Active Lives Actual Lapses to Expected Comparisons

Figure 27. Actual-to-Expected Lapses, Individual Active Lives, by Policy Duration, With and Without Margins

Figure 28. Actual-to-Expected Lapses, Individual Active Lives, by Issue Age Group, With and Without Margins
Figure 29. Actual-to-Expected Lapses, Individual Active Lives, by Martial Status and Underwriting Class, With and Without Margins

Figure 30. Actual-to-Expected Lapses, Group Active Lives, by Policy Duration, With and Without Margins
Figure 31. Actual-to-Expected, Group Active Lives, by Issue Age Group, With and Without Margins
Appendix 3—Recommended Lapse Tables

Double-click this icon to download an Excel version of these recommended individual and group lapse tables:

LTC Lapse Tables.xlsx

Table 10. Recommended Individual Lapse Rates—Total Lives (With Margins)

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Table 11. Recommended Group Lapse Rates—Total Lives (With Margins)

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Table 12. Proposed Individual Lapse Rates—Active Lives (No Margins)

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Appendix 4—Recommended Mortality Tables

Please double-click this icon to download an Excel version of the recommended mortality tables:

LTC Mortality
Tables.xlsx

The Long-Term Care Valuation (B) Subgroup of the NAIC Health Actuarial (B) Task Force’s Long-Term Care Actuarial (B) Working Group requests the assistance of the Society of Actuaries with the following:

- Evaluation of the appropriateness of using the 2012 Individual Annuity Reserving Tables (2012 IAR), or an appropriate percentage of it, as a mortality basis for individual long-term care insurance reserving for policies issued after a given future date instead of the currently used 1994 Group Annuity Mortality Table (1994 GAM).

- Evaluation of the appropriateness of using 2012 IAR, or an appropriate percentage of it, as a mortality basis for group long-term care insurance reserving for policies issued after a given future date instead of the currently used 1994 Group Annuity Mortality Table (1994 GAM).

Ideally, the Society of Actuaries will provide the Long-Term Care Valuation (B) Subgroup with periodic progress updates, culminating in a recommendation for or against the use of the 2012 IAR as a mortality basis for long-term care insurance reserving.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/HEALTH INS and MANAGED CARE (B) COMMITTEE/Health Actuarial (B) TF/Conference Calls/3-9 LTCAWG/LTC Val SG Request to SOA 6-3-14.docx
Experience Studies

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<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
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<tr>
<td>2000-2011 LTC Lapse and Mortality Valuation Assumptions</td>
<td>Develop a replacement mortality LTC valuation table and a proposal to replace the current LTC voluntary lapse parameters. Work done in conjunction with the AAA.</td>
<td>6/30/2023</td>
</tr>
<tr>
<td>2006-2015 Individual Disability Income – Experience Modifications to the 2013 Individual Disability Income Valuation Table Claim Termination Rates</td>
<td>Complete a study of claim termination for individual disability and release a report of Experience Modifications to the 2013 Individual Disability Income Valuation Table Claim Termination Rates.</td>
<td>5/17/2022</td>
</tr>
<tr>
<td>2006-2015 Individual Disability Income – Experience Modifications to the 2013 Individual Disability Income Valuation Table Incidence Rates</td>
<td>Complete a study of claim incidence rates for individual disability and release a report of Experience Modifications to the 2013 Individual Disability Income Valuation Table base incidence factors.</td>
<td>6/30/2023</td>
</tr>
<tr>
<td>2000-2019 Long Term Care Experience Study - Data Request</td>
<td>Develop a database for Long-Term Care claim termination and incidence experience.</td>
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Practice Research

<table>
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<th>Project Name</th>
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</thead>
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<tr>
<td>2022 Health Care Cost Model v4.0</td>
<td>Release a model that will enable users to estimate health care cost levels in insured plans across a wide variety of benefit plan scenarios. (Robert Wood Johnson Foundation funded project)</td>
<td>5/31/2022</td>
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<tr>
<td>Social Model v6.0 update</td>
<td>Social model user interface (UI) update</td>
<td>6/4/2023</td>
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<tr>
<td>Health Actuarial and Managed Care (B) Committee</td>
<td>Quantitative SOA research project</td>
<td>5/15/2022</td>
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<tr>
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<td>Health Actuarial and Managed Care (B) Committee</td>
<td>5/31/2022</td>
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<tr>
<td>Analysis of Health Care Cost Factors with Race, Ethnicity and Socioeconomic Status</td>
<td>Identify and further enhance methods to assess on socio-economic/demographics, and socioeconomic related to medical care, industry, and geography in U.S. health insurance pricing</td>
<td>5/31/2022</td>
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<tr>
<td>Health Underwriting</td>
<td>Well on a previous project designed to provide a theoretical methodology for Medicaid rate setting across states to determine the appropriate way to evaluate the risk associated with enrollees in the various underlying life-risk.</td>
<td>5/1/2023</td>
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<tr>
<td>Stakeholders (v2) – Provider: Identifying Characteristics of the Top 50% spenders by cost who drove 50% of Medical Expenses</td>
<td>Identify the total providers through total costs and average annual costs by percentile group. Analyze ability to predict the 50% based on prior claims and risk factors. Calculate transition probabilities between different groups.</td>
<td>5/1/2023</td>
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<tr>
<td>Social Periodical and Demographics of Health</td>
<td>Quantitative SOA research project</td>
<td>5/1/2023</td>
</tr>
<tr>
<td>Change impact of using SDOH on HealthCare costs and Medical conditions</td>
<td>Study that will examine the impact of primary diagnoses on patient claims and medical conditions.</td>
<td>5/1/2023</td>
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<tr>
<td>SOA White Paper</td>
<td>Surveys Risk Adjusted Pie charts to create a white paper that will outline current costs through the analysis of risk and offers members through the analysis of risk and offers members through 75% (Robert Wood Johnson Foundation funded project)</td>
<td>5/1/2023</td>
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<tr>
<td>Practice Wellness and Health Care</td>
<td>Use the output of results, data scientists and analysts will examine the impact of disease and healthcare costs, cost and quality of care on wellness across various racial, ethnic, socioeconomic groups.</td>
<td>5/1/2023</td>
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</table>

Presentation Disclaimer

Presentations are intended for educational purposes only and do not replace independent professional judgment. Statements of fact and opinions expressed are those of the participants individually and, unless expressly stated to the contrary, are not the opinion or position of the Society of Actuaries, its cosponsors or its committees. The Society of Actuaries does not endorse or approve, and assumes no responsibility for, the content, accuracy or completeness of the information presented. Attendees should note that the sessions are audio-recorded and may be published in various media, including print, audio and video formats without further notice.
### American Academy of Actuaries

**Health Practice Council**

**Spring 2022 Updates**

Barbara Klever, MAAA, FSA  
Vice Chairperson, Health Practice Council  
American Academy Of Actuaries

March 29, 2022—NAIC Health Actuarial (B) Task Force (HATF) Meeting

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### Public Policy and the Academy

The Academy, through its public policy work, seeks to address pressing issues that require or would benefit from the application of sound actuarial principles. The Academy provides unbiased actuarial expertise and advice to public policy decision-makers and stakeholders at the state, federal, and international levels in all areas of actuarial practice.

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### About the American Academy of Actuaries

The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy and its boards also set qualification, practice, and other professionalism and ethical standards for actuaries credentialed by one or more of the five U.S.-based actuarial organizations in the United States.

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### Health Practice Council—Key Policy Priorities for 2022

- Health Equity
- COVID-19: Implications for Health Care Utilization and Spending
- Insurance Coverage
- Long-Term Care
- Medicare Sustainability
- Payment and Delivery Reform
- Climate Change and Health
Health Equity

- Discussion Briefs:
  - Health Equity from an Actuarial Perspective (2021)
  - Health Equity and Financial Pricing (2021)
  - Health Equity and Pricing of Health Insurance (2021)
  - Health Equity, and Provider Contract/Network Development (2021)
  - Health Equity and Risk-Based Premium Regulation (2021)
  - Data Collection for Measurement of Health Disparities (forthcoming)

- Comment letters:
  - Comment Letter to the Colorado Division of Insurance on the implementation of Colorado Revised Statutes (C.R.S.) § 25-19-706(2) (2022). This new section prohibits health discrimination based on certain personal characteristics—race, color, national or ethnic origin, sex, sexual orientation, disability, gender identity, or gender expression—as any insurer practice that unfairly discriminates against individuals with these characteristics (2022)
  - Request for Information on Annuity Whether or not Actual Practice

COVID-19: Implications for Health Care Utilization and Spending

- Issue Briefs / Papers:
  - Considerations for Reflecting the Impact of COVID-19 in Medicaid Managed Care Plan Rate Setting (2021)

Health Insurance Coverage

- Issue Briefs:
  - Drivers of 2023 Health Insurance Premium Changes (forthcoming)

- Comment Letters:
  - Comments on Draft 2023 Actuarial Value (AV) Calculator Methodology (2022)
  - Comments on 2023 Notice of Benefit and Payment Parameters (NBPP) (2022)
  - Comments to HHS, DOL, and the Treasury on the No Surprises Act (2021)

Long-Term Care

- Comment Letters
  - Comment letter to CMS on the Proposed Rule for the 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (comments involved D-OHPs and MLRs) (2022)
  - Reports
    - Long-Term Care Insurance Mortality and Lapse Study (2021)
    - Request from NAIC Long Term Care Actuarial Working Group (LTCAWG)
    - Presentation to NAIC HATF in November 2021; discussion with NAIC LTCAWG in March 2023
### Medicare Sustainability

- **Statements/Testimony**
  - *Statement for the Record* to the U.S. Senate Committee on Finance Subcommittee on fiscal responsibility and economic growth on the Hospital Insurance Trust Fund and the future of Medicare financing (2022)

### Payment and Delivery Reform

- **Issue Briefs / Paper**
  - *Issue Brief on Hospital Price Variation* (2022)
- **Comment Letters**
  - *Comments on 2023 Notice of Benefit and Payment Parameters (NBPP)* (2022)
  - *Comments to CMS on Payment Parameters Proposed Rule* (2021)

### Climate Change and Health

- In November of 2021, the Academy launched the Climate Change Joint Task Force
  - Membership is comprised of the Health Practice Council (HPC), the Casualty Practice Council (CPC), and the Risk Management and Financial Reporting Council (RMFRC)
- **Comment Letters**
  - *Comment letter* to the RFI from the U.S. Department of the Treasury and FIO on Climate-Related Financial Risk and the Insurance Sector (2021)—and forthcoming to the Department of Labor on Environmental, Social, and Governance (ESG)

### HPC NAIC Workstreams—HATF

- **Health Actuarial (B) Task Force (HATF)**
  - Request for comments on proposal to modify the definition of “actuarial assets” as used in the instructions for the Health Statement of Actuarial Opinion (SAO)
  - *April* and *May* 2021 Academy comment letters
  - March 2, 2022, NAIC HATF meeting to finalize language within the Health SAO
**HPC NAIC Workstreams—HRBC**

- **Health Risk-Based Capital (E) Working Group (HRBC)**
  - Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula
    - July 2021 Academy comment letter
    - January 2022 Academy report
      - Exposed for comments by NAIC HRBC until March 16, 2022; comments discussed on March 18 HRBC call. HRBC has asked whether an educational presentation by the rating agency would be possible to the Working Group.

**HPC NAIC Workstreams—LTC (EX)**

- **NAIC Long-Term Care Insurance (EX) Task Force Long-term Care Insurance MSA Framework.** Academy comments on:
  - Long-Term Care Insurance (LTC) Multistate Rate Review Framework
  - Actuarial Sections
  - Operational and Actuarial Sections, Sept. 2021 Exposures
- **Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup**
  - Academy comments on exposure draft, Issues Related to LTC Wellness Benefits

**HPC NAIC Workstreams—LTCAWG**

- **NAIC Long-Term Care Actuarial (B) Working Group**
- **Long-Term Care Insurance Mortality and Lapse Study**
  - Report released November 2021
    - Developed by the Long Term Care Valuation Work Group of the American Academy of Actuaries and the Society of Actuaries Research Institute
    - Presentation to NAIC HATF in November 2021
- Discussion during March 9, 2022, NAIC LTCAWG meeting. NAIC will contact Academy on next steps on the potential use of more recent data for an updated report.

**2022 HPC Hill Visits (virtual)**

- **Thursday, March 10, and Friday, March 11, 2022**
- 19 meetings via zoom; over 20 Academy volunteers
- Issues discussed included Medicaid and the unwinding of the public health emergency, Medicare program sustainability, health equity, telehealth, COVID-19, price transparency, prescription drug prices, LTC, and the Affordable Care Act (ACA)
Academy 2022 Annual Meeting and Public Policy Forum

- American Academy of Actuaries 2022 “Annual Meeting and Public Policy Forum” in Washington, DC
- TBA - October or early November 2022

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Under the Public Policy tab, access Academy:
- Comments and letters
- Issue briefs
- Policy papers
- Presentations
- Reports to the NAIC
- Testimony

Thank You

Questions?

Contact: Matthew Williams, JD, MA
Senior Health Policy Analyst
williams@actuary.org

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/HEALTH%20INS%20and%20MANAGED%20CARE%20(B)%20COMMITTEE/Health%20Actuarial%20(B)%20TF/Conference%20Calls/3-29%20HATF/Academy_HPC_Updates_to_NAIC_HATF_3.29.22.pptx
MEMORANDUM

TO: Commissioner Andrew N. Mais (CT), Chair of the Health Actuarial (B) Task Force and Fred Andersen (MN), Chair of the Long-Term Care Valuation (B) Subgroup

FROM: Steve Drutz (WA), Chair of the Health Risk-Based Capital (E) Working Group

DATE: Feb. 25, 2022

RE: AG 51 – Asset Adequacy Testing

The Health Risk-Based Capital (E) Working Group established the Health Test Ad Hoc Group in 2018 to review the health test language within the Annual Statement Instructions due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Currently, a company passes the health test if the following requirements are met:

- The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

  AND

- The entity passing the Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

  AND

- At least 75% of the entity’s current year premiums are written in its domiciliary state.

  OR

- The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

The intent of the Ad Hoc Group was to evaluate if changes were warranted to the health test because of industry changes since its original development. The Ad Hoc Group has drafted a phase 1 proposal that will delete the requirements for an entity being licensed and actively issuing and/or renewing business in five states or less and at least 75% of the entity’s current year premiums being written in their domicile state. The Ad Hoc Group is continuing to evaluate the current 95% premium and reserve ratios.

Through the evaluation and discussion of the 95% reserve ratio, there was a question brought up as to whether an entity would still be required to perform asset adequacy testing of long-term care (LTC)
business if the entity moved from the life blank to the health blank. It is the Ad Hoc Group’s understanding that asset adequacy testing is required, regardless of the blank if the criteria for asset adequacy testing are met. The Working Group is asking the Health Actuarial (B) Task Force to consider adding a sentence to Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) that would indicate that regardless of the blank the entity files, asset adequacy testing is required by the entity if the criteria are met.

This clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.

If you have any questions regarding the suggested clarification, please contact Crystal Brown (cbrown@naic.org).

cc: Eric King, Crystal Brown
REGULATORY FRAMEWORK (B) TASK FORCE

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The Regulatory Framework (B) Task Force met March 23, 2022. The following Task Force members participated: Vicki Schmidt, Chair (KS); Sharon P. Clark, Vice Chair (KY); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Anthony L. Williams, William Rodgers, and Yada Horace (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney and Wendy Hill (CA); Michael Conway represented by Kate Harris and Debra Judy (CO); Andrew N. Mais represented by Jared Kosky and Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk and James Dunn III (FL); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Amy L. Beard represented by Alex Peck and Cory Best (IN); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Renee Campbell, Chad Arnold, and Karen Dennis (MI); Grace Arnold represented by Galen Benshoof and Sherri Mortensen-Brown (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby and Robert Croom (NC); Jon Godfread represented by Chrystal Bartsuka (ND); Eric Dunning and Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton and Jason Dexter (NH); Marlene Caride represented by Chanell McDevitt (NJ); Russell Toal (NM); Judith L. French represented by Laura Miller and Marjorie Ellis (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by Jesse O’Brien (OR); Michael Humphreys (PA); Patrick Tigue represented by Patrick Smock (RI); Larry D. Deiter represented by Jill Kruger and Candy Holbrook (SD); Carter Lawrence represented by Scott McAnally (TN); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Shelley Wiseman and Heidi Clausen (UT); Scott A. White represented by Julie Blauvelt, Bob Grissom, Bradley Marsh, and James Young (VA); Mike Kreidler represented by Molly Nollette and Jane Beyer (WA); Nathan Houdek (WI); and Allan L. McVey (WV). Also, participating was: Erica Weyhenmeyer (IL).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner Clark made a motion, seconded by Ms. Kruger, to adopt the Task Force’s Nov. 30, 2021, minutes (see NAIC Proceedings – Fall 2021, Regulatory Framework (B) Task Force). The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

   a. **Accident and Sickness Insurance Minimum Standards (B) Subgroup**

Ms. Arp said the Subgroup met March 21, March 7, Feb. 14, 2022, and Dec. 6, 2021. She said that during these meetings, the Subgroup continued its discussion of revisions to Sections 1–7 of the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) based on the comments received by the July 2, 2021, public comment deadline. The Subgroup also discussed its approach for reviewing and considering revisions to Model #171, including whether to begin its review of potential revisions for supplemental products first and then consider potential revisions for short-term, limited-duration (STLD) plans.

Ms. Arp said the Subgroup devoted most of its discussion during its March meetings on how to address indemnity products in Model #171 given the different plan designs for this product, differing state approaches to regulating this product, and complex federal law and regulations related to this product. She said the Subgroup requested comments, including redline language, to revise Section 7B—Hospital Indemnity or Other Fixed Indemnity Coverage to address the issues raised during the Subgroup’s discussions. She said any comments received will be discussed during the Subgroup’s April 18 meeting.
Ms. Arp said that in an effort to educate stakeholders on the types of products to be regulated under Model #171, the Subgroup has also had extensive discussions on these types of products, their purpose, how they are marketed, and how they are sold. She said she anticipates a significant amount of the Subgroup’s work will be focused on adding provisions to Model #171 regulating STLD plans. She said this work will be extensive because of the product’s characteristics and the lack of existing language in Model #171 regulating it.

Ms. Arp said the Subgroup’s goal is to finish its work revising Model #171 by the end of the year and forward the revised model to the Task Force for its consideration.

b. **ERISA (B) Working Group**

Mr. Wake said the Employee Retirement Income Security Act (ERISA) (B) Working Group met March 22. During this meeting, the Working Group exposed a revised draft case summary of *Rutledge v. Pharmaceutical Care Management Association (PCMA)* for inclusion in the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) for a 30-day public comment period ending April 21. The Working Group also discussed potential updates and issues to consider for inclusion in the ERISA Handbook. Mr. Wake said the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), paragraph 8 (consideration of strategic planning issues), and paragraph 9 (any other subject required to be kept confidential) of the NAIC Policy Statement on Open Meetings.

Superintendent Toal asked if the Working Group will be able to come to some consensus related to the regulation of pharmacy benefit managers (PBMs) and ERISA preemption because New Mexico and most likely other states are looking for some direction with respect to their regulatory authority. Mr. Wake said he believes that some of these issues are within the purview of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. He said he believes the Working Group will be able to state what is the law at this point. He noted that many of the issues related to ERISA preemption are still being litigated with the federal circuit courts taking different approaches. He said that when a case does not involve insurance, the Working Group does not have a “right” or “wrong” view. Mr. Wake said that the recent wave of state laws regulating PBMs do not really involve insurance regulation, but the states have deliberately decided for public policy reasons that such regulation is important and to the extent federal law allows it, they want to regulate PBMs and the field of pharmacy benefits even if such regulation falls outside of the insurance regulatory sphere.

c. **MHPAEA (B) Working Group**

Ms. Weyhenmeyer said most of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group meetings to date have been in regulator-to-regulator session to provide the opportunity for Working Group members and interested state insurance regulators to discuss MHPAEA enforcement and compliance issues, including its last meeting on March 1. She said that during its March 1 meeting, the Working Group discussed potential changes to the mental health parity chapter of the *Market Regulation Handbook*. She explained that the Working Group will review the chapter and forward any suggested revisions to the Market Conduct Examination Guidelines (D) Working Group for its consideration. She explained that stakeholders will have the opportunity to comment on any suggested changes to the mental health parity chapter during the Market Conduct Examination Guidelines (D) Working Group’s discussions of the revisions.

Ms. Weyhenmeyer said that during its March 1 meeting, the Working Group also discussed potential agenda items for its April 5 meeting at the Spring National Meeting. She said the Working Group plans to hold an open session during which it plans to hear: 1) a presentation from Illinois and Washington on a designation in behavioral health parity analysis under development by the Insurance Regulatory Examiners Society (IRES); 2) a presentation from
d. Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Ms. Arp said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup met March 16. During this meeting, the Subgroup adopted its 2021 Fall National Meeting minutes. The Subgroup also heard a presentation from the Montana Department of Insurance (DOI) on its PBM law and implementation. NAIC staff provided an update on their work to compile state PBM laws and regulations regulating PBM business practices.

Ms. Arp said that during its April 4 meeting at the Spring National Meeting, the Subgroup plans to hear an update from the Oklahoma DOI on its PBM law and implementation, as well as suggestions on best practices and lessons learned. The Subgroup also will hear from Oregon on PBM regulation and beyond, including its efforts related to prescription drug transparency and affordability. She said the Subgroup welcomes additional presentations from the states on an ongoing basis on what they are doing with respect to PBM regulation consistent with the Subgroup’s 2022 charge. She said the Subgroup also will hear from the NAIC consumer representatives. They will provide a consumer perspective on the Subgroup’s 2022 charge to develop a white paper on PBM business practices, including a discussion on the impact the Rutledge decision has, if any, on state regulation PBM business practices.

Ms. Arp said that with respect to the Subgroup’s future meetings, the Subgroup conducted a survey of its members early this year to gain information on which speakers would be most helpful for the Subgroup to hear from in terms of background presentations on PBM regulation. She also noted that the Subgroup’s 2022 charge is broader than PBM regulation. As a result, the Subgroup will need to broaden its discussion to get a better understanding of the entire prescription drug supply chain. She said one of the Subgroup’s first speakers will be Dr. Neeraj Sood from the University of Southern California (USC), who will present in April on his latest work on prescription drug pricing and supply chain economics. The Subgroup plans to receive background presentations throughout the period before the Summer National Meeting.

Ms. Arp said the Subgroup hopes to begin writing the white paper after it completes its background presentations. She said the Subgroup will establish small ad hoc groups to work on specific issues and/or components of the paper with a goal of completing its work by the Fall National Meeting. She said the Subgroup knows there is a lot of interest in PBM regulation, particularly state activities related to PBM regulation. The Subgroup is compiling information it receives from the states and posting it on the Subgroup’s web page. Ms. Arp explained that because an analysis of the Rutledge decision is part of its 2022 charge to develop a white paper, the Subgroup will rely on the expertise of the ERISA (B) Working Group and await its analysis of the decision to incorporate in the white paper.

Commissioner Clark suggested that the Subgroup provide notice of its upcoming meetings to all state insurance regulators. Ms. Arp agreed to work with NAIC staff to ensure that notice of the Subgroup meetings, including specific planned speakers and presentations, is provided.

Commissioner Schmidt requested that the states send information to the Subgroup and NAIC staff on their PBM laws, including those recently enacted during just concluded legislative sessions. She said the Subgroup is compiling these laws as a resource for the states, and it is important that it is as accurate and up to date as possible because stakeholders are looking at it.
Commissioner Clark made a motion, seconded by Ms. Nollette, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its March 21, 2022 (Attachment One), March 7, 2022 (Attachment Two), Feb. 14, 2022 (Attachment Three), and Dec. 6, 2021 (Attachment Four) minutes; the ERISA (B) Working Group, including its March 22 minutes (Attachment Five); the MHPAEA (B) Working Group; and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its March 16 minutes (Attachment Six). The motion passed unanimously.

3. Heard an Update on the CHIR’s Work

Maanasa Kona (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s recent and forthcoming work. She highlighted the work the CHIR has been doing related to the implementation of the federal No Surprises Act (NSA). Ms. Kona said that because the NSA does not include provisions related to surprise bills for ground ambulance services, the CHIR decided that it was important to understand what the states have done in this area. She said the CHIR compiled information on state protections for ground ambulance surprise bills to provide such a resource. She said the CHIR has a new interactive map on the roles of federal and state officials on various aspects of the NSA—issuer enforcement, provider enforcement, and the interaction between federal and state balance billing laws. She said the interactive map can be found on the Commonwealth Fund’s website. Ms. Kona said the CHIR expects to soon publish an issue brief based on interviews with 12 state DOIs on their approaches to NSA implementation.

Ms. Kona said the CHIR is continuing its work related to the COVID-19 public health emergency (PHE), including research on state preparations for the end of the PHE based on interviews with Medicaid and state-based marketplace (SBM) officials from 11 states. She said other work the CHIR is doing related to the COVID-19 PHE includes examining the lack of compliance with COVID-19 testing coverage mandates and studying the impact of COVID-19 on small business health insurance.

Ms. Kona said the CHIR is also continuing to examine issues with alternative types of noncompliant federal Affordable Care Act (ACA) coverage. One such issue is the misleading marketing of such plans during the COVID-19 Special Enrollment Period (SEP). She noted that data from Massachusetts on health care sharing ministries (HCSMs) revealed that their finances put consumers at risk. She said the CHIR recently released an issue brief on state “easy enrollment” programs, which found that such programs have gained momentum and potentially lay the groundwork for additional efforts to expand coverage. The CHIR plans CHIRblog posts on SBM outreach and advertising efforts during the most recent Open Enrollment Period (OEP). She said the CHIR is also planning a state spotlight on California’s CHIRblog post.

Ms. Kona said the CHIR has released other issue briefs of potential interest and reading, including issue briefs on 1) leveraging the new federal health care transparency rules to contain costs; and 2) network adequacy standards and oversight. She said upcoming issue briefs and CHIRblog posts include comparing network adequacy rules across marketplaces and Medicaid managed care organizations (MCOs), state efforts to improve federal MHPAEA compliance; and SBM efforts to improve health equity.

3. Heard a Discussion on the HSA, HDHP, and Prescription Drug Copayment Accumulator Issue

Carl Schmid (HIV + Hepatitis Policy Institute) and Jeffrey Klein and Roy Ramthun (American Bankers Association [ABA] Health Savings Account [HSA] Council) discussed the HSA, high-deductible health plan (HDHP), and prescription drug copayment accumulator issue.

The discussion highlighted the importance of prescription copayment assistance to consumers and its role in helping to reduce out-of-pocket costs. The speakers discussed: 1) the percentage of plans in states with copayment accumulator policies and states with laws banning copayment accumulators; 2) potential conflicts of
state copayment accumulator ban laws with federal requirements related to HSA-qualified HDHP and continued eligibility to contribute to an HSA in light of such a law; and 3) potential solutions and options to address this issue, including a suggestion that the Task Force consider developing a model bulletin that state DOIs can use to educate consumers on the issue. The speakers also suggested model language for those states that may be contemplating enacting legislation banning copayment accumulator use as a carve-out for HSA-qualified HDHP plans to address any potential conflict with federal HSA-qualified HDHP requirements.

Kris Hathaway (America’s Health Insurance Plans—AHIP) said AHIP submitted a comment letter to the Task Force on two issues it believes affects many health care consumers and purchasers: 1) copayment coupons, which AHIP believes increase costs for consumers for drug manufacturers’ own financial gain; and 2) HSA-qualified HDHP eligibility to contribute to an HSA in light of state laws banning copayment accumulators. She acknowledged the Task Force’s current discussion of the second issue during this meeting. She said AHIP urges the Task Force to consider taking additional action following this meeting to address this issue, including: 1) raising this issue with the federal agencies charged with implementing the HSA Internal Revenue Service (IRS) law and requesting updated clarifying guidance; 2) educating state legislators about the potential impacts banning coupon accumulators may have on HSA coverage and encourage an exemption or safe harbor language within any proposed legislation that has been initiated in their states; and 3) in states that have passed laws, supporting new legislation to exempt HSAs from these laws.

With respect to the issue of copayment coupons, Ms. Hathaway said AHIP recommends that the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup include the issue of coupons as part of its white paper because it is an issue of critical importance to premiums for a state’s entire population. The paper should include information that enlists a better understanding of the market and the impact of copayment coupons, as well as offer specific guardrails that protect consumers equally.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 21, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Cynthia Amann (MO); Glynda Daniels (SC); Rachel Bowden (TX); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet, Mary Block, and Christine Menard-O’Neil (VT); and Ned Gaines (WA).

1. Discussed Revisions to Model #171

The Subgroup continued its discussion of revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). The Subgroup focused its discussion on indemnity products and how best to address regulating such products in the Model #171 revisions given the different product designs, variation in state insurance regulation of the product and federal law and regulations related to the product, and the concept of “excepted benefits.”

Ms. Arp asked for comments on whether a product should be considered an indemnity product when there is a reference price list for procedures the plan would pay for provided outside and not as a part of the contract or policy. Ms. Daniels said South Carolina has a company selling a product designed like this and that South Carolina considers that product to be an indemnity product. She said South Carolina has issued a bulletin that specifies what types of products sold in South Carolina will be considered indemnity products. Ms. Daniels described the provisions in the bulletin. She explained that the key language in the bulletin that South Carolina relies on in determining whether a product is an indemnity product is in Section II, item 2—“The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage.” She said for the product Ms. Arp is referring to, using the language in this bulletin and because it proposes to pay a fixed amount and would pay that amount directly to the consumer, South Carolina determined that it is a fixed indemnity product. Ms. Arp asked what is meant by the language “regardless of the amount of the expenses incurred.” She said when a plan has a price list, which may be calculated using a percentage of what Medicare would pay for a procedure, it uses that as a basis to pay for a procedure, and that is the cost of the expense the consumer incurred. Ms. Daniels said that South Carolina decided that even if the price is determined by a percentage of Medicare, that is still a fixed amount and given that, it determined that it is a fixed indemnity plan.

Ms. Bowden said she understands the different interpretations of what is considered a fixed indemnity product. She said Texas does not have the language “regardless of the amount of the expenses incurred” in its fixed indemnity plan definition regulations. She said Texas approved the sale of the plan in Texas as an “other fixed indemnity” product because it did not seem to “fit” any other category. She said she hopes that the revisions to Model #171 will help states like Texas clarify what is and is not a type of fixed indemnity product. The Model #171 revisions need to provide language that substantively distinguishes the excepted benefit plans from major medical coverage. Ms. Bowden said she personally believes it is problematic to allow what she would consider a type of fixed indemnity product using a reference-based pricing list, which could be seen as essentially offering major medical coverage without being subject to any of the same standards and consumer protections as federal Affordable Care Act (ACA)-compliant major medical coverage.
Ms. Bowden said she would like the Model #171 revisions to address this in some manner and provide more guidance around the “regardless of the amount of the expenses occurred” language.

The Subgroup discussed whether it would be beneficial to add language to Model #171 clarifying this issue. J.P. Wieske (Health Benefits Institute—HBI) said that if the Subgroup wants to add clarifying language, it can probably be done. He cautioned, however, that not all states have taken the same approach to fixed indemnity coverage, including in determining what is and is not fixed indemnity coverage. Given this, the Subgroup might have to add a drafting note explaining this and alerting states that they may want to use other language that is consistent with their regulations for this type of coverage.

The Subgroup also discussed the need for the model revisions to require disclosures and marketing for these products to include clear information on their purpose, how they are intended to be used, the benefits they offer, and what they do and not do with respect to coverage.

Chris Petersen (Arbor Strategies LLC) pointed out that this is a minimum standards model and highlighted the differences in how states regulate them. He suggested that the Subgroup consider language highlighting this in a drafting note. He also urged the Subgroup not to align language in the model with federal regulations because they could change and have changed from presidential administration to presidential administration. Ms. Arp said that she believes there is a need for the Subgroup to clarify these issues with indemnity products because based on discussions she has participated in, the states are looking for clarity.

Lucy Culp (Leukemia & Lymphoma Society—LLS) expressed support for the Subgroup revising the disclosures for fixed indemnity products for more clarity in the language about what benefits they offer and add requirements on where the disclosure language should be placed in the policy, such as the first page or cover page. Ms. Arp agreed that it is important that the Subgroup revise Model #171 to require meaningful disclosures, which ultimately make it easier for state insurance regulators to determine compliance. Ms. Bowden said she does not believe this discussion about indemnity products is a minimum standards issue. She believes it is a definitional and possibly scope issue. “What does fixed indemnity mean?” “What is the scope of this model?” There are many valid interpretations of what this term means and the model’s scope.

Ms. Arp said that based on the discussion during this meeting, there appears to be some desire to provide clarity around fixed indemnity coverage. She asked Subgroup members, interested state insurance regulators, and interested parties to submit language for the Subgroup’s consideration during its April 18 meeting defining “fixed indemnity.” Specifically, she asked for redline language for provision “B. Hospital Indemnity or Other Fixed Indemnity Coverage” and its drafting note on pages 12–13 of the Model #171 working draft that would provide clarity on fixed indemnity coverage—what it is and what it is not.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 7, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair, represented by Cuc Nguyen, Landon Hubbart, and Rebecca Ross (OK); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Shari Miles (SC); Rachel Bowden (TX); Shelley Wiseman and Heidi Clausen (UT); and Ned Gaines (WA).

1. Discussed Revisions to Model #171

Jolie H. Matthews (NAIC) reviewed a revised draft of proposed revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) based on the Subgroup’s discussions to date. She highlighted some of the more substantive anticipated revisions, including: 1) adding a new section, Section 5—Definitions, to include terms used in the model; 2) adding language to Section 4—Applicability to address how revisions to the model will affect policies and contracts in effect prior to the date the revised model is adopted by the state; and 3) revisions to Section 6—Policy Definitions, formally Section 5, to address an insurer’s ability to alter the policy definitions, but only in a manner that does not restrict coverage. She also pointed out that many of the anticipated revisions reflect changes intended to make Model #171 consistent with its companion model, the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act). She explained that as part of its review, the Subgroup will have to review those suggested revisions for accuracy.

Ms. Bowden suggested that the Subgroup consider adding a definition of “excepted benefits” consistent with the federal definition for that term to the proposed new definitions section. She said having such a definition could possibly allow the use of it to distinguish it from short-term, limited-duration (STLD) plans. She said having this term could also assist in establishing the structure of Model #171 as not applying to major medical coverage. Chris Petersen (Arbor Strategies LLC) said currently, the term “excepted benefits” is not used in Model #171. Ms. Bowden agreed. She said her suggestion contemplates the Subgroup actively looking to use the term to address the issues she highlighted as it moves forward with its review of Model #171 and to help state departments of insurance (DOIs) align with federal regulations with respect to what products are considered excepted benefits. Mr. Petersen suggested that when the Subgroup reviews the product standards for the products regulated under Model #171, it considers whether the standards are consistent with the federal definition of “excepted benefits” instead of defining the term. The Subgroup discussed Ms. Bowden’s suggestion and the concept of “excepted benefits.” The Subgroup also discussed different plan designs submitted to the states for form filing approval that seem to blur what may be considered under federal law and regulations as an excepted benefit or a limited benefit type of coverage, particularly with respect to certain types of indemnity products and reference-based pricing.

Ms. Bowden reiterated that she would like the model revisions to be clear that if a product does not satisfy the excepted benefits structure, it is not an excepted benefit product. She said Model #171 needs to be clear on this, particularly given the emergence of innovative products that seem to blur the lines between major medical products and supplemental products. The Subgroup discussed adding a definition of “excepted benefits” as a placeholder until it completes its review of the product standard provisions. The Subgroup also discussed adding language in Section 7—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits, specifically Section 7B—Hospital Indemnity or Other Fixed Indemnity Coverage, to address this issue. The
Subgroup also discussed the different treatment of individual products and group products in the federal rules and Model #171.

Ms. Arp said the issue of excepted benefits she has encountered most frequently concerns indemnity products. She asked for comments from stakeholders on a product structured as an indemnity product that looks like a charge master or fee schedule. Cindy Goff (American Council of Life Insurers—ACLI) noted that this type of product has been an issue since before the federal Affordable Care Act’s (ACA’s) enactment because of the desire by some companies to sell so-called “mini-meds,” which are no longer allowed to be sold. She urged the Subgroup to be cautious about including overly prescriptive language, such as limiting the number of benefits and other potentially restrictive product designs, in Model #171 given that it is a minimum standards model.

Ms. Arp asked the Subgroup to consider as it moves forward with its work whether: 1) the revisions should include language clarifying the scope of indemnity products and what reference pricing means in relation to these products; or 3) the Subgroup should not include such language to avoid potential unintended consequences of including such language because the issues with indemnity products are old long-standing issues, and as such, it would be better to leave Model #171 as is.

Ms. Bowden said the Subgroup should align the language in Model #171 on fixed indemnity plans with the federal regulations. She said whether the Subgroup should add clarifying language and how it should be added, such as in a drafting note or another approach, would be something the Subgroup could think about and decide later.

The Subgroup decided to continue its discussions on indemnity plans and other issues discussed during this meeting during its next meeting March 21. The Subgroup also plans to discuss as it moves forward with its work whether it wants to review the comments and consider revisions to Model #171 for supplemental products first and go back and consider revisions to Model #171 for STLD plans after completing that review.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Feb. 14, 2022. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Robert Wake (ME); Camille Anderson-Weddle, Amy Hoyt, and Cynthia Amann (MO); Rachel Bowden (TX); Heidi Clausen (UT); Anna Van Fleet, Mary Block, Christine Menard-O’Neil, and Jamie Gile (VT); and Ned Gaines (WA).

1. **Continued Discussion of Revisions to Model #171**

The Subgroup continued its discussion of revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)* based on the comments received, beginning with the policy definition of “preexisting condition” in Section 5L—Policy Definitions.

Ms. Arp acknowledged the Subgroup’s extensive discussion of this policy definition during its last meeting. She expressed a desire to find a middle ground on how to define “preexisting condition” for supplemental products and short-term, limited-duration (STLD) plans. The Subgroup discussed different approaches, including, for supplemental products, eliminating the so-called prudent layperson standard language in the definition and retaining the two-year look-back and developing a different policy definition of “preexisting condition” for STLD plans. After additional discussion, the Subgroup agreed, for supplemental products, to delete the prudent layperson standard language and consider developing another policy definition for “preexisting condition” for STLD plans.

The Subgroup discussed its approach for considering revisions to Model #171 after it completes its review and discussion of the comments received on Section 5—Policy Definitions. Ms. Arp asked for comments on whether the Subgroup moving forward should first discuss revisions to Model #171 in the context of supplemental products while keeping in mind whether and how the provisions would apply to STLD plans. The Subgroup discussed Ms. Arp’s suggestion. During the discussion, some stakeholders suggested that other types of products also would need to be considered separately, such as limited scope dental plans and disability income protection plans. The discussion also included how Model #171’s companion model, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)* (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), treats STLD plans differently from supplemental products. The Subgroup discussed different approaches. One approach discussed removing language from the policy definitions related to minimum standards and placing it in the substantive provisions for those products. Another approach discussed the possibility of developing different model regulations for the various products regulated under Model #170.

Ms. Arp reiterated her suggestion for the Subgroup to begin with the approach of focusing on supplemental products while keeping in mind the similarities or differences and application for other products, such as STLD plans. The Subgroup continued the discussion of possible approaches, including discussing whether the Subgroup needed to work on the STLD plan provisions first because there is already a regulatory framework for supplemental products. Some stakeholders agreed and suggested that as part of this work, the Subgroup look at whether a particular provision: 1) only applies to STLD plans; 2) only applies to supplemental products; or 3) applies to both types of products.
After additional discussion and to assist the Subgroup on deciding its approach in moving forward with its review, NAIC staff agreed to develop a working draft of Model #171 reflecting the Subgroup’s discussions to date. The Subgroup plans to discuss the working draft and continue its discussions on the approach to take for its discussions of revisions to Model #171 during its next meeting March 7.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Dec. 6, 2021. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Camille Anderson-Weddle, Amy Hoyt, and Carrie Couch (MO); Gayle Woods (OR); Shari Miles (SC); Rachel Bowden (TX); Shelley Wiseman and Heidi Clausen (UT); Anna Van Fleet, Emily Brown, Mary Block, Christine Menard-O’Neil, and Jamie Gile (VT); Ned Gaines (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Continued Discussion of Revisions to Model #171

The Subgroup continued its discussion of revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) based on the comments received, beginning with the definition of “partial disability” in Section 5J. Jolie H. Matthews (NAIC) said after the Subgroup previously discussed the comments received on this definition, particularly the NAIC consumer representatives’ comments, the NAIC consumer representatives withdrew their comments, leaving the provision unchanged. The Subgroup confirmed the decision to leave Section 5J unchanged.

The Subgroup next discussed the definition of “physician” in Section 5K. Ms. Matthews explained that the Subgroup’s previous discussion of this provision concerned the perceived lack of clarity of some of the language in the definition and whether the Subgroup should try to clarify it. Mr. Schallhorn asked the Subgroup if anyone had any suggestions for clarifying the language. J.P. Wieske (Health Benefits Institute—HBI) said the intent of the language in Section 5K(2) is to address potential fraud by restricting certain individuals who may have a personal relationship with the insured from being considered a “physician” for the purposes of this model. In response to the Washington Department of Insurance’s (DOI’s) question about the meaning of the terms “qualified physician” and “licensed physician” in Section 5K(1), Mr. Wieske also said he believes this language is intended to restrict an insurer from raising an issue about certain providers, for the purposes of making a claim for any provider of medical care and treatment, if the services provided are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws. After additional discussion, the Subgroup decided to leave the language unchanged.

The Subgroup next discussed the definition of “preexisting condition” in Section 5L. Ms. Matthews explained that the Subgroup’s previous discussions ended with this definition. She also noted that the Subgroup received additional comments on this definition as part of its request for comments on Sections 1–7 ending July 2. Mr. Schallhorn said America’s Health Insurance Plans (AHIP) suggests separate definitions of “preexisting condition” for supplementary products and short-term, limited-duration (STLD) plans. He asked for comments.

Mr. Wake said he believes there should be one definition of “preexisting condition” but different look-back periods for these two types of coverages. The Subgroup discussed his comments, including the implications of changing the definition on existing policies and contracts. Lucy Culp (Leukemia & Lymphoma Society—LLS) asked about the typical length of a look-back period, such as six months or 12 months. Mr. Wieske said for some types of products, it would probably be about a two-year look-back period. He explained that these types of products typically have limited medical underwriting. As such, the purpose of the look-back period is to protect against an individual purchasing, for example, a cancer-only policy when they knew they had cancer prior to the policy purchase.
The Subgroup discussed potential differences in the typical look-back period for supplementary products and STLD plans. Some interested parties favored a two-year look-back period for both types of coverages as a minimum standard. Other interested parties expressed support, generally, for shorter look-periods for all coverage types. Ms. Culp said the NAIC consumer representatives suggest a six-month look-back period. Chris Petersen (Arbor Strategies LLC) said based on the provisions in the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act), the companion model for Model #171, revising the definition of “preexisting condition” to provide for a six-month look-back period would not be possible. He said AHIP could support a two-year look-back period for supplementary products. For STLD plans, he said AHIP would be open to discussing a shorter look-back period because it is a different type of coverage; although, AHIP does not believe a shorter look-back period is needed. Cindy Goff (American Council of Life Insurers—ACLI) said the ACLI supports a two-year look-back period for supplementary products, but the ACLI has no position on STLD plans because none of its members sell such coverage.

The Subgroup continued its discussions regarding the look-back periods and the provision in Section 7A and Section 7B of Model #170 related to this issue. The Subgroup also discussed whether it should separate the look-back period provision from the policy definition of “preexisting condition” because it affects whether a condition is in fact a “pre-existing condition.” The Subgroup also discussed whether the preexisting condition policy definition should retain the prudent layperson standard. Some interested parties expressed concern with removing the prudent layperson standard if the look-back period is shortened to six months and the potential for abuse because of such a revision. The Subgroup discussed the Missouri DOI’s suggested revision that would remove the prudent layperson standard. The Subgroup did not reach any decisions on the issue and agreed to continue the discussion during its next meeting in early 2022.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met March 22, 2022. The following Working Group members participated: Robert Wake, Chair (ME); Yada Horace (AL); Jason Lapham (CO); Andria Seip (IA); Julie Holmes (MO); Paul Hanson (MN); Carrie Couch (MO); Laura Arp (NE); Jeremy Christensen (NV); Tracy Biehn (NC); David Barney (OH); Candy Holbrook (SD); Tanji J. Northrup (UT); Charles Malone (WA); and Richard Wicka (WI). Also participating were: Paige Duhamel (NM) and Jon Thayer (NY).

1. **Exposed a Revised Draft Case Summary of the Rutledge v. Pharmaceutical Care Management Association (PCMA) Decision for Inclusion in the ERISA Handbook**

Mr. Wake said the first item on the agenda is to discuss exposing for comment the revised case summary in the case of Rutledge v. Pharmaceutical Care Management Association (PCMA). He explained that this summary has been exposed in other contexts, but he said the Working Group needs a meaningful comment period to give the opportunity to suggest edits before it officially adopts it for inclusion in the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook).

Ms. Arp said that, in her opinion, the case summary is ready for public comment. There were no objections made.

The Working Group agreed to expose the revised draft case summary (Attachment Five-A) for a 30-day public comment period ending April 21.

2. **Discussed Additional Updates to the ERISA Handbook**

Mr. Wake explained that the ERISA Handbook was revised to reflect the 2018 U.S. Department of Labor (DOL) association health plan rule. However, in March 2019, significant provisions of the rule were invalidated in federal court and remanded back to DOL. The current administration is not interested in revisiting the AHP rule, and it remains to be seen whether future administrations might seek to revisit it. The question is whether the Handbook should be revised to reflect this reversal and what it should say instead.

J.P. Wieske (Horizon Government Affairs) cautioned against complete removal of the revisions and suggested that some pieces of it should be archived. He said that although the rule is obsolete, it is still the subject of some public policy debate, and there is likely value to having some of the pieces in the ERISA Handbook available for reference.

Carl Schmid (HIV+Hepatitis Policy Institute) said he is looking forward to commenting on the Rutledge summary. He said that it is important to review the entire ERISA Handbook and not just insert this case summary. He said there may be other sections where clarifying changes are needed, and the NAIC funded consumer representatives may have some additional changes to propose in other sections.

Ms. Duhamel said she is interested in updates regarding ERISA preemption of state requests for information post-Gobeille v. Liberty Mutual Ins. Co. She said she is aware of at least one case that allowed for a state to obtain information from an ERISA plan that is de minimus. Mr. Wake said this was definitely a topic of interest for the Working Group, even if it is not quite ripe for inclusion in the Handbook.

Mr. Wake asked whether there was any interest in adding to the ERISA Handbook information about regulatory oversight of fully insured as well as self-funded multiple employer welfare arrangements (MEWAs). Ms. Seip said
that Iowa has a regulation on this topic that she is happy to share with the Working Group if they choose to look at adding something to the ERISA Handbook.

Mr. Thayer said New York is seeing a recent proliferation of professional employer organizations (PEOs) treated like large groups under state law but covering mostly small employers. Mr. Thayer said this is a significant issue in New York and that the number of people who have their health care through PEOs is almost as large as the small group market. He said his main concern is the applicability of the look-through rules of the federal Affordable Care Act (ACA) to PEO coverage.

Mr. Wake referenced the 2010 case of Payroll Solutions Group Ltd. v. Nevada, where a federal trial court held that a state law cannot decide what is an ERISA plan for purposes of federal law, but states can decide treatment under state law. Mr. Wake acknowledged that analysis is complicated when both what the state law permits and the ACA permits have to be considered, and sometimes states prohibit what the ACA permits, but they cannot permit what the ACA prohibits. Ms. Duhamel said that New Mexico is also seeing increased discussions about PEOs and asked whether other states are as well. Mr. Wake said he is not aware of discussions in Maine.

Having no further business, the ERISA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 1 (potential or pending litigation or administrative proceedings), paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), paragraph 8 (consideration of strategic planning issues), and paragraph 9 (any other subject required to be kept confidential) of the NAIC Policy Statement on Open Meetings.
In *Rutledge v. PCMA*, the Court upheld an Arkansas law, Act 900, which required pharmacy benefits managers ("PBMs")\(^1\) to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. Act 900 required PBMs to provide administrative appeal procedures for pharmacies to challenge reimbursement prices that are below the pharmacies’ acquisition costs, and it also authorized pharmacies to decline to dispense drugs when a PBM would provide a below-cost reimbursement. Act 900 applied to all transactions between PBMs and pharmacies, including transactions where the PBM was acting on behalf of a self-insured ERISA plan. Thus, the saving clause was not at issue in this case.

In a suit brought by Pharmaceutical Care Management Association ("PCMA"), a national trade association representing 11 PBMs, the Eastern District of Arkansas had ruled that Act 900 was preempted by ERISA, and the Eighth Circuit affirmed.\(^2\) Both courts relied on a recent Eighth Circuit decision striking down a similar Iowa law because it “made ‘implicit reference’ to ERISA by regulating PBMs that administer benefits for ERISA plans”\(^3\) and “was impermissibly ‘connected with’ an ERISA plan because, by requiring an appeal process for pharmacies to challenge PBM reimbursement rates and restricting the sources from which PBMs could determine pricing, the law limited the plan administrator’s ability to control the calculation of drug benefits.”\(^4\)

The Supreme Court, however, held that because Act 900 “regulates PBMs whether or not the plans they service fall within ERISA’s coverage,” it is analogous to the law upheld by the Court in *Travelers*, “which did not refer to ERISA plans because it imposed surcharges ‘regardless of whether the commercial coverage [was] ultimately secured by an ERISA plan, private purchase, or otherwise.’”\(^5\) The Court held that under *Travelers*, “State rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage are not preempted by ERISA.”\(^6\)

The Court rejected PCMA’s contention “that Act 900 has an impermissible connection with an ERISA plan because its enforcement mechanisms both directly affect central matters of plan administration and interfere with nationally uniform plan administration.”\(^7\) The Court acknowledged that Act 900 required ERISA plan administrators to “comply with a particular process” and standards,\(^8\) but explained that those enforcement mechanisms “do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” for PBMs.\(^9\) The Court emphasized that State law

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\(^1\) As the term is spelled in Act 900. Supreme Court style refers to “pharmacy benefit managers.”

\(^2\) *PCMA v. Rutledge*, 891 F.3d 1109 (8th Cir. 2018).

\(^3\) 141 S.Ct. at 479, quoting *PCMA v. Gerhart*, 852 F.3d 722, 729 (8th Cir. 2017).

\(^4\) Id. at 479, quoting *Gerhart*, 852 F.3d at 726, 731.

\(^5\) Id. at 481, quoting *Travelers*, 514 U.S. at 656.

\(^6\) Id. at 480, citing *Travelers*, 514 U.S. at 668.

\(^7\) Id. at 481–482.

\(^8\) Id. at 482, quoting PCMA brief at 24.

\(^9\) Id.
governs disputes between plans and providers. The Court held further that ERISA did not preempt Act 900’s decline-to-dispense provision, even though it “effectively denies plan beneficiaries their benefits” because any denial of benefits would be the consequence of the lawful state regulation of reimbursement rates and the PBM’s refusal to comply.

Finally, the Court rejected PCMA’s claim that the law had an impermissible “reference to” ERISA. As the Court explained, Act 900 “applies to PBMs whether or not they manage an ERISA plan,” and Act 900 did not treat ERISA plans differently than non-ERISA plans.

However, Rutledge does not represent an open-ended approval of state pharmacy benefit regulation in general. The Court only considered the provisions of the Arkansas PBM law as they stood at the time PCMA filed its preemption challenge. While Rutledge was making its way through the appellate courts, Arkansas amended its PBM law to add new requirements and prohibitions, so it is important that Rutledge not be read as a finding that the Court analyzed Arkansas’ PBM law as it existed in 2020. Additionally, the Court did not address issues that have been raised by other State PBM-pharmacy laws, including laws regulating networks, prohibitions and limitations on corporate practice of medicine, and laws regulating what pharmacies may discuss with their patients. The Rutledge decision has opened the door to additional ERISA challenges, which, at the time of this writing are making their way through the courts.

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10 Id.
11 Id.
12 Id. at 481.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met March 16, 2022. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp, Vice Chair, and Eric Dunning (NE); Sarah Bailey (AK); Anthony L. Williams (AL); Beth Barrington (AR); Jessica Ryan (CA); Paul Lombardo and Kathy Belfi (CT); Howard Liebers (DC); Andria Seip (IA); Vicki Schmidt (KS); Daniel McIlwain (KY); Jeff Zewe (LA); Chad Arnold and Joe Stoddard (MI); Cynthia Amann and Amy Hoyt (MO); Sherri Mortensen-Brown and Norman Barrett Wiik (MN); David Dachs (MT); Ted Hamby and Robert Croom (NC); Ralph Boeckman and Erin Porter (NJ); Paige Duhamel (NM); Ana Paulina Gomez (PA); Katrina Rodon (SC); Brian Hoffmeister and Scott McAnally (TN); Tanji J. Northrup (UT); Don Beatty and Stephen Hogge (VA); Jennifer Kreitler and Ned Gaines (WA); Nathan Houdek and Jennifer Stegall (WI); Michael Malone and Ellen Potter (WV); and Jeff Rude and Bryce Hamilton (WY). Also participating was: Robert Wake (ME).

1. Adopted its 2021 Fall National Meeting Minutes

Mr. Lombardo made a motion, seconded by Mr. Beatty, to adopt the Subgroup’s Dec. 11, 2021, minutes (Attachment Six-A). The motion passed unanimously.

2. Heard an Update from Montana on its PBM Law

Mr. Keen said the Subgroup’s next agenda item is to hear from Montana about its pharmacy benefit manager (PBM) law and other related activities. He explained that the agenda has Oklahoma also providing an update, but due to unforeseen circumstances, Oklahoma will provide that update during the Subgroup’s meeting at the Spring National Meeting.

Mr. Dachs discussed Montana’s PBM law and related activities over the past few years beginning with the U.S. Senate (Senate) Bill 71, which the Montana Legislature passed with bipartisan support in 2019, but it was vetoed by the governor. He explained that one central provision in Senate Bill 71 was to set up a mechanism to lower the cost of health insurance for consumers. The provision required that all compensation remitted by or on behalf of a manufacturer, labeler, repacker, or wholesale distributor that is directly or indirectly related to a health benefit plan be remitted to and retained by the health benefit plan and used to lower health benefit plan premiums for covered persons. Mr. Dachs explained that this provision was really aimed at spread pricing and trying to ensure consumers received a share of those remitted monies to lower their health insurance premiums. He said Senate Bill 71 reflected Montana’s approach to PBM regulation, which is different than what other states were doing at the time by focusing on the financial aspects of the prescription drug supply chain and looking at areas where it may be able to lower costs.

Mr. Dachs said after its experience with Senate Bill 71 and a change in leadership at the Montana Department of Insurance (DOI), it has taken a more measured approach. He said like many other states, Montana decided to clarify its regulatory authority over PBMs and require that PBMs be licensed in the state. He said Montana also decided to focus on price transparency. In 2021, the Montana Legislature passed the Montana Pharmacy Benefit Manager Oversight Act, which became effective Jan. 1. Mr. Dachs said the bill establishes a PBM licensing requirement and includes other provisions, including some reporting requirements and prohibited practices. He said Montana believes this legislation is something it can build on as it moves forward. He discussed developing
regulations related to the licensing requirements, including network adequacy requirements. He said he anticipates Montana will end up licensing about 20 PBMs.

Mr. Dachs said based on its work related to Senate Bill 71, Montana found that due to contractual requirements, it was difficult for pharmacists to share information with the Montana DOI on what was in their contracts to facilitate investigating complaints. To address this—i.e., the recently enacted statute—the prohibited practices provision includes language allowing pharmacists to share information with the Montana DOI when it is investigating issues related to PBM business practices. Mr. Dachs outlined the Montana DOI’s steps for moving forward with promulgating regulations to implement the recently enacted law.

Mr. Keen asked Mr. Dachs if the Montana law includes any exemptions from the PBM licensing requirements or the reporting of data. Mr. Dachs said he does not believe there are any specific exemptions. He explained how the law is structured and how terms are defined. He said given this structure, some types of entities are automatically carved out. Ms. Seip asked about Montana’s PBM network adequacy requirements and how the Montana DOI determines the accuracy of a PBM’s compliance. Mr. Dachs said the Montana DOI has a template of community pharmacies that it uses. He explained that in some areas in Montana, there may not be pharmacies. In those situations, the Montana DOI will use a health carrier’s GeoAccess plan in addition to looking at where the plan enrollees are located, and the community pharmacies are located to access network adequacy. Mr. Dachs explained that to not stifle innovation, particularly innovation that could lower costs for consumers, the Montana DOI regulations allow for flexibility if a health benefit plan wants to have a narrow network, but the hope is that health benefit plans include at least 80% of the community pharmacies.

3. Heard an Update from the ERISA (B) Working Group

Mr. Wake provided an update on the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group related to its revisions to the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook) to include a case summary on the U.S. Supreme Court’s decision in Rutledge vs. the Pharmaceutical Care Management Association (PCMA). He said the Working Group plans to meet March 22 to discuss an initial draft of the case summary. He anticipates that after that review and discussion, the Working Group will expose the draft for a public comment period.

Mr. Wake said as part of its work in 2022, the Working Group will provide its expertise to the Subgroup, as the Subgroup considers necessary, related to the Rutledge decision in relation to the Subgroup’s 2022 charge to develop a white paper discussing state laws regulating PBM business practices, including the implications of the Rutledge decision on such business practices and any challenges, if any, the states have encountered in implementing such laws and/or regulations.

Mr. Keen said the Subgroup welcomes the Working Group’s assistance and expertise as it moves forward with the white paper, including an analysis of the Rutledge decision, including its progeny and impact, if any, on the state regulation of PBM business practices. He said this collaboration is important to ensure consistency in any conclusions related to the Rutledge decision across NAIC groups.

4. Heard an Update on State PBM Law Compilation

Jolie H. Matthews (NAIC) said along with the Subgroup’s meeting agenda for today, she distributed two charts: 1) a compilation of state PBM licensing and registration laws; and 2) a compilation of state PBM business practice laws. She said these state PBM law compilations relate to and are meant to support the Subgroup’s efforts to complete its 2022 charge to develop a white paper on issues related to the state regulation of certain PBM business practices. She said she received corrections and updates to the charts for inclusion in the next versions
of each chart. She said she hopes to complete the updated versions sometime in late April or early May. She requested additional information from stakeholders on any missing state PBM laws to include in the updated versions.

Ms. Matthews said she has posted the compilation charges on the Subgroup’s web page under a new heading “State PBM Laws Charts.” She said she anticipates updating each chart moving forward on at least a quarterly basis, and the updated charts will be posted at this location on the Subgroup’s web page.

5. Discussed its Spring National Meeting Agenda and Future Meetings

Mr. Keen discussed the Subgroup’s agenda for its April 4 meeting during the Spring National Meeting and an outline for the Subgroup’s next few meetings. He said in addition to receiving an update from Oklahoma on its PBM law implementation, for the April 4 meeting, the Subgroup will hear a consumer perspective on the Subgroup’s white paper charge. The Subgroup will also hear from Oregon on some of its work related to prescription drug pricing transparency and prescription drug supply chain issues. Mr. Keen said the Subgroup will also hold level-setting and background meetings over the next few months to hear from speakers suggested by Subgroup members. He said the goal of these meetings is to ideally have the Subgroup begin its work drafting the white paper with a common level of understanding and knowledge about the issues to be discussed in the white paper.

6. Discussed State Pharmacy Complaint Processes

Mr. Hamilton said Wyoming has seen a recent rise in complaints from pharmacies alleging violations of certain provisions of its existing laws. He asked if any states set up a formal adjudication process to handle pharmacy complaints, including developing and using a specific template for such complaints. He explained that under Wyoming’s existing laws, it has a maximum allowable cost (MAC) appeals law and a law on pharmacy audit procedures.

Mr. Keen said Oregon has not received a high volume of such complaints. Mr. Beatty said for complaints from pharmacies, when Virginia first enacted its law, it did not receive a large volume of complaints because pharmacists found its website too complicated to file such complaints. He said to address this problem, Virginia developed a specific complaint form for pharmacists.

Mr. Hamilton asked that if anyone else has any information to assist Wyoming in developing a formal adjudication process to handle pharmacist complaints, he would appreciate it if they would reach out to him. Mr. Hogge said in addition to Virginia, Ohio and Oklahoma have developed specific pharmacist complaint forms. He suggested that as a starting point, Mr. Hamilton should look at what these states have done.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup met in San Diego, CA, Dec. 11, 2021. The following Subgroup members participated: TK Keen, Chair (OR); Laura Arp, Vice Chair, and Martin Swanson (NE); Lori K. Wing-Heier (AK); Yada Horace (AL); Alan McClain (AR); Bruce Hinze (CA); Paul Lombardo and Kathy Belfi (CT); Andria Seip (IA); Julie Holmes (KS); Shawn Boggs (KY); Jeffrey Zewe (LA); Kathleen A. Birrane and Mary Kwei (MD); Chad Arnold (MI); Chlora Lindley-Myers and Cynthia Amann (MO); Tracy Biehn (NC); Gale Simon (NJ); Paige Duhamel (NM); Shannen Logue (PA); Brian Hoffmeister (TN); Tanji J. Northrup (UT); Don Beatty (VA); Molly Nollette (WA); Nathan Houdek and Jennifer Stegall (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating were: David Altmaier (FL); Jon Godfread (ND); and Glen Mulready and Kelli Price (OK).

1. **Heard an Update on the Pharmaceutical Care Management Association v. Wehbi Ruling**

Commissioner Godfread updated the Subgroup on the recent decision by the Eighth Circuit of the U.S. Court of Appeals in *Pharmaceutical Care Management Association v. Wehbi*. He said the Eight Circuit’s decision upheld two laws enacted during North Dakota’s 2017 legislative session. These laws were enacted as an effort to prohibit pharmacy benefit managers (PBMs) from engaging in what have been considered deceptive and anti-competitive practices, which ultimately drive up prescription drug costs. The *Pharmaceutical Care Management Association v. Wehbi* case is the first to consider at the federal appellate level the scope of the U.S. Supreme Court’s unanimous decision last year in *Rutledge v. Pharmaceutical Care Management Association*, which upheld an Arkansas state law regulating the abusive practices of PBMs.

Commissioner Godfread said based on the North Dakota Department of Insurance’s (DOI’s) legal analysis of the *Pharmaceutical Care Management Association v. Wehbi* decision, the North Dakota DOI believes the *Pharmaceutical Care Management Association v. Wehbi* decision significantly expands upon the *Rutledge v. Pharmaceutical Care Management Association* decision, which provided a framework that places a broader category of laws presumptively beyond the Employee Retirement Income Security Act’s (ERISA’s) preemptive scope—i.e., health care cost regulation—including state legislation regulating PBMs in this area. He said *Pharmaceutical Care Management Association v. Wehbi* took that a step further to uphold laws regulating PBMs against ERISA preemption where the laws regulate matters of transparency; the imposition of fees, fines, and arbitrary performance metrics; and other requirements upon pharmacy providers, thereby preventing anti-competitive practices by PBMs. He said he believes the *Rutledge v. Pharmaceutical Care Management Association* and *Pharmaceutical Care Management Association v. Wehbi* decisions now open the door for states to pass more laws that regulate PBMs more comprehensively and have those laws upheld as applied to ERISA plans, as long as the laws pass the ERISA “tests” established in these cases.

Mr. Keen thanked Commissioner Godfread for bringing the *Pharmaceutical Care Management Association v. Wehbi* decision to the Subgroup’s attention. He said he believes the Subgroup will find the North Dakota DOI’s analysis of the case helpful as it moves forward with its work to develop a white paper on issues related to the state regulation of certain PBM business practices. He also said he assumes the ERISA (B) Working Group will be examining the *Pharmaceutical Care Management Association v. Wehbi* decision as well. As such, the Subgroup will coordinate it discussions on the case with the Working Group.
2. **Heard from the States on the Implementation of PBM Laws**

Mr. Keen said the Subgroup’s next agenda item is to hear from Connecticut, Oklahoma, Virginia, and Wisconsin on their PBM laws. He said this agenda item was added at the request of Subgroup members wanting to know what other states have done with respect to PBM regulation and oversight. He said he believes this information will be helpful to the Subgroup as it moves forward with the white paper and potentially for additional Subgroup discussions about developing another draft PBM model.

a. **Connecticut**

Mr. Lombardo discussed Connecticut’s PBM law. He said Connecticut requires PBMs to register with the state. He discussed Connecticut Gen Stat § 38a-479ppp (2019), which was enacted under Public Act 18-41. He said this statute requires PBMs for insured business in the state to file a report each year with the commissioner that includes information on the aggregate dollar amount of all rebates for outpatient prescription drugs the PBM collected from pharmaceutical manufacturers and the aggregate dollar amount of all rebates for outpatient prescription drugs, excluding any portion of the rebate received by health carriers, the PBM collected from the pharmaceutical manufacturers. He said Connecticut received the first of this data at the beginning of 2020 and will receive the second set of data at the beginning of 2022. He said this information will be made public sometime in the first quarter of 2022. He said although not strictly related to PBMs, Public Act 18-41 also requires health insurers to provide information on their rebate practices. He said based on this information, the commissioner prepares an annual report, which is posted on the DOI’s website, containing: 1) an explanation of the manner in which health carriers accounted for rebates in calculating premiums for health care plans delivered, issued for delivery, renewed, amended, or continued during such year; 2) a statement disclosing whether, and describing the manner in which, health carriers made rebates available to insureds at the point of purchase during such year; 3) any other manner in which health carriers applied rebates during such year; and 4) such other information as the commissioner, in the commissioner’s discretion, deems relevant. He also discussed a provision in Connecticut law modeled after a California law requiring health insurers as part of their rate filing to provide data on prescription drugs; i.e., the top 25 most costly drugs and the top 25 most utilized drugs.

Ms. Belfi discussed Connecticut’s review of affiliated agreements health insurers have with PBMs as part of the DOI’s financial analysis requirements of the companies.

Mr. Lombardo explained that as part of this financial analysis work, the Connecticut DOI realized it needs to learn more about every aspect of the prescription drug distribution system, which ultimately resulted in a draft, non-public white paper that Connecticut has shared with the Subgroup. He noted that as part of this process, the Connecticut DOI came to realize the possibility of unintended consequences of any PBM legislation meant to address one aspect of PBM business practices, such as rebating, on other aspects of the prescription drug distribution system.

b. **Oklahoma**

Ms. Price discussed Oklahoma’s Patient’s Right to Pharmacy Choice Act, which was effective Nov. 1, 2019. She explained that the Act establishes minimum and uniform access to a provider and standards and prohibitions on restrictions of a patient’s right to choose a pharmacy provider. These minimum standards include provisions: 1) barring PBMs from reimbursing independent pharmacies at a lesser amount than PBM-owned pharmacies; 2) outlining geographical requirements for urban, suburban, and rural pharmacy access; and 3) prohibiting incentives related to mail-order, cost-sharing, co-payments, or other discounts.
Ms. Price explained how the *Rutledge v. Pharmaceutical Care Management Association* case and, ultimately, the U.S. Supreme Court’s decision in that case affected the Oklahoma DOI’s implementation and enforcement of the Act.

Ms. Price also discussed the Oklahoma DOI’s initiatives related to ensuring PBM compliance and enforcement of the Act. She said the Oklahoma DOI created a division focused solely on PBM compliance and enforcement. It hired staff, including an industry expert/pharmacist consultant, with the applicable knowledge and expertise in these areas.

Ms. Price said the Oklahoma DOI created a process on its website for consumers to submit complaints about PBMs online. As part of this, and to make the process as smooth as possible, the division developed templates for typical correspondence sent to PBMs and consumer complainants, including a “blue sheet” specific to PBM alleged violations, which can be used for Oklahoma DOI investigators to succinctly summarize their investigations and more quickly refer cases to the legal division for enforcement actions. Based on the Oklahoma DOI’s experiences, Ms. Price also offered suggestions to states considering PBM legislation and currently implementing PBM laws.

Ms. Price said since Sept. 1, 2020, the Oklahoma DOI has received and reviewed over 135,000 alleged violations of the Act. She said approximately 27,000 have been resolved to date, and 32 alleged violations have been referred to the Oklahoma legal division for an enforcement action.

Mr. Houdek asked Ms. Price if staff hired for the new division were newly hired staff or repurposed staff. Ms. Price said it was a combination of new staff and repurposed staff. Mr. Houdek asked Ms. Price about the nature of complaints filed. Ms. Price said most of the complaints related to transaction fee issues and maximum allowable cost (MAC) pricing appeals and reimbursement amounts.

Ms. Arp asked about the fiscal note attached to the Act. Commissioner Mulready said such a fiscal note would have been approximately $500,000 from the Oklahoma DOI’s perspective. Ms. Duhamel asked about the MAC appeals. Ms. Price described how the Oklahoma DOI has uncovered such violations. She explained that the pharmacy services administrative organizations (PSAOs) have alerted the Oklahoma DOI about alleged MAC pricing appeal violations.

c. **Virginia**

Mr. Beatty discussed Virginia’s PBM law, which was effective Oct. 1, 2020. He explained that Virginia’s PBM law places the responsibility on the health insurer for compliance with the law. Under the law, PBMs must be licensed. Mr. Beatty explained that if the PBM fills out the application correctly, the PBM law requires the Virginia DOI to issue the license. He described the PBM law’s prohibitions on certain conduct by a health carrier or by a PBM under contract with a carrier. These prohibitions include: 1) reimbursing a pharmacy or pharmacist an amount less than the amount the PBM reimburses a PBM affiliate for providing the same pharmacist services; and 2) penalizing or retaliating against a pharmacist or pharmacy for exercising rights provided under the law.

Mr. Beatty said the Virginia law also prohibits a health carrier or a PBM under contract with a carrier from: 1) including any mail order pharmacy or PBM affiliate in calculating or determining network adequacy; and 2) conducting spread pricing.

Mr. Beatty said currently, Virginia has 39 licensed PBMs. He said the Virginia DOI has not received a lot of complaints related to its law. He explained that because of this seemingly lack of complaints, the Virginia DOI decided to create and post on its website a specific complaint form that can be used to file complaints related to
the PBM law. He said even with the specific complaint form, the Virginia DOI still has not received a lot of complaints specific to the PBM law.

Mr. Beatty also described Virginia’s quarterly reporting requirements related to rebates and its examination requirements. He said the Virginia DOI plans to submit legislation for consideration during the 2022 legislative session changing the quarterly rebate reporting requirements to an annual report since the Virginia DOI will not review the information until the end of each calendar year.

Ms. Arp asked Mr. Beatty about the confidentiality of the examination reports and the fee for such examinations. Mr. Beatty described the Virginia law’s confidentiality requirements, which is consistent with the NAIC’s model confidentiality language regarding examination reports and any working papers, documents, reports, and other information compiled during an examination. He explained that the Virginia DOI does not charge companies for financial or market conduct examinations. The money to pay for examinations comes from the Virginia DOI’s general assessment.

d. Wisconsin

Mr. Houdek discussed the work of the Governor’s Task Force on Reducing Prescription Drug Prices before Wisconsin’s proposed PBM law was introduced. He said the Task Force held eight public meetings from November 2019 to August 2020. The Task Force heard from 24 organizations representing a multitude of stakeholders. He said the Task Force issued a report in October 2020, which centered on the following key policy provisions: 1) lowering prices and controlling costs; 2) increasing transparency and consumer protections; and 3) access for vulnerable populations.

Mr. Houdek said with respect to increasing transparency and consumer protections, among its recommendations, the Task Force recommended the creation of the Office of Prescription Drug Affordability. He said similar to Oklahoma’s approach, the Task Force recognized that the Wisconsin DOI does not have the capacity and appropriate expertise to implement and enforce the requirements for a law regulating PBMs and the prescription drug market.

Mr. Houdek said 20 of the Task Force’s recommendations were included in the governor’s 2021–2023 biennial budget. He said during the budget process, the Task Force’s recommendations were removed and introduced as separate, stand-alone bills and packaged as “Less for Rx.” However, due to the COVID-19 public health emergency and other circumstances, the PBM legislation died during the 2020 legislative session.

Mr. Houdek said a slimmed down version of what was initially introduced was introduced in January 2021 and enacted in March 2021 (2021 Wisconsin Act 9). Key provisions in the law include: 1) a prohibition on gag clauses; 2) an annual PBM rebate reporting requirement; 3) a PBM licensure requirement; and 4) limitations on a PBM’s ability to retroactively deny or reduce a pharmacy’s claim after adjudication.

Mr. Houdek discussed the Wisconsin DOI’s next steps, which include: 1) tracking complaints and correspondence received; 2) learning from the efforts of other states as they implement their PBM oversight laws; and 3) continuing to work with stakeholders to build support to advance the other Task Force recommendations. He also said the fiscal note for the initial PBM bill included: 1) seven new staff; and 2) $500,000 in information technology (IT) upgrades. He said this fiscal note request was attached to the January 2021 legislation; but ultimately, the Wisconsin DOI received no new dollars to assist with implementation and enforcement. He said the Wisconsin DOI’s market regulation division has been tasked with implementing the new PBM law and has been working over the past few months to create a dedicated website and develop complaint templates, consumer-facing materials, and other information necessary for a smooth implementation process.
3. **Discussed its Next Steps**

Mr. Keen said the Subgroup will continue its discussions on its white paper charge during a meeting early next year.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.
SENIOR ISSUES (B) TASK FORCE

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  Comment Letter Regarding the Federal Centers for Medicare & Medicaid Services’ (CMS’s)
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  Comment Letter to the CMS Regarding the Treatment of Nonparticipating Durable Medical
  Equipment (DME) Suppliers Under Medicare’s “Limitation on Beneficiary Liability”
  (Attachment Three) ................................................................................................................. 6-134
The Senior Issues (B) Task Force met March 17, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Brian Bressman (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Alexander Borkowski (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Cam Jenkins (MN); Chlora Lindley-Myers (MO); Troy Downing represented by Ashley Perez (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Ana K. Pace (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Patrick Smock (RI); and Tana Howard (WY).

1. **Adopted its Feb. 25, 2022; Feb. 8, 2022; and 2021 Fall National Meeting Minutes**

The Task Force met Feb. 8 and agreed to submit comments in response to the federal Centers for Medicare & Medicaid Services’ (CMS’s) proposed rule on stricter marketing guidelines for Medicare Advantage (MA) plans.

The Task Force met Feb. 25 and adopted a letter in support of the CMS’s proposed rule on stricter marketing guidelines for MA plans.

Ms. Kruger made a motion, seconded by Director Lindley-Myers, to adopt the Task Force’s Feb. 25, 2022 (Attachment One); Feb. 8, 2022 (Attachment Two); and Nov. 30, 2021 (see NAIC Proceedings – Fall 2021, Senior Issues (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Letter to CMS Regarding the Treatment of Nonparticipating DME Suppliers Under Medicare's "Limitation on Beneficiary Liability"**

Mr. Rhoads made a motion, seconded by Mr. Grissom, to adopt the Task Force’s letter to the CMS (Attachment Three). The motion passed unanimously.

3. **Heard a Presentation Regarding Medicare Part D and Auto-Enrollment**

Harry Ting (Health Consumer Advocate) presented an issue that poses difficulties for State Health Insurance Assistance Program (SHIP) counselors and the harm inflicted on Medicare Part D enrollees. He said he is asking the Task Force to endorse some actions and contact the CMS regarding this problem.
Dr. Ting said the situation arises when an insurer discontinues one of its Medicare Prescription Drug Plans (PDPs) for the next calendar year and the beneficiary is then crosswalked to another of the insurer’s PDPs. He said enrollees are notified via the Annual Notice of Change (ANOC) mailing in September, and in 2021, 3.2 million PDP enrollees were crosswalked into a different PDP for 2022.

Dr. Ting said many of these ANOCs are confused with junk mail and thrown out by the beneficiary. He said the same ANOC formats are sent out every year to all Medicare Part D enrollees, but the choice they are presented with is confusing, and the beneficiaries are not given proper guidance. He provided an example of a client being crosswalked from the Mutual of Omaha Rx Value Plan and thus being switched from one of the lowest cost plans in the beneficiary’s area to one of the highest. He said the change in premium for this client went from $22.20 a month to $77.90 a month. He said it is not really the fault of the insurance plan but rather the problem with the CMS’s rules and regulations.

Dr. Ting said the ANOC tells beneficiaries to check the changes to the benefits and costs to see if they affect the beneficiary. He said this is very difficult for many beneficiaries to do. For example, he said one client of his takes 43 different medications and drugs, and the ANOC tells the beneficiary to go to the online drug list if there are changes. He said the online drug list is a 45-page formulary for the seniors to go through. He said the ANOC asks whether one’s drugs are in a different tier with different cost sharing and points out that there are five tiers with 10 cost-sharing categories. He said the ANOC asks whether one’s drugs have new restrictions, and it instructs the senior to call their insurer; if the senior can use the same pharmacy, the senior is instructed to go to a website or call to obtain a directory. He said there is no mention of Medicare or SHIP resources, and the section entitled “additional resources” tells the senior to call their insurer, which is not helpful when seeking unbiased and objective answers.

Dr. Ting said there are three changes the CMS can do to address this issue, and he asks that the NAIC act in contacting the CMS to implement these changes. He said the first change is for the CMS to notify crosswalked Medicare Part D enrollees directly so the ANOC letters are not confused as junk mail and the beneficiary has notice from the CMS about upcoming changes. He suggested a sample letter that the CMS could implement. He said the second change is to modify the ANOC template currently being used. He said additional language should be made available beyond the current standard language that this document is available in (e.g., Spanish, braille, and large print). He suggested that the section start with advising the beneficiary to call their SHIP or the 800 Medicare number, as well as provide the Medicare.gov web page.

Dr. Ting said the first two suggestions can be done by the CMS through its current rules. He said the third suggestion is for the CMS to allow crosswalked Part D plan enrollees to switch Part D plans during the January through March period, the same as MA enrollees. He said he believes this can be implemented through the CMS’s regulations, but if not, he would propose it as an amendment. He said he would like the Task Force and the NAIC to support the three suggestions and ask the CMS to modify its Medicare Part D ANOC template to include objective resources and tell the CMS to give crosswalked Medicare Part D drug plan enrollees the same protections as those in MA plans.

Commissioner Caride asked if Task Force members have heard about these complaints. Mr. Henderson, Ms. McGaughey-Bowker, Ms. Seip, and Ms. Hohl said they have heard and are aware of these issues in their states. Ms. Hohl asked Dr. Ting if he has reached out to the CMS about whether the CMS has given any explanation as to why these suggestions are not already a requirement. Dr. Ting said he has reached out but has not received any response from the CMS. Commissioner Caride suggested that Task Force members take time to review the slides Dr. Ting presented, and the Task Force can discuss this matter in more detail at its next meeting.
4. **Heard a Discussion About Home Care Plans and Marketing Insurance**

Bonnie Burns (California Health Advocates—CHA) said the issue she wants to bring to the attention of the state insurance regulators is a matter she has not dealt with in almost 10 years, and it involves the sale of access to home care through what is essentially a service contract. She said in the past, it was masqueraded as insurance and sold by insurance agents.

Ms. Burns said it has arisen again in the form of a membership organization where one pays a membership fee plus an annual fee, and that entitles the person to a certain number of home care hours. She said in the past, these hours could have been discounted costs from participating home health agencies or other entities. She said the last time she was involved with one of these contracts was in 2013 when the San Diego district attorney prosecuted and charged a person with seven felonies regarding this scheme. She said the company in question had operated in many different states and under a variety of names, and people were paying for access to what was essentially a discounted home care membership organization.

Ms. Burns said she is raising this because there may be some organizations operating in this space currently (e.g., she became aware today of an insurance product that is being sold as a home care indemnity product), and she believes they are using the short-term insurance model to provide these benefits. She said she wanted to bring this to the attention of state insurance regulators in case complaints are being received about this or people have made inquiries about this matter. She said as she learns more about the current adaptation of these home care indemnity products, she will give a presentation to the Task Force.

Commissioner Caride said her department has not received any calls or complaints about this matter, but that is not to say it is not happening across the country, and she asked if anyone is hearing about this in their state. Ms. Burns said the way these organizations operate is that complaints are not heard until the claims are not paid or the organization pays the small claims but not the larger ones.

5. **Heard a Federal Legislative Update**

David Torian (NAIC) said the fiscal year (FY) 2022 Omnibus legislation, which funds the government through Sept. 30, was passed by the U.S. House of Representatives (House) and the U.S. Senate (Senate) and signed into law by the president, and SHIP funding is maintained at $57,115,000 for FY 2022.

Mr. Torian said the Omnibus includes two senior protection provisions. One is the creation of the Senior Scams Prevention Advisory Group, and the second is the Senior Fraud Advisory Office within the Federal Trade Commission (FTC). He said both provisions are aimed at improving interagency coordination on efforts to protect seniors from falling victim to fraud and scam attempts. He said the details about each provision is detailed in the printed version of the update, which is posted on the Task Force’s web page unless the chair would like the details read in full. Commissioner Caride said anyone interested in the details can go to the Task Force’s web page, and they can contact Mr. Torian if they have any questions.

Having no further business, the Senior Issues (B) Task Force adjourned.

*SITF 03-17-22 Minutes*
The Senior Issues (B) Task Force conducted an e-vote that concluded Feb. 25, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara (CA); Andrew N. Mais (CT); Trinidad Navarro (DE); John F. King (GA); Colin M. Hayashida (HI); Dean L. Cameron (ID); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James L. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey (NC); Jon Godfread (ND); Eric Dunning (NE); Barbara D. Richardson (NV); Judith L. French (OH); Jessica K. Altman (PA); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Michael S. Pieciak (VT); Mike Kreidler (WA); Nathan Houdek (WI); and Allan L. McVey (WV).

1. **Adopted a Letter in Support of the CMS’ Proposed Rule on Stricter Marketing Guidelines for Medicare Advantage and Medicare Part D Plans**

The Task Force conducted an e-vote to consider adoption of a comment letter in support of the Centers for Medicare & Medicaid Services’ (CMS’) proposed rule on stricter marketing guidelines for Medicare Advantage (MA) and Medicare Part D plans.

Without objection, the Task Force adopted the comment letter (Attachment One-A).

Having no further business, the Senior Issues (B) Task Force adjourned.

*SITF 02-25-22 Minutes*
February 25, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Via Regulations.gov

To Whom It May Concern:

The following comments on CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P), as published in the Federal Register on January 12, 2022, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories. The comments specifically address the portion of the proposed rule focused on the practices of third-party marketing organizations (TPMO) of Medicare Advantage (MA) Plans.

CMS notes in its own explanation of its proposed rule that the Federal government is seeing an increase in beneficiary complaints associated with TPMO advertisements and has received feedback from beneficiary advocates and stakeholders concerned about marketing practices. State insurance regulators have also heard many complaints regarding these TPMOs and the advertisements of MA plans.

The NAIC’s Senior Issues (B) Task Force and the Improper Marketing of Health Insurance (D) Working Group have heard from many state regulators regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers. One insurance commissioner described some of these ads as somewhat misleading at the very best and close to fraudulent at the very worst.

State insurance regulators and consumer advocates have noted an increase in the improper marketing of MA plans geared toward seniors that have included not only the running of television commercials that provided incorrect information, but a significant increase in social media ads, unsolicited phone calls to seniors and mass mailings from unidentified entities attempting to solicit business. During the past several years, advertising for these plans has increased and has emphasized extra or chronic care benefits often only available in particular sets of circumstances and not to the average MA plan enrollee.

The NAIC and state regulators have heard many stories in which beneficiaries have enrolled in or been enrolled in plans with narrow networks that didn’t include their current providers, had pharmacy benefits with higher costs, imposed higher copayments than expected, didn’t have the benefits they had seen advertised, or that were completely inappropriate for their particular needs and not what they thought they were buying. These sales often involve agents/brokerages or TPMOs that represent only some of the options available to Medicare beneficiaries.

Many of these TPMOs have names with “Medicare” or “Seniors” (i.e. American Medicare Advisors, Medicare Insurance Advisors, Medicare Plan Store, Senior Health Plans, etc.) and/or contain endorsements by known celebrities adding further confusion and misrepresentation. Many complaints involve agents or third-party marketers cold-calling or going door-to-door, often in senior-living housing/communities.

The NAIC notes there are gaps in MA regulation. The states are only allowed, by federal law, to initially license the plan, ensure the financial solvency of the carrier, and hold the license of both the carrier and insurance producer who
sells the plan. The federal government oversees the MA plans themselves and sets out rules for the marketing of them.

Many state insurance regulators work with State Health Insurance Assistance Programs (SHIP) coordinators and state Senior Medicare Patrol (SMP) coordinators on multiple complaints from beneficiaries but are confronted with limited or no positive results. State regulatory authority for these plans is limited to the agents and any misrepresentation; however, most complaints fall into an area that limits any actions states can take against these agents/brokers or TPMOs.

Some states, using state laws, have successfully prosecuted producers when they have violated CMS rules in the sale of the product. We ask CMS to provide the states all of the evidentiary information CMS collects for prosecution.

While the proposed rule may not go far enough for some, we feel this is a good start. We have received suggestions and recommendations that CMS should consider additional language; stronger marketing disclosure language; labeling the marketing disclosures in a separate color or in a text box with defined borders in at least a larger font that garner attention from the consumer; and requiring all producers to identify existing coverage and inquire about an applicant’s intent to replace existing coverage before taking an application from someone already covered.

Other suggestions and recommendations CMS should consider include requiring TPMOs to inform beneficiaries of the option to use 1-800-MEDICARE or www.medicare.gov to compare the total cost of drugs that the beneficiary will incur if they select any MA or Part D plan and requiring TPMOs to report the number of complaints they receive each month from consumers.

Finally, consumers must have a source of unbiased information in the very complex Medicare world. CMS should consider adding contact information for states’ SHIP programs, SMP programs, and other Medicare consumer advocate divisions and programs to marketing disclosure requirements and to written, oral and online information about Medicare enrollment.

The NAIC will continue to review proposed rules and provide comments on the potential impact on market competition and consumer protections. We are available to discuss these or other issues as this proposed rule is finalized.

Sincerely,
The Senior Issues (B) Task Force met Feb. 8, 2022. The following Task Force members participated: Marlene Caride, Chair (NJ); Jon Pike, Vice Chair (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Willard Smith (AL); Alan McClain represented by Carroll Astin (AR); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altmaier represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen (IA); Dean L. Cameron represented by Kathy McGill (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Stephanie McGaughy-Bowker (KY); James J. Doneelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Theodore Patton (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning and Martin Swanson (NE); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Tynesia Dorsey (OH); Jessica K. Altman represented by Michael Gurgiolo (PA); Elizabeth Kelleher Dwyer represented by Patrick Smock (RI); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Dannette Smith (TX); Scott A. White represented by Bob Grissom (VA); Michael S. Pieciak represented by Mary Block (VT); Mike Kreidler represented by Molly Nollette (WA); Nathan Houdek represented by Jennifer Stegall (WI); and Allan L. McVey (WV). Also participating were: Eric Anderson (IL); Kay Warrington (MS); Ingrid Marsh (NH); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Glen Mulready (OK); Andrew Dvorine (SC); and Mavis Earnshaw (WY).

1. **Discussed the CMS’s Proposed Rule on Stricter Marketing Guidelines for MA Plans**

Commissioner Caride said the purpose of this Task Force meeting is to examine the proposed rule promulgated by the Centers for Medicare & Medicaid Services (CMS) to impose stricter marketing guidelines for Medicare Advantage (MA) plans. She said this meeting is not to target MA plans but to focus on the deceptive marketing advertisements to sell MA plans. She said the Task Force has heard from state insurance regulators, most notably from Louisiana and Nebraska, regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers.

Mr. Swanson gave some background on what he has heard from Nebraska and other states regarding these solicitations. He said Nebraska has a very good working relationship with its regional CMS representatives and shares information with other states. He said these issues have been raised and are being examined by the Improper Marketing of Health Insurance (D) Working Group; and because many of these Working Group calls are regulator-only, frank discussions are had with the CMS and the federal Center for Consumer Information and Insurance Oversight (CCIIO). He said some of these calls have died down after open enrollment closed, but MA plan open enrollment does not end for another month.

Commissioner McVey said he has seen these advertisements; they are somewhat misleading at the very best, and they are close to fraudulent at the very worst. He said he would like to address this situation; even though he has seen one of the ads revamped, it is still not a good situation, and more complaints will come.
Mr. Henderson said one of the biggest issues is that those third-party callers who are not necessarily agents can call seniors asking if they would like to change their plan, and the next thing the senior discovers is that they have been switched into another plan, and that new plan does not even take the senior’s doctor. He related a story he told before about being present when a call came in to a senior; when he took the phone to ask for the caller’s license, the caller hung up. He said Commissioner Schmidt, the Director of the Louisiana State Health Insurance Assistance Program (SHIP), is constantly making changes on behalf of seniors who have been moved out of their plans. He said many seniors are being incentivized to make changes because the marketing caller tells them they are not getting all they deserve when in fact they are getting what they need. He said it must be emphasized to the CMS that these third-party marketing callers are using unlicensed persons to make the calls and then hand the call over to a licensed person.

Commissioner Caride asked the Task Force if it would agree to comment on the CMS’s proposed rule and any objections to commenting. Mr. Swanson said the regional CMS personnel he has engaged with would appreciate input from the NAIC to get the attention of the officials in the District of Columbia. Commissioner Caride noted that both Idaho and Missouri concur with Mr. Swanson’s comments. She asked if there are any interested parties that wish to comment.

Bonnie Burns (California Health Advocates—CHA) said the CHA submitted a letter to the Task Force laying out its position and what it has commented to the CMS. She said there has been a massive increase in the number of people being switched to plans they either did not want or were not appropriate for them. She said she has seen those dually eligible being moved from their non-premium plans to plans with premiums and plans that have co-payments when they should not have any co-payments. She said the CMS’s own statistics show there has been a jump in complaints. She said in 2020, the CMS received a total of 15,497 complaints related to marketing; and in 2021, excluding December, the CMS received 39,617 complaints. She said this is an indication of companies fighting for market share and agents and brokers fighting for sale commissions.

Ms. Burns said one area of great concern is that there is no indication to how any enforcement is taking place. She said some states have memoranda of understanding (MoUs) with the CMS so there would be a transfer of information, but when an agent or a broker where these actions are taking place is identified, there does not appear to be any formal process in the CMS proposed rule for these agents and brokers who are licensed to be disciplined through the states’ licensing and enforcement system. She said the CMS is proposing a disclaimer to be added to websites and advertisements stating that the consumer is not being given all the information about plans available to them. She said such a disclaimer is ineffective, and she said she proposed in the letter to the Task Force what would be an adequate disclosure to consumers. She said SHIPs are not even referenced in the proposed rules, and she strongly believes SHIPs must be included. She also said the proposed rule should require agents and brokers to sign an attestation to show that what is being offered and sold is an improvement to the consumer from what they are already enrolled in. She said this already exists for Medicare Supplement plans, so it should apply to MA plans.

Mr. Henderson pointed out that most of the SHIPs are in states’ Aging and Elderly offices, so if there is no connection to the state insurance departments, many of these issues are going unheard and are not being reported to insurance departments.

Harry Ting (Health Consumer Advocate) said he is an NAIC consumer representative and SHIP counselor. He said he had a client who was cold called, told the caller she did not want to change but was changed to a new plan that did not fit her needs. He said when he asked the new plan who the producer was who called the client and switched her to the new plan, they said they did not know. He said these marketing organizations have very little incentive to discipline their people, and when he asked the client if she would like to file a complaint, she was reluctant to do so.
Dr. Ting said he agrees with Ms. Burns that the CMS proposed rule is not impactful enough. He proposed that the CMS use its complaint tracking module that counted over 39,000 complaints in 2021 to enter a star system calculation and assign a certain number of stars to those plans. He said it would make the marketing organization more sensitive and willing to take action to reduce complaints.

Commissioner Mulready said the Oklahoma Insurance Department has received dozens and dozens of calls and complaints, and it is supportive of letting the CMS know what states are experiencing. Ms. Burns said holding plans or marketing organizations accountable is laudable, but it does no good if the complaints and information are not getting to the states’ departments of insurance (DOI), and in turn, there is no action on a state level holding these actual sellers accountable.

Commissioner McVey made a motion, seconded by Commissioner Pike, that the Task Force submit comments in response to the CMS’s proposed rule on stricter marketing guidelines for MA plans. The motion passed unanimously.

Commissioner McVey asked about the process of submitting comments. Commissioner Caride asked David Torian (NAIC) to explain. Mr. Torian said he would like comments to be submitted by week’s end, or Monday, Feb. 14 at the latest. He said he would collate the comments into a single letter for the Task Force to adopt via an e-vote. He reminded the Task Force that time is of the essence, as the deadline for comments to the CMS is March 7, and any comments adopted by the Task Force will need approval from the Government Relations (EX) Leadership Council. Commissioner Caride asked if there are any issues or problems with that process, and none were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.

SITF 02-08-22 Minutes
Hon. Chiquita Brooks-LaSure - Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

We are writing on behalf of the National Association of Insurance Commissioners’ (NAIC) Senior Issues (B) Task Force to request guidance from CMS regarding the treatment of nonparticipating durable medical equipment (DME) suppliers under Medicare's "Limitation on Beneficiary Liability" (the so-called "balance billing limits").

The NAIC is the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories.

The NAIC’s Senior Issues (B) Task Force (SITF) is charged with considering policy issues; developing appropriate regulatory standards; and revising, as necessary, the NAIC models, consumer guides, and training materials on Medicare supplement (Medigap) insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

The SITF seeks critical guidance from CMS that a nonparticipating supplier of scooters or other DME items and services may only charge 15% more than the Medicare approved amount. The SITF has heard from many state regulators, consumer advocates and industry representatives about Medigap insurers being presented with "excess charges" claims for expensive motorized "scooters" that are submitted as Medicare covered DME. These claims are submitted by nonparticipating suppliers to Medicare for payment and beneficiaries are "balance billed" an enormous amount. The insurers have been paying these "excess charges" claims in full to satisfy policyholders and to avoid complaints.

These "excess charge" claims are becoming more frequent and more expensive. Insurers and state regulators are concerned about the appropriateness of these claims by nonparticipating DME suppliers and the resulting impact on Medigap premiums. The SITF has been presented with many examples of these excessive charges. One example illustrated billed charges from one scooter supplier ranging from $15,789, to $31,000, depending upon the model of the scooter. The Medicare approved amount is significantly lower than the actual billed amount. In one instance, Medicare was billed $43,485.10, for a power wheelchair and the Medicare approved amount was $4,702. The remaining "excess" balance of $38,783.10 was then presented to a Medigap insurer for payment in full as an "excess charge."

Medigap policies are required to pay benefits based upon "Medicare eligible expenses." This term is defined in the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model #651) to mean "expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare." See Model #651 at Section 5.G ("Policy Definitions and Terms"). See also Model #651 at Sections 8, 8.1, 9. 9.1 ("Minimum Benefit Standards"). Accordingly, Medigap benefit payments require that Medicare must first determine that expenses are covered and must be recognized as reasonable and necessary.
Model #651 requires that certain standardized plans must include a benefit for payment of Medicare Part B "Excess Charges." This benefit is described in Model #651 as coverage for a percentage of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. See Model #651 at Sections 8.C; 8.1.C; 9.E; 9.1.E; and 10.M-N.

The benefit for "Medicare Part B Excess Charges" was adopted following the enactment of the 1990 federal Medigap standardization legislation. The NAIC debated how to properly characterize and phrase the requirement. There was agreement that these "excess charges" were billed by providers in amounts that were above the Medicare-approved amount, and so otherwise would not be paid for by the plans.

The NAIC considered changing the term "Medicare Part B Excess Charge" to "Part B Balance Billing" but concluded that the change would mean nothing to an average consumer. See Model #651, Proceedings Citation, Section 8C at page PC-651-8; and Section 17D at page PC-651-26. Separately, CMS defines "excess charge" as an amount that is "the difference between the Medicare-approved amount and the legally permitted higher charge." See CMS-NAIC, "Guide to Choosing a Medigap Policy-2021" at page 49 ("Definitions").

As described in the "Guide to Choosing a Medigap Policy" the phrase referring to "the legally permitted higher charge" is clearly a reference to the limits on "balance billing." Based on the timing of the NAIC's consideration of the "excess charges" benefit, and the NAIC debate about the phrase, it is clearly intended to address the so-called "balance billing" circumstances discussed below.

In 1993 the Congress amended the "balance billing" protection provision to clarify that the "extra-billing" limits also applied to non-participating "suppliers or other persons." See H.R. 2264, OBRA Act of 1993, Section 13517 (entitled "Extension of Physician Payment Provisions to Nonparticipating Suppliers and Other Persons"). The conference committee explanation simply states that the "nonparticipating suppliers would be prohibited from billing or collecting from any person an actual charge in excess of the Medicare limiting charge." See H.R. Rep. No. 213, 103d Cong. at 769-771 (August 4, 1993) (Conference Report to Accompany H.R. 2264)

Therefore, a nonparticipating supplier is legally only permitted to charge 115% of the Medicare-approved amount. The statutory text of the Social Security Act's "Limit on Beneficiary Liability" applies to a "nonparticipating physician or nonparticipating supplier (emphasis added) or other person who does not accept payment on an assignment-related basis for a physician's service" that is furnished to a Medicare beneficiary. See Social Security Act Section 1848(g)(1)(A).

Arguably the Social Security Act's "Limits on Beneficiary Liability" provisions apply to these "balance billing" claims for motorized scooters as well as other DME items submitted by nonparticipating DME suppliers.

In addition, CMS states that: "No longer are services of suppliers and other nonphysicians … excluded from the limiting charge." See Medicare Carriers Manual, Part 3 - Claims Process, Section 17002 ("Limiting Charge") at page 17-7 (July 11, 2003).

The term "nonparticipating supplier" in this section of the statute does not provide any exception for a DME supplier or any other type of supplier. It is broadly defined elsewhere as "a supplier or other person that is not a participating supplier." See Social Security Act Section 1842(i)(2). The statute further provides that no person may bill or collect an actual charge for the service in excess of the...
limiting charge. See Social Security Act Section 1848(g)(1)(A)(i). Furthermore, the statute provides that no person is liable for payment of any amounts billed for the service in excess of such limiting charge. See Social Security Act Section 1848(g)(1)(A)(ii).

CMS regulations provide that a "supplier" who is nonparticipating and does not accept assignment may charge a beneficiary an amount up to the limiting charge. The regulations establish specific limits on the actual charges of nonparticipating suppliers for both "items and services" at 115% of the Medicare approved charge. See 42 CFR 414.48 (a)-(b) ("Limits on actual charges of nonparticipating suppliers").

Medicare Part B pays for DME that is used in a patient's home. A DME supplier is defined as an entity with a valid Medicare supplier number (both participating and nonparticipating). A power mobility device (PMD) is a covered item along with power wheelchairs and motorized scooters. To be covered a PMD requires: (1) first, a written order or prescription from a physician; (2) a face-to-face encounter with a physician; and (3) supporting documentation for "medical necessity." See 42 CFR 410.38(a)-(d).

A "supplier" is defined broadly in the CMS regulation as "an entity other than a provider that furnishes health care services under Medicare. See 42 CFR 400.202. In the preamble to the 1993 final rule CMS explains changes to the regulations that "in addition, the limiting charge provision will apply to nonparticipating suppliers or other persons. Previously, it had applied to the services of nonparticipating physicians only." See 58 Fed. Reg. 230 at page 63646 (December 2, 1993).

Finally, the consumer reliance on the marketing of these DME items at no cost to Medicare beneficiaries, who are then more likely to agree to purchase those items, contributes to driving up the costs to Medicare. It isn't just the cost to insurers and the impact on Medigap premiums but the resulting cost to Medicare Part B.

The Social Security Act's "Limitation on Beneficiary Liability" clearly references a "nonparticipating supplier or other person" without qualification or exceptions. See Social Security Act Section 1848(g)(1)(A). The Act's DME payment provisions clearly refer to providers of DME as "suppliers." See Social Security Act Section 1834(a).

The SITF requests guidance from CMS regarding nonparticipating DME suppliers and looks forward to CMS’ response as it will help the State regulators, Medigap insurers and Medicare beneficiaries understand better how to address this matter.

Sincerely,

Marlene Caride
Chair, Senior Issues (B) Task Force
Commissioner, New Jersey Department of Banking and Insurance

Jon Pike
Vice Chair, Senior Issues (B) Task Force
Commissioner, Utah Insurance Department
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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Property and Casualty Insurance (C) Committee
Kansas City, Missouri
April 7, 2022

The Property and Casualty Insurance (C) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Mike Chaney, Chair (MS); Alan McClain, Co-Vice Chair (AR); Anita G. Fox, Co-Vice Chair (MI); Jim L. Ridling (AL); Ricardo Lara (CA); Andrew N. Mais, George Bradner, and Wanchin Chou (CT); Trinidad Navarro (DE); Colin M. Hayashida represented by Martha Im and Kathleen Nakasone (HI); Vicki Schmidt (KS); James J. Donelon (LA); Chris Nicolopoulos (NH); Glen Mulready (OK); Larry D. Deiter (SD); Tregenza A. Roach (VI); Allan L. McVey (WV). Also participating were: David Altmaier (FL); Eric Dunning (NE); Martha Lees (NY); Mike McKenney (PA); and Eric Slavich (WA).

1. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner McVey made a motion, seconded by Director Fox, to adopt the Committee’s Dec. 15, 2021, minutes (see NAIC Proceedings – Fall 2021, Property and Casualty Insurance (C) Committee). The motion passed unanimously.

2. **Adopted the Reports of its Task Forces and Working Groups**

A. **Casualty Actuarial and Statistical (C) Task Force**

Mr. Slavich said the Casualty Actuarial and Statistical (C) Task Force March 8 in lieu of the Spring National Meeting. During that meeting, the Task Force adopted a document with guidance for the regulatory review of random forest rate models. This document is a follow-up to the Task Force’s white paper titled *Regulatory Review of Predictive Models*, which was adopted last spring. In writing the initial white paper, the Task Force focused on just one predominant type of multivariate analysis: generalized linear models (GLMs). The new guidance deals with random forest models, and the Task Force intends to continue working to create guidance for other types of models.

Mr. Slavich said the Task Force has been discussing an issue raised by the American Academy of Actuaries (Academy) related to accounting practices for portfolio retroactive reinsurance. In May 2019, the Academy wrote to the Task Force and the Statutory Accounting Principles (E) Working Group about this issue, and the Working Group asked the Task Force for input. After investigating the issue and after a long period of discussion, the Task Force decided to proceed with writing some suggested revisions to the instructions for Schedule P and perhaps also for paragraph 36 and paragraph 37 in the *Statement of Statutory Accounting Principles (SSAP) No. 62R—Property and Casualty Reinsurance*. The Task Force will provide these suggestions to the Statutory Accounting Principles (E) Working Group for its consideration.

Mr. Slavich also said the Statistical Data (C) Working Group has been working with statistical agents to implement accelerated publishing of average premium data. The Working Group decided to include accelerated average premiums every year for the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report). This will result in the production of two reports in 2022: 1) the normal report with 2020 data; and 2) an accelerated report with 2021 data. Only one report will be needed in subsequent years. Discussions about expedited reporting for the *Auto Insurance Database Report* (Auto Report) are ongoing.
Mr. Slavich also reported the Task Force continues to meet regularly, including both a monthly Book Club meeting to educate on predictive modeling and a monthly regulator-to-regulator meeting to discuss rate filing issues. These discussions have proven to be a valuable resource for regulatory actuaries (and non-actuary regulators), and the Task Force intends to continue with these meetings.

B. Surplus Lines (C) Task Force

Commissioner Donelon said the Surplus Lines (C) Task Force has not met yet in 2022, but it plans to meet soon to hear from the drafting group looking at the Nonadmitted Insurance Model Act (#870). That drafting group is working to modernize this model to bring it in line with the federal Nonadmitted and Reinsurance Reform Act (NRRA).

C. Title Insurance (C) Task Force

Director Dunning said the Title Insurance (C) Task Force met April 5 to hear states report on how they deal with wire fraud issues referred by title agents, as well as how states handle closing protection letters (CPLs). The Task Force also heard a presentation from industry on CPL policy language, including exclusions, and discussed its work plan for the year.

Director Dunning said the work plan includes meeting in regulator-to-regulator session in June with the Consumer Financial Protection Bureau (CFPB) to discuss recent changes, Real Estate Practices Act (RESPA) activities, and how states should collaborate with the CFPB. Additionally, the work plan calls for hearing from industry on what the post-pandemic future of the title insurance industry will look like, particularly in regard to virtual closings. It also calls on industry to share how complications arise from the required use of plans by some states that include rules or forms tailored to other lines of insurance. Director Dunning said the Task Force will review the Title Insurance Model Act to determine if there is a need to make a recommendation to remove the requirement for on-site review of underwriting and claims practices.

Director Fox asked if there was a date scheduled for the next Title Insurance (C) Task Force meeting, to which Director Dunning replied that it had not been set yet.

D. Workers’ Compensation (C) Task Force

Commissioner McClain said the Workers’ Compensation (C) Task Force met March 21 in lieu of the Spring National Meeting. The Task Force heard updates on federal legislation, including original language included in the Build Back Better Act that provided funding to the U.S. Department of Labor (DOL) Office of Workers’ Compensation Programs (OWCP) for “monitoring of state workers’ compensation programs.” That language was ultimately removed. The Task Force heard updates on cannabis, independent contractor, and single-payer health care, and state and federal legislation as related to workers’ compensation.

E. Cannabis Insurance (C) Working Group

Commissioner Lara said the Cannabis Insurance (C) Working Group met March 24 in lieu of the Spring National Meeting. During its meeting, the Working Group heard from two presenters on the state of the cannabis insurance industry. It also heard an update on federal cannabis-related legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan includes monitoring cannabis-related federal legislative activities and discussed its 2022 work plan. The work plan include...
Commissioner Lara said the work plan also calls for continued discussion with the Producer Licensing (D) Task Force on whether there is a need to collaborate to study social equity issues in states where cannabis is legalized for medical and/or recreational use.

Commissioner Lara said the work plan calls on the Working Group to explore emerging issues and market availability constraints through additional presentations. This includes exploring the risks of minor CBD-derived intoxicants and social consumption lounges and how a federal cannabis regulatory framework could help inform insurers’ coverage offerings.

F. Catastrophe Insurance (C) Working Group

Commissioner Altmaier said the Catastrophe Insurance (C) Working Group met March 4 and in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group April 4. The Working Group is currently working on updates to the *Catastrophe Modeling Handbook*. NAIC staff sent a survey to states regarding the Handbook in order to collect information from the states to help guide the update of the Handbook. A drafting group has met once to begin the process of updating the Handbook.

Commissioner Altmaier said the Working Group stays informed about catastrophic events in other states and shares lessons learned and processes other states use in the aftermath of a storm or other catastrophic event. On April 4, the Working Group heard an update from Iowa and Tennessee state insurance regulators regarding recent catastrophic weather events. Commissioner Altmaier reported that the NAIC has been partnering with FEMA on regional events to help state departments of insurance (DOIs) form better relationships with their FEMA partners. During the April 4 meeting, Commissioner Mulready provided the Working Group with an overview of past FEMA regional meetings, as well as the upcoming FEMA Region 6 meeting that will be held in Oklahoma City, OK, May 3–4. Commissioner Altmaier also said NAIC staff continue to add information to the Catastrophe Resource Center and are looking for state insurance regulator input.

Commissioner Chaney reported the Missouri Department of Commerce and Insurance will be cohosting the Central U.S. Quake Insurance Summit May 23–24 in St. Louis, MO.

G. Pet Insurance (C) Working Group

Commissioner Chaney provided an update on the status of the Pet Insurance Model Act. The model was previously adopted by the Property and Casualty Insurance (C) Committee but was pulled off the Plenary agenda at the 2021 Fall National Meeting because a couple states brought forth concerns about the producer training section of the model.

Commissioner Chaney said the model will be exposed with small revisions, and comments will be discussed during an upcoming meeting of the Pet Insurance (C) Working Group. Commissioner Chaney said the Pet Insurance (C) Working Group was not reappointed in 2022 because it was thought its work was complete.

Commissioner Schmidt made a motion, seconded by Director Deiter, to adopt a charge for the Pet Insurance (C) Working Group to “complete the development of a model law to establish appropriate regulatory standards for the pet insurance industry.”

Director Fox made a motion, seconded by Commissioner McVey, to adopt an extension to the Summer National Meeting for revisions to the proposed Pet Insurance Model Act. The motion passed unanimously.
H. Terrorism Insurance Implementation (C) Working Group

Ms. Lees said the Terrorism Insurance Implementation (C) Working Group has not met yet this year, but it does plan to meet in the near future to receive an analysis of the recently received workers’ compensation data, as well as last year’s data received in the non-workers compensation portion of the state insurance regulator data call. Ms. Lees said the Federal Insurance Office (FIO) and the NAIC formally notified insurers of this year’s data call on April 1 by providing instructions to insurers for submitting the data to both locations. She said the due date will be May 16, and additional information can be found on the NAIC and the U.S. Department of the Treasury (Treasury Department) websites.

I. Transparency and Readability of Consumer Information (C) Working Group

Mr. Bradner said the Transparency and Readability of Consumer Information (C) Working Group has been working on a project over the past year to draft regulatory best practices that serve to inform consumers of the reasons for significant premium increases related to property/casualty (P/C) insurance products. The Working Group formed drafting groups in three areas: 1) disclosure language; 2) rate filing checklist; and 3) consumer education. He said the disclosure language and the rate filing checklist drafting groups have completed their work, and the consumer education drafting group has sent its final document to Brenda J. Cude (University of Georgia) to be reviewed for readability. These documents will be combined into a single “best practices” document. Mr. Bradner said the Working Group will meet in April to review the document and expose it for comment. The Working Group anticipates this project to be complete sometime in May and sent to the Property and Casualty Insurance (C) Committee for consideration of adoption during the Summer National Meeting.

Commissioner Mulready made a motion, seconded by Commissioner Ridling, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Cannabis Insurance (C) Working Group (Attachment One); Catastrophe Insurance (C) Working Group (Attachment Two); Pet Insurance (C) Working Group; Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group. The motion passed unanimously.

3. Heard a Presentation on PPA Insurance Results

Aaron Brandenburg (NAIC) said NAIC staff was asked by the Committee to analyze Annual Statement data to show trends in private passenger auto (PPA) premiums and losses through 2021 when possible. He noted most of the data comes from the Insurance Expense Exhibit in order to create combined ratios. This exhibit comes into the NAIC on April 1, so combined ratios for 2021 are not presented within the analysis.

For PPA liability, written premium fell in 2020 due to the COVID-19 pandemic. Premium rose every year over the past 10 years, typically in the 2%–7% range, except for in 2020, when it fell 2%. Premium rebounded in 2021 with about a 6% increase. Loss ratios for PPA liability typically ranged from 63%–71% over the last 10 years, with a 10-year average of 65.5%. The loss ratio for 2020 was 56%, and 2021 is at the 10-year average. The 10-year average for combined ratio is 103%, with 2020 as the only year below 100% at 94.8%. Mr. Brandenburg said it seems likely that 2021 will be close to average in the low 100 percentile.

Mr. Brandenburg said PPA physical damage premium rose every year over the past 10 years, but it fell in 2020. Physical damage usually rises between 2% and 9%, with 2020 the only decrease at about 1%. PPA physical damage premium rose 9% in 2021. The 10-year average loss ratio is 64.4%, with 2020 at 55% and 2021 at 71.5%. The combined ratio for PPA physical damage is 97.3%, with 2020 at 89.2%.
Mr. Brandenburg noted the PPA market of $250 billion or $260 billion is historically around 35% of the total P/C insurance industry. The total PPA market usually rises from 3% to 8% in premium, but premium fell nearly 2% in 2020, with a 7% increase in 2021. The 10-year average loss ratio for the PPA industry as a whole was 65%, with 2020 under 56%, and 2021 at 68%. The combined ratio was about 101%, with 2020 at a 92.5% combined ratio. Mr. Brandenburg said it is expected that 2021 will see a combined ratio above 100%.

Mr. Brandenburg said the NAIC’s annual Report on Profitability By Line By State (Profitability Report) is produced later in the year, so 2021 results are not available. However, he said the average return on net worth (RNW) for the PPA line as a whole is 4.86%. He said the years 2018–2020 were above average, with 2020 coming in at 10.2% RNW. It is expected 2021 RNW decrease, and that number will be shared with the Committee when available.

Mr. Brandenburg asked if the Committee would like additional quarterly data. He said the Annual Statement has quarterly data showing national loss ratios for PPA. In addition, the NAIC and states receive Fast Track data from statistical agents. The Fast Track data represents not all but a significant portion of the PPA industry and is received on a quarterly basis. Mr. Brandenburg said NAIC staff have created charts showing quarterly trending with frequency and severity figures. He noted the data is a snapshot in time and only a subset of larger writers within the market. He also said the Statistical Data (C) Working Group is reviewing the Statistical Handbook of Data Available to Insurance Regulators, which describes statistical data submitted to states.

Director Fox said state insurance regulators would find value in reviewing quarterly data especially related to reduced driving and whether there has been an increase in automobile part costs.

Mr. Chou asked if NAIC staff would be working with the Statistical Data (C) Working Group to update average premium figures. Mr. Brandenburg said the NAIC publishes the Auto Report annually, which includes average auto premiums by state, and the Statistical Data (C) Working Group is considering changes that would move the publication of those figures up.

Binny Birnbaum (Center for Economic Justice—CEJ) said the CEJ and the Consumer Federation of America (CFA) reported at the Property and Casualty Insurance (C) Committee meeting in December 2021 that the auto insurance industry had received windfall profits. He said industry results can be deceptive because they combine mutual insurer results with publicly traded insurers. He said the industry focuses on increasing claim costs when convenient, but it does not talk about a decrease in claims such as in 2020. He also said the industry receives additional premium as vehicle values increase. He said the windfall profits of 2020 were not offset by 2021 and 2022. He noted that insurers asked for rate increases in 2021 and that insurers did not lose money in 2021 or 2022. Mr. Birnbaum said state insurance regulators need improved data and authorities to prevent future windfall profits.

Director Fox asked about profitability results and the relationship between premium and claims and distinguishing between what came from premium compared to investment income. Mr. Birnbaum said combined ratios have other expenses included but not profits from investment income. He said investment income has been relatively stable and does not change dramatically.

4. Heard a Presentation Related to the Effects of Inflation on Auto and Homeowners Lines

Susanna Gotsch (CCC Intelligent Solutions) said CCC Intelligent Solutions is a software as a service (Saas) provider that handles repair costs in auto physical damage claims. She said the COVID-19 pandemic saw a significant drop-off in driving, with a greater than 13% decline in miles driven in 2020. She said miles driven recovered throughout 2021 and exceeded pre-pandemic levels. She said CCC processed about 12 million claims in 2021, where a normal year pre-pandemic would see about 16 million claims. She said claims continue to increase.
Ms. Gotsch said a claim often flags whether a vehicle is drivable or not because a non-drivable vehicle will typically see average repair costs of around $6,000 compared to around $3,000 for a drivable vehicle. During the pandemic, the industry started to see a steady uptick in the percent of claims that were non-drivable losses, with higher repair costs. She said vehicle repair costs climbed more than 9% in 2021. She noted a lot of these increases have to do with a changing vehicle fleet and the content of those vehicles with more expensive components within the vehicle. She said the average new vehicle contains more than 100 semiconductor chips. She noted that raw materials costs have been increasing, with average costs paid per auto part up more than 8%. She also explained that supply chain disruptions and the Russian invasion of Ukraine are adding significant cost pressures to the average replacement part.

Ms. Gotsch said the benefits of the advanced driver-assistance systems (ADAS) have become less beneficial because of congested roads and higher speeds. She said 96% of repair shops have a backlog for repairs. She said used vehicle values will remain elevated and that the cost of total loss claims showed a 25% increase in 2021. She noted that the auto insurance industry is seeing more distracted driving, higher speeds, and more severe injuries.

Robert Hartwig (University of South Carolina) said the year-over-year (YOY) inflation rate was 7.5% in January 2022, with February at 7.9%, the highest figure in 40 years. He said the personal auto claims severity is as high as it has been over the past several decades. He also noted people are driving more and involved in more accidents. He said police departments are showing an increase in excess speed and substance abuse.

Mr. Hartwig said PPA loss ratios have increased quickly throughout 2021 in each quarter. The physical damage loss ratio has increased quickly after falling in 2020. The homeowners loss ratio has increased by 15 points since 2019 and in 2021 was 12.8 points higher than the all-property and casualty lines average.

Mr. Hartwig said lumber and wood product prices have more than doubled from pre-COVID-19 and have come down about a third since then. He also explained investment yields in 2021 were depressed, down about 2.6% in the first three quarters of 2021, the lowest figures since 1960. Net investment income has dropped about 12% since 2018. He said P/C insurance profitability is significantly below that of the Fortune 500 companies. The ratio of premium to policyholder surplus is relatively stable over time. Inflation-adjusted insured catastrophe losses have increased over the past five years, which is driving up the cost of property insurance. The P/C insurance industry is experiencing a sharp increase in claim severities affecting property, liability, and auto coverages. Mr. Hartwig noted inflation, catastrophe losses, demand surge, and increased dangerous driving behaviors are all contributing to the increase in severities and loss ratios. Investment income has been falling in recent years. He said rate adequacy is a concern. He noted insurers use current trend data to develop rates prospectively, hence the pressure to adjust rates accordingly.

Commissioner Mulready asked what state insurance regulators could do help navigate these sharp increases in costs.

Mr. Hartwig said some of the things are beyond control, such as the decrease in seatbelt use and increase in excessive speeding. He said there is hope that new technologies will decrease accidents, but this also leads to more expensive repairs. Ms. Gotsch said though driver-assistance features improve safety, they also increase driver distraction generally.

Commissioner McVey said state insurance regulators can provide additional consumer education about how people can reduce their claims through human behavior. He asked whether there would be some stabilization in the inflation rate. Ms. Gotsch said the semiconductor shortage has caused a decline in new vehicle production, which has put more people into the used vehicle market and has driven up the cost of U.S. vehicle prices. Mr. Hartwig said eventually inflation will come down from current levels, but wages and prices will normalize at a new, higher level.
Mr. Chou asked about bodily injury severity increasing by 14%, while physical damage increased 6.7%. Mr. Hartwig said bodily injury is most heavily influenced by medical costs. He said more impaired driving and distracted driving will result in more severe accidents.

Mr. McKenney said the data he has seen shows an increase in severity but declines in accident frequency. He said a decrease in severity does not usually offset the decline in frequency on the liability side. He said liability also has limits, which means severity has a limited impact. He said he believes insurers should not just increase rates on everyone, particularly those with lower limits who are not contributing to the increased severity. He noted that loss ratios are the most misunderstood statistic in actuarial science as they represent so many different things.

5. Discussed its Charge Related to Parametric Insurance Products

Commissioner Chaney said the Committee has a charge related to parametric insurance products that asks the Committee to provide a forum for discussing issues related to parametric insurance and to consider the development of a white paper or regulatory guidance. He said the Committee will hear from parametric insurance providers in the future. In addition, the Climate and Resiliency (EX) Task Force has a workstream looking at innovation that has heard from numerous parametric insurance providers related to climate risks. Commissioner Chaney said NAIC staff will look at those presentations and begin to create a document that would summarize the various products being introduced in the market along with some potential regulatory issues. He said the Committee will begin to work on a white paper related to parametric insurance with a goal of drafting a paper in 2022.

6. Heard a Presentation on Gun Owners Liability

Peter Kochenburger (University of Connecticut School of Law) said San Jose, California, recently passed an ordinance requiring residents who possess guns to have liability insurance to cover accidental gun deaths. He said the number of firearm deaths and injuries have increased in the past few years. He noted the idea of the ordinance is that by requiring gun owners to have insurance, this will lead to insurers to study the risk and ask the questions necessary to evaluate whether a gun owner is storing and using the gun in the safest manner possible.

Mr. Kochenburger said the ordinance includes a $25 fee and requires the gun owner to maintain a liability policy that specifically covers losses resulting from the accidental use of the firearm. Mr. Kochenburger said the provision has been challenged in court. He noted that virtually all homeowners and renters policies currently cover the accidental usage of firearms. In 2020, 95% of gun deaths were suicides and homicides and accidental discharges account for only 1.2% of all deaths. He said using the traditional functions of insurance to address a social problem has been done before, but this particular ordinance is not likely to be very effective. He also noted that it injects insurers into a contentious public policy debate.

7. Heard a Federal Update

Brooke Stringer (NAIC) said the NAIC attended a virtual roundtable with Republican committee members, insurers, and policyholders to discuss pandemic risk insurance. The NAIC submitted a statement for the record supporting the development of a federal business interruption mechanism provided it does not undermine regulatory authorities, jeopardize insurer financial condition, and is otherwise affordable to policyholders. The NAIC has not taken a position on any specific proposal at this time. No Republicans support Rep. Carolyn B. Maloney’s (D-NY) Pandemic Risk Insurance Act (PRIA) (H.R. 5823), which would establish a federal Pandemic Risk Reinsurance Program to provide a system of shared public and private compensation for business interruption (BI) losses resulting from a pandemic, subject to certain conditions, deductibles, and caps. The NAIC will continue to monitor proposals, but given the insurance trades’ opposition to PRIA, Republican opposition to the bill, and significant
funding with the pandemic and infrastructure bills, there may not be much of an appetite for developing such a new federal program at this time.

Ms. Stringer said NAIC staff have met with the staff of Rep. Maxine Waters (D-CA), chair of the U.S. House Committee on Financial Services, to discuss the House Subcommittee on Diversity and Inclusion’s plans to study the insurance industry. They have previously produced reports on banks/investment firms. She noted that the insurance industry has begun to receive letters, and the Subcommittee hopes to have a report finalized before the elections.

Ms. Stringer reported that the FIO is preparing an auto insurance availability and affordability report for Congress focusing on underserved communities and the impact of non-driving factors. The FIO issued a request for information in 2021 soliciting input as follow up to its 2017 report.

Ms. Stringer said the staff of Sen. Sherrod Brown (D-OH), chair of the U.S. Senate Committee on Banking, Housing, and Urban Affairs, are drafting a bill to expand the federal Liability Risk Retention Act (LRRA) to allow risk retention groups (RRGs) to sell property insurance provided they serve nonprofits and meet certain other requirements. The NAIC continues to raise concerns and provided information on the regulatory authorities (particularly non-domiciliary state authorities) that would be preempted by such an expansion.

Ms. Stringer said that in February, the House passed the SAFE Banking Act as part of the America COMPETES Act to provide a safe harbor from violations of federal law for those engaged in the business of insurance participating in cannabis industry activity that is permissible under state law.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 24, 2022. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Jennifer Bruce (AR); Angela King (DC); Christina Miller (DE); C.J. Metcalf (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov (NV); Raven Collins (OR); Sebastian Conforto (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Isabelle Turpin Keiser (VT); and Michael Walker (WA).

1. Adopted its 2021 Fall National Meeting Minutes

The Working Group met Dec. 1, 2021, and took the following action: 1) adopted its Oct. 21, 2021, minutes; 2) received a status report on the drafting of the updated Understanding the Market for Cannabis Insurance white paper; 3) discussed the potential to collaborate with the Producer Licensing (D) Task Force; 4) heard a presentation from the University of Colorado on emerging scientific issues in the cannabis space; and 5) heard a presentation from the Cannabis Regulators Association (CANNRA) on cannabis policy and regulation trends.

Mr. Currier made a motion, seconded by Ms. Brown, to adopt the Working Group’s Dec. 1, 2021, minutes (see NAIC Proceedings – Fall 2021, Property and Casualty Insurance (C) Committee, Attachment Two). The motion passed unanimously.

2. Heard a Presentation on the State of the Union in the Cannabis Insurance Industry

Erich Schutz (Jencap Specialty Insurance Services) stated that the cannabis space is experiencing massive growth, with sales expected to exceed $30 billion in 2022. There is a wide breadth of cannabis insurance products, but depth is an issue. For instance, there are only a few carriers writing cyber coverage. Putting together a $75 million property tower for a single location is not uncommon, but it is very difficult to do. Some carriers do not offer high enough limits on equipment breakdown. Workers’ compensation and auto coverage vary by state. Michigan and Massachusetts are good examples of states that have very robust assigned risk pools for both coverages. Other states do not have as many options. For example, auto placement in California is difficult, expensive, and often has coverage gaps. The reinsurance marketplace is limited in the cannabis space. There are approximately eight A-rated package markets writing leaf touching cannabis coverage currently supported by only two to three reinsurers of that population. Several of the markets are very conservative with catastrophe wind and will put a named source storm exclusion on any property policy written anywhere on the eastern seaboard. It is a big issue because this exclusion will apply to properties that are 150 miles inland from the coast. Parametric insurance is the only coverage available for outdoor crop, which is not practical or cost prohibitive. Federal outdoor crop insurance will not include marijuana until it is federally legalized or decriminalized. The market has not responded yet to the need for multiple coverages to be written by one market. For delivery-only risk, different markets will write the liability and products coverages. Likewise, coverages for premises (social) consumption are usually broken up among more than one carrier. The market for directors and officers’ coverage has doubled in capacity over the last 18 months to approximately 12 players. However, this does not address the needs of the many small mom and pop growers who need more robust and affordable liability coverages. Additionally, many of the smaller operations do not take up coverages unless it is mandated. Michigan has a law that all cannabis license holders must have $100,000 of product liability coverage with no exclusions. If the licensee operates in both the recreation and medical cannabis space, then they must have $100,000 for each. A specific carrier began offering a policy that
specified $100,000 had no exclusions to meet this need. The dram shop law, passed in the last year, states that a person is financially responsible for any bodily injury or property damage they incur while consuming cannabis. The law stipulates the coverage must be on admitted paper, which is limited at best.

Jodi Green (Miller Nash LLP) stated that the 2018 Farm Bill removed hemp, defined as cannabis and derivatives of cannabis with extremely low concentrations of the psychoactive compound delta-9-tetrahydrocannabinol (THC) (no more than 0.3% THC), from the definition of marijuana in the Controlled Substances Act (CSA). This created nuances that led to the development of an additional gray market for minor cannabinoids such as delta-8 and delta-10. Cannabinoids are naturally occurring in very small quantities in the plant. They are created by converting cannabinoids (CBD) and distillate into delta-8 or delta-10. Companies are creating minor cannabinoids because they have psychoactive affects and present a way to bypass federal law. Some state jurisdictions have banned these compounds entirely, and others have not addressed it. This inconsistent legal standing has created confusion among companies as to how these products can or cannot be sold.

The industry is maturing, with medical cannabis legal in 39 states and adult-use cannabis legal in 19 states. There are several federal bills pending that are attempting to fully legalize marijuana. The Secure and Fair Enforcement (SAFE) Banking Act of 2021 is attempting to create insurance regulations that will insulate insurance providers from federal prosecution. These federal bills are unlikely to pass this year, but there will be new states passing medical or recreational-use marijuana legislation. Regulations vary by state and locality, which makes it difficult for operators to comply with regulations and ties into carriers’ reluctance to offer coverage in the cannabis space. As the cannabis industry has matured, companies have felt safer to enforce their right under state law. This has led to more litigation. There have been many corporate governance lawsuits. Product liability lawsuits may come to the forefront given the numerous state product recalls. The largest product liability claims have come from a handful of lawsuits against Pure Leaf for mixing up their CBD and THC products, which resulted in consumers unknowingly consuming psychoactive products. This highlights the importance of liability coverage and adequate risk management in the industry. There have also been several employment lawsuits related to employee pay for time spent dining, golfing, or changing clothing. This highlights the need for more education on compliance protocols within the industry. There has been an uptick in cyber claims over the past year related to the collection and storage of customer information in the cloud. Rising risks from wildfires in places such as California and Colorado highlight the need for coverage of water, fire, and smoke damage. There have been significant theft issues, especially in Washington and California with armed robberies. There have been intellectual property lawsuits involving copyright or trademark infringement of products that are being sold. For instance, there were edibles resembling Skittles or other candies around Halloween that created concern for children’s safety. Environmental claims arise from using different solvents, chemicals, and pesticides in crop production. There have also been lawsuits related to California Prop 65, which requires companies to disclose the levels of certain harmful chemicals inherent in the product on its label.

Carriers are now paying claims, unlike five years earlier when many denied coverages. For instance, Hannover paid a couple claims in excess of $1 million. The health hazard exclusion is highly problematic. Carriers have sought to deny coverage for bodily injury and other claims based on this exclusion. Carriers also deny based on cannabis exclusions. There should be a carve-out on policies with these exclusions for companies that are operating in compliance with state law. Claims are frequently denied based on protective safeguard requirements, such as a certain number of cameras. There is not an issue with the amount of coverage available in the market but with the quality of the coverage. Carriers need to be educated that the minimum limits available under state law are designated for licensing requirements and are not meant to be what companies should be getting. There have been several lawsuits involving manufacturers and malfunctioning vaping products where the battery exploded and caused injury. Yet, one of the biggest failures throughout the cannabis industry is the continued lack of products coverage. Broker education is needed on this.
Ms. Brown asked what Mr. Schutz has heard about the homeowners residual market, as Colorado has recently heard about issues with the homeowners Fair Access to Insurance Requirements (FAIR) plans excluding marijuana. Mr. Schutz said he has seen this occurring in the Massachusetts risk pools, as well as the residual markets. This is a large concern, as residual markets are the markets of last resort.

Ms. Michael asked Ms. Green to elaborate on why she is not optimistic about the passing of a federal bill this year. Ms. Green stated that her views reflect that most pending bills are just iterations of earlier bills. The cannabis industry itself has not fully supported any one bill, as it is fragmented in terms of supporting piecemeal or wholistic legislation. Mr. Schutz stated that the political climate is not conducive to a bill passing in part due to the focus on Ukraine.

Mr. Currier asked for more information on the named storm exclusions and what could be done to create a reinsurance market short of federal legalization. Mr. Schutz stated that there is a limited pool of reinsurers. Education and advocacy are the best path forward until federal legalization. Brokers and carriers need to understand how well built the risk profiles are of the insureds who are in compliance with the law but are rated as if they are a higher risk because of the negative perception of the cannabis industry.

Ms. Michael asked what led to the doubling of directors and officers (D&O) coverage over the last year. Mr. Schutz said it’s a social equity issue. Most cannabis companies are either of a size they don’t need this coverage or they are in greater need of other coverages. However, carriers only heard from the people with deep pockets sitting on corporate boards about needing this coverage. Ms. Green said she agreed that the large corporate companies were pushing for this and it’s not helpful to small operators lacking basic coverage because its too costly.

3. **Heard a Report on Federal Cannabis-Related Legislative Activities from NAIC Staff**

Brooke Stringer (NAIC) stated that the NAIC is on record supporting both the SAFE Banking Act and the Clarifying Law Around Insurance of Marijuana (CLAIM) Act. The U.S. House of Representatives (House) passed the SAFE Banking Act last month for the sixth time on a bipartisan basis. It was added as an amendment to the American Competitiveness Of a More Productive Emerging Tech Economy Act (COMPETE) Act. Congressman Ed Perlmutter (D-CO) has been a strong supporter and advocate on this legislation for the SAFE Banking Act and will soon be retiring. U.S. Speaker of the House Nancy Pelosi has promised to advocate for legislation when the House conferences with the U.S. Senate (Senate) because the Senate has passed the COMPETE Act without the SAFE Banking Act in it. However, both leaders of the Senate do not support the SAFE Banking Act for assorted reasons. The SAFE Banking Act is not likely to pass because there is concern that a piecemeal approach will not be sufficient to address the issues.

4. **Discussed its 2022 Work Plan**

Ms. Michael stated that there would not be time to discuss its 2022 work plan. She requested that feedback on the plan be sent to NAIC staff. The work plan includes monitoring cannabis-related federal legislation, finishing updates on and moving for adoption of the *Understanding the Market for Cannabis Insurance* white paper by the Fall National Meeting, and hearing presentations and panel discussions on emerging issues.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
Catastrophe Insurance (C) Working Group
and the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group
Kansas City, Missouri
April 4, 2022

The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met in Kansas City, MO, April 4, 2022, in joint session with the NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee. The following Working Group members participated: David Altmaier, Chair, and Susanne Murphy (FL); Mike Causey, Vice Chair, represented by Tracy Biehn (NC); Mike Causey, Vice Chair, represented by Tracy Biehn (NC); Brian Powell, Alan McClain (AR); Lucy Jabourian (CA); George Bradner and Wanchin Chou (CT); Travis Grassel (IA); Shannon Whalen (IL); Julie Holmes (KS); Matthew Mancini (MA); Joy Hatchette (MD); Jo LeDuc (MO); Mike Chaney (MS); Tom Botsko (OH); Glen Mulready (OK); Brian Fordham and Trisha Goldsmith (OR); David Buono, Shannen Logue, and Katie Merritt (PA); Alexander S. Adams Vega (PR); Stephanie Cope (TN); Mark Worman (TX); Brian Welch (WA); and Allan L. McVey (WV). The following Advisory Group members participated: Glen Mulready, Chair (OK); Carter Lawrence, Vice Chair, represented by Stephanie Cope (TN); Brian Powell (AL); Lucy Jabourian (CA); George Bradner and Wanchin Chou (CT); Travis Grassel (IA); Amy L. Bearn (IN); Julie Holmes (KS); Joy Hatchette (MD); Jo LeDuc (MO); Brian Fordham and Trisha Goldsmith (OR); Marly Santoro (VA); Brian Welch (WA); and Allan L. McVey (WV).

1. **Adopted the Working Group’s and Advisory Group’s Minutes**

Mr. Botsko made a motion, seconded by Ms. Cope, to adopt the Working Group’s March 4 minutes (Attachment Two-A) and the Advisory Group’s March 25 minutes (Attachment Two-B). The motion passed unanimously.

2. **Heard an Update on Federal Legislation**

Patrick Celestine (NAIC) said the National Flood Insurance Program (NFIP) is operating under an extension through Sept. 30, and the NAIC continues to reiterate support for a long-term reauthorization.

While there has not been much progress on a long-term reauthorization, there have been some reauthorization bills introduced. The NFIP Reauthorization and Reform Act of 2021 has been introduced in both the U.S. House of Representatives (House) and the U.S. Senate (Senate). This bill would allow for a five-year reauthorization, cap annual rate increases at 9% (compared to the current 18%), cap the Write Your Own (WYO) compensation at 22.46% of written premiums (versus the current 30%), and require each agent that sells NFIP policies to complete a three-hour continuing education (CE) course every two years. The CE course would need to be approved by the insurance commissioner in the state where the agent is a legal resident.

Mr. Celestine said the Continuous Coverage for Flood Insurance Act has also been introduced in both the House and the Senate. This bill would clarify that a flood insurance policy purchased in the private market would count as “continuous coverage” under the terms of the NFIP. Therefore, policyholders could return to the NFIP without losing any previous subsidy.

Mr. Celestine said FEMA began phase two of its implementation of Risk Rating 2.0. Policies renewing on or after April 1 will be issued under Risk Rating 2.0. A bipartisan group of coastal senators unsuccessfully advocated postponing the implementation of Risk Rating 2.0, warning FEMA about the impact of premium increases. This will remain a key issue for the reauthorization of the NFIP.
Mr. Celestine said the Flood Insurance Pricing Transparency Act was introduced in the Senate. This bill would require FEMA to publish the formulas used to calculate mitigation credits for policyholders under Risk Rating 2.0. The bill would also require FEMA to release a toolkit that could be used to estimate the cost of insurance for new construction, without compromising proprietary information.

Lastly, Mr. Celestine said the Senate Committee on Homeland Security and Governmental Affairs approved the Community Disaster Resilience Zones Act of 2022, advancing it to the full Senate. Chairman Gary C. Peters (D-MI) and Ranking Member Rob Portman (R-OH) sponsored the bill. The Reinsurance Association of America (RAA) has also been a strong proponent of this bill. The bill would amend the Stafford Disaster Relief and Emergency Assistance Act to make permanent the National Risk Index, or a similar tool, and utilize its data to identify and designate community disaster resilience zone communities that are the most at risk to natural hazards. This would allow FEMA to identify what communities are most in need of assistance for mitigation projects.

Commissioner Mulready said a few weeks ago, Oklahoma had the privilege of hosting David Maurstad (FEMA) and the director of FEMA Region 6 in Tulsa, OK. He said Tulsa was one of only two communities in the country with the highest NFIP ratings based on a community rating system on a city’s stormwater management.

3. Discussed the *Catastrophe Computer Modeling Handbook* Updates

Commissioner Altmaier said the Working Group is charged with updating the *Catastrophe Computer Modeling Handbook* (Handbook). He said a drafting group consisting of several state insurance regulators has been formed, and the drafting group met last week to discuss a work plan for updating the Handbook. He said future drafting group calls will include interested parties that have expressed interest in attending these calls. He asked NAIC staff to provide and update of the drafting group’s meeting last week.

Sara Robben (NAIC) said the purpose of the Handbook is to serve as a guidebook for state insurance regulators to use. The drafting group discussed including sections in the Handbook that will encompass guidance for state insurance regulators in the areas of rates, forms, legal, etc. The intention of the Handbook is to steer away from theoretical information and provide guidelines for state insurance regulators. It is expected that the Handbook will cross-reference information with more technical information that can be found in the Society of Actuaries (SOA) documentation.

Ms. Robben said the drafting group also plans to send a survey to states, consisting of easy to answer questions regarding bulletins and regulations states have in place regarding catastrophe models. The drafting group hopes to put this information in the form of a chart with links to the actual document for easy reference.

Ms. Robben said anyone that has not yet joined the drafting group should reach out to her to be added to the list.

4. Heard an Update from the Iowa Insurance Division Regarding Recent Tornadoes

Mr. Grassel said Iowa has seen numerous catastrophic events in the last few years. He said these events included derechos, flooding, and severe convective storm activity most recently that caused some destructive tornadoes. He said these types of events appear to be happening with greater frequency.

Mr. Grassel said March was a turbulent month for many states. On March 5, there were at least 13 tornadoes reported, and one area of activity included an EF-4 strength tornado lasting approximately 90 minutes and stretching for approximately 70 miles. Mr. Grassel said the tornadoes resulted in at least seven fatalities and caused severe property damage. He said tornado wind speeds were reported to be as high as 170 miles per hour. Following the March 5 tornadoes, a snowstorm that produced three to five inches of snow occurred, which
hindered recovery efforts in the short-term. Mr. Grassel said Iowa’s Deputy Insurance Commissioner, Jared Kirby, experienced a direct hit to his home, causing extensive damage.

Mr. Grassel said hoping for the best, while preparing for the worst will ensure resiliency and safety when devastation strikes. He said building structurally strong homes and buildings or retrofitting homes and buildings make them more resistant to damage caused by severe convective storm activity. Wind resistant structures include a masonry home or reinforced building materials, including entrance doors, windows, roof, and garage doors. Stronger structures are more likely to be resilient during a severe wind event.

Mr. Grassel said the following items are important to do prior to a disaster: 1) know the safe space in your home; 2) make sure you have appropriate insurance from a reputable insurer; 3) periodically evaluate your insurance products and the coverage limits in your insurance policies; 4) read your insurance policy and speak with an insurance company representative or insurance agent with questions; and 5) annually record a home inventory to ensure proof of ownership for your belongings.

Amy Bach (United Policyholders) asked Mr. Grassel what type of deductibles they are seeing in Iowa regarding wind. Mr. Grassel said he does not have information on this specific event, but in the rate filings, they see higher deductibles and percentage deductibles for wind events. He said the deductibles have a range of $500 to $2,500.

5. Heard an Update from the TDCI Regarding Recent Catastrophic Events

Ms. Cope said flooding continues to be one of the largest issues for Tennessee consumers. She said the Tennessee Department of Commerce and Insurance (TDCI) has focused on education and outreach efforts regarding flooding in the past year.

Ms. Cope said the TDCI has an internal team that serves to process consumer complaints and educate communities. She said the team actively meets with local emergency planning committees in various counties throughout the state. Ms. Cope said the TDCI wants to ensure consumers understand the necessity of proper insurance coverage.

Ms. Cope said in the wake of the deadly Waverly floods, the TDCI set up disaster recovery centers in the affected areas. She said the TDCI wanted to be available for consumers on the spot, so they had what they needed when they needed it the most. She said due to the increased severity of natural catastrophes over the past few years, two counties became NFIP communities. She said the TDCI hopes this will encourage consumers to get the coverage they need.

Ms. Cope said after the tornadoes of 2020, the TDCI set up five claim centers across the state and requested that the top 10 insurance writers bring their catastrophe teams to handle claims on-site for their policyholders.

Ms. Cope said following the December 2021 tornadoes, the TDCI attended town hall meetings in Humphreys and Dresden counties. She said the TDCI consistently makes itself available to consumers, so consumers understand they have the support of the TDCI.

Ms. Cope said most recently, the TDCI responded to the wildfires near Gatlinburg, TN. She said over 100 structures were damaged, and more than 11,000 people were evacuated. As a result, the TDCI requested that insurers send representatives to the county fairgrounds to assist with on-site claims. Ms. Cope said Commissioner Lawrence and the Consumer Insurance Services team were at the site to help consumers with any claims and claims processing questions.
Ms. Cope said the TDCI believes in the power of educating consumers so they can make the best decisions for themselves and their families.

6. **Heard an Overview of FEMA Regional Meetings**

Commissioner Mulready said state insurance regulators have had several workshops with FEMA. The most recent workshop was held last year in a virtual format with FEMA Regions 8, 9, and 10. He said he has been told that state insurance regulators have enhanced their relationships with their FEMA colleagues as a result of these workshops.

Commissioner Mulready said FEMA Region 4 formed a working group following its FEMA workshop. This working group meets every other month with its FEMA colleagues to discuss issues related to disasters and make sure they are better prepared in advance of a disaster.

Commissioner Mulready said the Oklahoma Insurance Department will be hosting the FEMA Region 6 workshop on May 3 and May 4 in Oklahoma City, and invitations went out last week. He said attendees will be touring the National Weather Center in Norman, OK, on the evening of May 3.

Commissioner Mulready said any states wanting to conduct a workshop in their FEMA region could reach out to him or Aaron Brandenburg (NAIC).

7. **Received an Update on the NAIC Catastrophe Resource Center**

Ms. Robben said she would be reaching out to the departments of insurance (DOIs) to be sure the names on the catastrophe contact list are current. She asked states about what types of information are not on the web page that would be helpful to add. No one had any immediate comments. Commissioner Altmaier suggested that the NAIC send out a survey to Working Group and Advisory Group members to better meet the needs of the state insurance regulators.

Mr. Bradner said the Northeast Zone is reconvening a group of catastrophe contacts within each of the northeast state DOIs. He said they would be meeting sometime in April or May. He said in the past, some of the things they discussed included what is happening in each state regarding items such as hurricane deductibles, policy language changes, etc. He said if a catastrophic event approaches the Northeast, the group can hold a call to discuss what each state is doing to prepare for the event.

Having no further business, the Catastrophe Insurance (C) Working Group and the NAIC/FEMA (C) Advisory Group adjourned.
The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 4, 2022. The following Working Group members participated: David Altmaier, Chair, Alexis Bakofsky and Susanne Murphy (FL); Timothy Johnson, Vice Chair (NC); Shauna Nickel and Katie Hegland (AK); Jimmy Gunn and Brian Powell (AL); Jimmy Harris (AR); Ken Allen, Lucy Labourian, Giovanni Muzzarelli, Lisbeth Landsman-Smith, and Lynne Wehmueller (CA); George Bradner and Wanchin Chou (CT); Colin M. Hayashida and Roland Teruya (HI); Travis Grassel (IA); Judy Mottar (IL); Tate Flott, Brenda Johnson, and Julie Holmes (KS); James J. Donelon and Warren Byrd (LA); Caleb Huntington and Matthew Mancini (MA); Robert Baron, Ronald Coleman, Walter Dabrowski, and (MD); Cynthia Amann and Jo LeDuc (MO); Cuc Nguyen and Andrew Schallhorn (OK); Ying Liu (OR); David Buono (PA); Elizabeth Kelleher Dwyer, Segun Daramola, and Beth Vollucci (RI); Stephanie Cope and Vickie Trice (TN); and Marianne Baker, J’ne Byckovski, and Mark Worman (TX). Also participating were: Linda Grant (IN); Sandra Anderson (MN); Chris Aufenthie (ND); Gennady Stolyarov (NV); and Mary Block and Isabelle Turpin Keiser (VT).

1. **Adopted its 2021 Fall National Meeting Minutes**

   Commissioner Hayashida made a motion, seconded by Mr. Grassel, to adopt the Working Group’s Dec. 12, 2021, minutes (*see NAIC Proceedings – Fall 2021, Property and Casualty Insurance (C) Committee, Attachment Three*). The motion passed unanimously.

2. **Heard a Presentation Regarding a Survey to States About the Catastrophe Modeling Handbook**

   Sara Robben (NAIC) said a survey regarding the NAIC *Catastrophe Modeling Handbook* (Handbook) was sent out to states late last year. The purpose of the questionnaire was to help aid the Working Group in determining what information to include in the Handbook to make it a useful tool for state insurance regulators. Ms. Robben said 22 states responded to the survey.

   The survey results indicated that 20 of the 22 states responding to the survey indicated that it would be helpful to add information on more perils. Currently, the Handbook includes the perils of earthquake and hurricane. The survey indicated that states would like to see the perils of flood; wildfire; convective storms; and other perils like cyber, terrorism, and winter storms in this order.

   The survey asked states if they had any state-specific filing requirements for catastrophe models. Seven of the 22 states responding indicated that they had specific requirements. This included some states having regulations and others issuing bulletins. Some states allow catastrophe models only for specific perils and have specific requirements.

   The survey asked each state if they coordinated with any other state regarding catastrophe models. Three of the states surveyed said they coordinate with other states regarding the use of catastrophe models, and 19 indicated that they do not coordinate with other states. Comments included:

   - If the state is aware of another state having the same or a similar model filed, it will contact that state.
   - A state used an actuarial firm for its 2020–2021 model review that subcontracted with experts who routinely work with the Florida Commission on Hurricane Loss Projection Methodology.
A state indicated that it works with other states in the Northeast Zone.

The survey asked each state the percentage of rate filings received that referenced a catastrophe model. Seventeen states indicated 0–25%, four states indicated 25–50%, and one state indicated 75–100%. Most of the states fall into the 0–25% category.

The survey also asked questions regarding the number of staff and amount of time staff spent on reviewing filings referencing a catastrophe model. These numbers correlated with the percentage of filings.

The survey asked if states used any tools in evaluating a catastrophe model. Three of the 22 states indicated that they used tools for evaluating a catastrophe model. These tools included the use of outside actuarial consulting firms, a standard support checklist, and the Florida Commission on Hurricane Loss Projection Methodology.

The survey indicated that three of the 22 states utilize the Handbook; however, several states indicated that they were not aware of the Handbook’s existence. The three states that utilize the Handbook indicated that they use it as a reference guide or to better understand how such modeling might be occurring and how it might be a part of a rate filing.

The survey asked if the following sections would be helpful to state insurance regulators:

- Section 3: General Overview of Catastrophe Models
- Section 4: Model Input Provided by Company
- Section 5: Model Output
- Section 6: Model Validation and Update

Twenty-one of the 22 states surveyed indicated that all these sections would be helpful.

The survey asked states if they used the questions in Section 7 of the Handbook when evaluating filings for catastrophe models. Eight states indicated that they use the questions, and five states indicated that they use some of the questions but not all of them.

The survey indicated that state insurance regulators would like to see the following tools:

- A set of questions for financial examiners.
- A set of questions for reviewers.
- A set of questions to understand the impact of climate risk on the insurer.
- A standard support checklist and to be able to send models to an NAIC review team, as needed.

Ms. Robben asked that any state that still wants to fill out the survey reach out to her for a link.

Mr. Chou asked which state answered 75–100% regarding rate filings referencing a catastrophe model. Ms. Robben said she would have to go back to the survey to see which state answered 75–100%. Since this meeting, the state that indicated the 75–100% reached out to the NAIC and said this was reported in error. Ms. Robben also said she would create a matrix of state answers for Working Group members.
3. **Discussed Next Steps Regarding the *Catastrophe Modeling Handbook***

Commissioner Altmaier said the survey responses indicated that the Handbook was not being used by many states. He said it was notable that not all state insurance regulators were aware of the existence of the Handbook. He said not only is this a timely opportunity to update the Handbook, but it is also an opportunity to raise awareness about the Handbook. Catastrophe events have grown in number and size, and there will likely be an increased use of catastrophe models, if not for ratemaking, in Own Risk and Solvency Assessments (ORSAs) and other tools.

Currently, the Handbook includes the following sections:

- Purpose and Background
- Selected Catastrophe Perils (Earthquake and Hurricane)
- A General Overview of Catastrophe Models
- Model Input Provided by Company
- Model Output
- Model Validation and Update
- Evaluating Models
- Regulatory Review and Acceptance
- Related Activities, Activities to Consider

Commissioner Altmaier said he believes everyone is aware of the establishment of a catastrophe model center of excellence (COE). He said while the COE has not yet been adopted, if adopted, its role would be to:

- Facilitate insurance department access to catastrophe modeling documentation and assistance distilling the information.
- Provide general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures.
- Conducting applied research analysis utilizing various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed for regulatory resilience priorities.

Commissioner Altmaier said it is important to note that the support services anticipated to be offered through the COE are not going to take the place of individual state department of insurance (DOI) activities involving catastrophe models. He said for example, the COE would not be approving vendor models and items of that nature, as the COE is intended to be a resource.

Commissioner Altmaier asked the Working Group what sections of the Handbook it feels should be retained in an updated Handbook and what kind of topics would best be covered in more detail through the COE if it is adopted.

Mr. Grassel said there is a broad evaluation in the catastrophe models being discussed. He said it makes sense that the COE would do more in-depth work, and there is some application in whether we are discussing market conduct reviews or rate review filings. He said catastrophe models affect several different areas for DOIs, so he believes this is something state insurance regulators should keep in mind going forward.

Commissioner Altmaier said the selected catastrophe perils currently included in the Handbook are earthquake and hurricane. He said flood is becoming the most prominent catastrophe across the country, and many states, including Florida, are in the process of reviewing new commercial models for flood insurance. He said the Working Group might want to consider whether to incorporate some information regarding flood models in the Handbook update.
Commissioner Altmaier said the Catastrophe Risk (E) Subgroup is working to develop catastrophe charges for the peril of wildfire. He said one of the challenges the Working Group has had is that wildfire models are not as robust as hurricane and earthquake models. He said it may be worthwhile to determine if wildfire models fit into the Handbook as well.

Mr. Chou said the Catastrophe Risk (E) Subgroup has adopted the wildfire peril as informational only. He said the Subgroup is still in discussion regarding the peril it will discuss next.

Commissioner Altmaier said he would also bring some focus to the sections of the Handbook regarding the input that goes into a catastrophe model. He said there is a commonly quoted phrase, “garbage in, garbage out.” He said he believes it is important for state insurance regulators to have a thorough understanding of what goes into a model, so it makes sense to spend some time evaluating this section of the Handbook. He said the Working Group should evaluate what information belongs in the Handbook and what information would be more suited to the COE.

Commissioner Altmaier said states have a variety of different processes regarding catastrophe modeling. He said some states have a formal process, while others do not. He said Florida uses the “Hurricane Loss Projection Methodology,” and Louisiana requires that insurers send in a narrative about the rationale behind the models they are using. He asked the Working Group if it would be helpful to consider compiling a list of bulletins or regulations around the country to help understand the similarities and differences between state approaches to the use of catastrophe models. This could be added as an appendix to the Handbook. Other states agreed.

Commissioner Altmaier said one of the things he found interesting is that many times, the way direct writers use catastrophe models is different from how reinsurers use catastrophe models. He said reinsurers will typically have more flexibility since they fall under regulatory jurisdictions outside of the U.S. He said reinsurance rates are oftentimes not subject to regulatory approval, so they have more flexibility regarding how they use catastrophe models. He suggested that the Working Group might consider hearing some presentations and feedback from reinsurers about how they use catastrophe models. This information could be incorporated into the Handbook if the Working Group deems it helpful. Mr. Grassel said he believes this would be helpful because reinsurers play a much bigger role.

Commissioner Altmaier said the Working Group will form a drafting group based on state insurance regulators that have previously volunteered and add any state insurance regulators that would like to volunteer to be a part of the drafting group. He asked state insurance regulators interested in participating to email NAIC staff.

NAIC staff asked states that have a set of questions regarding perils to please forward those to the NAIC.

Having no further business, the Catastrophe Insurance (C) Working Group adjourned.
The NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met March 25, 2022. The following Advisory Group members participated: Glen Mulready, Chair (OK); Carter Lawrence, Vice Chair (TN); Chad Bennett and Katie Hegland (AK); Dan Gates (AL); Ken Allen (CA); George Bradner (CT); Susanne Murphy (FL); Travis Grassel (IA); Kate Kixmiller (IN); Tate Flott, Brenda Johnson, and Craig VanAalst (KS); James J. Donelon and Warren Byrd (LA); Joy Hatchette (MD); Jo LeDuc (MO); David Dahl and James T. Thompson (OR); Beth Vollucci (RI); and Marc McLaughlin (VA).

1. **Heard a Presentation Regarding the NFIP’s Risk Rating 2.0**

Doug Iannarelli (FEMA) said the National Flood Insurance Program’s (NFIP’s) Risk Rating 2.0 was rolled out in a phased approach. New business policies began to be written with the Risk Rating 2.0 rating methodology on Oct. 1, 2021. Mr. Iannarelli said existing policyholders could move into Risk Rating 2.0 if they chose to. Beginning on April 1, existing policyholders will be transitioned into Risk Rating 2.0. Mr. Iannarelli said agents are saying Risk Rating 2.0 is a new quoting experience. In general, trends in premium changes are what FEMA had expected.

Mr. Iannarelli said consumers are inquiring about the new rating variables. FEMA has trained over 31,000 agents about Risk Rating 2.0. Agents and consumers asked about elevation certificates and whether flood zones still matter. Commissioner Mulready said he attended the FEMA training and encouraged other state insurance regulators to do so.

Mr. Iannarelli said state insurance regulators should visit the Risk Rating 2.0 website, which has information about changes in rates by county and ZIP code and how the rating structure is designed. He asked commissioners to encourage consumers to talk to their agent. He said Risk Rating 2.0 does not require an elevation certificate, as was required before, but policyholders can provide an elevation certificate, and it will be used if it reduces their premium. Mr. McLaughlin asked why an elevation certificate is not factored in unless a policyholder wants it to be if Risk Rating 2.0 accurately reflects risk. Mr. Iannarelli said the ground elevation is looked at, as well as the first-floor height of the building using different data sources, but if a surveyor determines the ground elevation and that provides better information, then that information will be used to rate the policy.

2. **Heard a Presentation Related to FEMA’s CRS**

Commissioner Mulready said the city of Tulsa, OK, recently achieved a “1” rating in FEMA’s Community Rating System (CRS), becoming only the second city to do so. Bill Lesser (FEMA) said the NFIP and the NAIC have shared ambitions in terms of serving consumers and ensuring that insurance is available. He said the CRS was created in 1990 as a way for communities to receive NFIP premium discounts if their community is implementing floodplain management practices that exceed the minimum requirements, like building code enforcement, regulatory provisions, and public information. He said the CRS was modeled after the fire rating system used by insurance companies.

Mr. Lesser said participation in the CRS is voluntary. There are about 22,500 communities in the NFIP nationwide, and about 1,500 communities are in the CRS. He said those 1,500 communities include the highest risk flood communities, leading to about 75% of all NFIP policies being in CRS communities. He said the CRS Coordinator’s Manual describes all aspects of the community’s participation, including how many points communities can
receive in the many different floodplain management activities. The goals of the program are to reduce and avoid flood damage to insurable property, strengthen and support certain insurance aspects of the NFIP, and foster comprehensive floodplain management.

Mr. Lesser said there are 10 classes within the CRS, with each class receiving a percentage discount on NFIP policies. He said Class “1” policyholders receive almost a 50% premium discount. He mentioned four broad categories of activities within the CRS: 1) public information; 2) mapping and regulations; 3) flood damage reduction; and 4) warning and response. Credits for flood insurance promotion can be achieved by working with agents or forming a committee to promote flood insurance, which supports the FEMA objective of closing the insurance gap. He noted that CRS communities are across the nation, and about 20 have achieved a 1–4 class rating.

Mr. Lesser said under Risk Rating 2.0, all policyholders will receive a premium discount if their community participates in the CRS, not just those in the Special Flood Hazard Area (SFHA). He said the growth of interest in the CRS is likely to lead to more affordable flood insurance.

Mr. Lesser said state insurance commissioners can become informed about CRS participation in their state, connect with the state office of the NFIP state coordinator, connect with the Association of State Floodplain Managers (ASFPM), and develop a CRS participation messaging platform within their state.

Mr. Grassel asked what Tulsa has done to help achieve CRS credits. Mr. Bradner said he hears from communities that there is a lot of work that goes into achieving a high score. Commissioner Mulready said Tulsa experienced devastating flooding decades ago, which motivated the community to act. He said it took many years to achieve the CRS Class “1” rating. He said Tulsa has made a lot of flood control and infrastructure improvements.

Mr. Lesser said most communities in the top four classes have experienced devastating flooding, sometimes more than once. He said Tulsa bought out at-risk communities, which earned them credits. He also said communities often have a learning curve in the first year of being in the CRS. He said many training webinars are available for communities. He said there are groups of community coordinators who come together in user groups to share best practices, and this is very helpful for communities. Mr. Bradner said using the agent community might help communities achieve CRS classes. Mr. Lesser said some of the user groups have agents involved.

Jeff Czajkowski (NAIC) asked if there would be overlap between the CRS and Verisk’s Building Code Effectiveness Grading Schedule (BCEGS), where communities could leverage resources by participating in both programs. Mr. Lesser said there are communities that participate in both, and the CRS requires a minimum BCEGS score. He said it is important for communities that are flood prone to have building codes and be able to enforce protective floodplain management practices as it relates to buildings and methods of construction. Dale Thomure (Verisk) said there is overlap between credits in the CRS and the BCEGS. He said Verisk works closely with the CRS in leveraging those programs. He said building code enforcement and building code regulations go hand in hand with flood plain management and are highly variable from jurisdiction to jurisdiction. Mr. Czajkowski said states might be able to leverage resources across the programs, and state insurance regulators should look at both programs.

Mr. Lesser said a state insurance commissioner could be a voice to advocate for better building codes. He said some states have building codes that are both a maximum and minimum, so communities cannot enact building codes of a higher standard. Some communities are not able to adopt a minimum elevation about base flood elevation.
3. **Heard an Update on the Spring National Meeting**

Commissioner Mulready said the Catastrophe Insurance (C) Working Group and the Advisory Group will meet jointly on April 4 at the Spring National Meeting. He said the Working Group will receive an update from the drafting group making edits to the *Catastrophe Computer Modeling Handbook*. The Advisory Group will: 1) hear reports about upcoming and recent FEMA regional meetings; and 2) receive an update on the status of the NAIC’s Catastrophe Resource Center. Commissioner Mulready said states may also report on their response to recent catastrophes during the meeting.

Having no further business, the NAIC/FEMA (C) Advisory Group adjourned.
CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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The Casualty Actuarial and Statistical (C) Task Force met March 8, 2022. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Phil Vigliaturo (MN); Jim L. Ridling represented by Daniel Davis (AL); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Greg Jaynes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Anthony Bredel and Judy Mottar (IL); Amy L. Beard represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by Nichole Torbla (LA); Kathleen A. Brrane represented by Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Rick Cohen (NC); Chris Nicoloopulos represented by Christian Citarella (NH); Russell Toal and Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Kate Yang (OK); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Kevin Clark and Michael McKenney (PA); Raymond G. Farmer represented by Will Davis (SC); Cassie Brown represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Mary Richter (VT); and Allan L. McVey represented by Juanita Wimmer (WV). Also participating was: Gordon Hay (NE).

1. **Adopted its Feb. 18, 2022; Feb. 8, 2022; Jan. 24, 2022; Jan. 10, 2022; and 2021 Fall National Meeting Minutes**

Mr. Slavich said the Task Force met Feb. 18, 2022; Feb. 8, 2022; Jan. 24, 2022; Jan. 10, 2022; and Dec. 7, 2021. During these meetings, the Task Force took the following action: 1) adopted the 2018/2019 Auto Insurance Database Report (Auto Report); 2) adopted the Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report); 3) adopted the 2020 Competition Database Report (Competition Report); 4) discussed comments received on Project #2019 -49: Retroactive Reinsurance Exception; and 5) discussed comments received on the regulatory review of random forest models proposal.

The Task Force also met Feb. 15 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

The Task Force held a Predictive Analytics Book Club meeting on Feb. 22. Liam McGrath (Willis Towers Watson—WTW) presented on the evaluation of models built in Emblem.

Mr. Botsko made a motion, seconded by Ms. Darby, to adopt the Task Force’s Feb. 18, 2022 (Attachment One); Feb. 8, 2022 (Attachment Two); Jan. 24, 2022 (Attachment Three); Jan. 10, 2022 (Attachment Four); and Dec. 7, 2021 (see NAIC Proceedings – Fall 2021, Casualty Actuarial and Statistical (C) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Report of the Actuarial Opinion (C) Working Group**

Ms. Krylova said the Actuarial Opinion (C) Working Group adopted proposed changes to the Property/Casualty (P/C) Statement of Actuarial Opinion (SAO) instructions on March 1 and sent the proposal to the Blanks (E) Working Group. The changes were described during the Task Force’s Feb. 8 meeting.
Ms. Krylova made a motion, seconded by Ms. Lederer, to adopt the report of the Actuarial Opinion (C) Working Group, including its March 1, Feb. 1, and Jan. 18 minutes (Attachment Five). The motion passed unanimously.

3. **Adopted the Report of the Statistical Data (C) Working Group**

Ms. Darby said the Statistical Data (C) Working Group met Jan. 27 to discuss proposed changes to the Competition Report, the Homeowners Report, and the Auto Report. While no structural changes to the reports were adopted at that time, the Working Group voted to collect data for the Homeowners Report on a faster timeline. NAIC staff sent requests to collect 2020 and 2021 data this year to produce two reports and speed up the timeline of the average premium data. The Working Group plans to meet March 10 to look at a similar approach for the Auto Report. The Working Group will focus on updates to the *Statistical Handbook of Data Available to Insurance Regulators* and plans to meet monthly to discuss and adopt any changes that would improve the collection and use of statistical data. As for the 2019 data year reports, the 2019 Homeowners Report is being released to the public on March 10, and the 2018/2019 Auto Report was released Jan. 31.

Ms. Darby made a motion, seconded by Mr. Chou, to adopt the report of the Statistical Data (C) Working Group, including its Jan. 27 minutes (Attachment Six). The motion passed unanimously.

4. **Discussed the Next Steps for Project #2019-49: Retroactive Reinsurance Exception**

Mr. Hay recapped Project #2019-49: Retroactive Reinsurance Exception. Having heard comments from interested parties on Feb. 8, the Task Force discussed three options for next steps: 1) forward the completed work and let the Statutory Accounting Principles (E) Working Group decide any further action. In this option, the Task Force would write a memo describing the issue and summarizing the PowerPoint presentation that was exposed and attach the two comment letters; 2) do option #1 and draft proposed edits to instructions for both Schedule P and paragraphs 36 and 37 in *Statement of Statutory Accounting Principles (SSAP) No. 62R—Property and Casualty Reinsurance*; and 3) do additional research to dig deeper into the issue and consult experts.

Mr. Bredel questioned whether an exception needs to be added to SSAP No. 62R for pooling. To qualify for the existing exception, they need to include equal assets to the reserves ceded for the retrospective portion of the pool. Mr. Hay said the *Interpretation (INT) 03-02: Modification to an Existing Intercompany Pooling Arrangement* conclusion is that for changes in pool shares, there is a presumption that when pool shares are retroactively moved around, there is an offsetting asset transfer. That then would loop intercompany pools into paragraph 36d of SSAP No. 62R, and no further changes need to be made. Mr. Bredel said with a prospective agreement, the reinsurance ceded premium is known. With a retrospective arrangement, there needs to be premium ceded to offset the nominal, and not discounted, value of the reserves.

Deciding actuarial knowledge is needed to draft Schedule P instructions, the Task Force agreed to move forward with option #2, with the recognition that the Statutory Accounting Principles (E) Working Group may make changes to what the Task Force drafts for SSAP No. 62R if any changes are proposed. A subgroup of volunteers, including Mr. Hay, Mr. Chou, and Robin Marcotte (NAIC), will draft proposed revisions for future Task Force consideration.

5. **Adopted the Regulatory Review of Random Forest Rate Models Document**

Mr. Slavich said during the Feb. 8 meeting, Risk & Regulatory Consulting LLC and Allstate presented their comments about the random forest proposal, and he asked NAIC staff to consider submitted comments and suggest changes to the proposed documents. Sam Kloese (NAIC) presented the proposed revisions.
Mr. Slavich said he would like to have the Task Force adopt the amended document but postpone any decision to officially attach the document to the white paper until the Task Force has created the package of similar documents for other models.

Mr. Stolyarov made a motion, seconded by Ms. Darby, to adopt the random forest models and associated terminology document with non-substantive editing (Attachment Seven). The motion passed unanimously.

6. Heard a Report About Coordination with the Innovation, Cybersecurity, and Technology (H) Committee and the Special (EX) Committee on Race and Insurance Workstream Three

Mr. Slavich said he and Mr. Vigliaturo met with commissioner leaders of the Innovation, Cybersecurity, and Technology (H) Committee and Workstream Three of the Special (EX) Committee on Race and Insurance to discuss coordination around potential bias issues in P/C rating. He said this issue may require more of the Task Force’s attention. Cathy O’Neil, who wrote “Weapons of Math Destruction” and has expertise in the societal impacts of big data and algorithms, participated in the discussion.

Mr. Slavich said the discussion focused on possible racial bias in insurance and what state insurance regulators should do when reviewing rates, marketing, claims processing, and risk selection. He said there were six key points he would address: 1) one should start with an idea of which outcomes should be considered. Areas that might be a concern include rating; eligibility, risk selection, and marketing; claims payments (e.g., amounts and promptness); payment plan options; coverage terms; and company assignment; 2) there are algorithms that can take a consumer’s first name, last name, and address and use that information to infer the consumer’s race. This, combined with other insurer information, is one way to evaluate disparate impact; 3) it is known that racial inference algorithms are not perfect; however, the imperfection is at least known directionally, and the degree of racial bias tends to be understated with the algorithms; 4) racial bias, correlation, or disparate impact should not be evaluated as a binary “yes” or “no,” but it should be thought of as a matter of degree. Every rating variable is going to have some amount of correlation with race. The issue is how to come up with a threshold for acceptability and consider insurers relative to other insurers, as well as rating plans relative to other rating plans; 5) a predetermined, tight list of characteristics that make a rating element legitimate should be used; and 6) a rating variable’s correlation with race can be obscured by analyzing it in combination with other rating variables. If one looks at a variable in isolation, it may have a high level of correlation with race. One might then argue that one needs to control for other factors, since these other factors may have distributional differences by race. If one analyzes multiple variables simultaneously, some of the correlation between the subject rating variable and race will appear to go away because more than one variable might be significantly correlated with race. So, it is important to have constraints on what control variables should be included in any analysis looking for racial bias and to not allow the list of control variables to keep growing. Mr. Slavich suggested that a consideration is whether allowing a control variable would tend to perpetuate existing bias.

7. Heard a Report from the Academy

The American Academy of Actuaries (Academy) presented a report on its current activities.

Lauren Cavanaugh (Academy) said the Academy’s Casualty Practice Council sent comment letters to the Federal Insurance Office (FIO) regarding the availability and affordability of auto insurance, climate-related insurance, and financial risk in the insurance sector. Other projects include updating the cyber risk toolkit and cyber papers on different issues, including silent cyber, the cyberthreat landscape, cyber risk, accumulation cyber risk, reinsurance ransomware war, and cyber terrorism. A cyber risk resource guide is being drafted.
Regarding diversity, equity, and inclusion (DE&I) efforts, Ms. Cavanaugh said the Academy established a Racial Equity Task Force and contributed to efforts with a letter provided to the Colorado Department of Insurance (DOI) on its law in place on unfair discrimination.

Ms. Cavanaugh reported that numerous papers are being drafted and published. Working with the Data Science and Analytics Committee, she said the plan is to publish a causation correlation issue brief this year and a data issue brief on the collection of protected class data. The Extreme Events Committee recently issued a wildfire risk issue paper that will be highlighted in a March 17 webinar. The Committee also plans to publish an Insurance-Linked Security Monograph in the next few months. The Property/Casualty Risk-Based Capital Committee is analyzing workspace capital. The Medical Professional Liability (MPL) Committee recently published an issue brief on the COVID-19 impacts related to MPL. The Workers’ Compensation Committee recently published on the opioid epidemic.

Derek Freihaut (Academy) said the Committee on Property and Liability Financial Reporting (COPLFR) submitted comments to the Blanks (E) Working Group on changes related to the disclosure agreements and losses. The P/C loss reserve opinions seminar was held; the 2021 practice note on opinions for P/C loss reserves and the P/C Loss Reserve Law Manual were both published in December 2021; and the risk transfer practice note is scheduled to be published in the second quarter of 2022 after a review by the certified public accountant (CPA).

8. Discussed Other Matters

Kris DeFrain (NAIC) said she was contacted by Mr. Steinert about the NAIC’s workers’ compensation loss cost multiplier (LCM) forms. The Task Force supported the idea of a drafting group proposing changes to the forms for future Task Force consideration.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Feb. 18, 2022. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Jim L. Ridling represented by Daniel Davis (AL); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Troy Downing (MT); Mike Causey represented by Kevin Conley (NC); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Cassie Brown represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and Allan L. McVey and Juanita Wimmer (WV).

1. **Adopted the Homeowners Report**

The Task Force conducted an e-vote to consider adoption of the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/PROPERTY%20and%20CASUALTY%20INS%20(C)%20COMMITTEE/Casualty%20Actuarial%20and%20Statistical%20TF/02-18%20CASTF%20Evote%20HO%20min.docx
The Casualty Actuarial and Statistical (C) Task Force met Feb. 8, 2022. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Connor Meyer (MN); Jim L. Ridling represented by Daniel Davis (AL); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Qing He and Wanchin Chou (CT); David Altmaier represented by Greg Jaynes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Nicole Boyd (KS); James J. Donelon represented by Nichole Torblaa (LA); Kathleen A. Birrane represented by Ronald Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers represented by Cynthia Amann and Julie Lederer (MO); Troy Downing represented by David Dombrowski (MT); Mike Causey represented by Rick Cohen (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Russell Toal and Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Kevin Clark, Michael McKenney, and Dennis Sloan (PA); Cassie Brown represented by Miriam Fisk (TX); and Michael S. Pieciak represented by Rosemary Raszka (VT).

1. **Received a Report on its 2022 Task Force Charges**

   Mr. Slavich described the Task Force’s 2022 charges. He said the Task Force will continue assisting other committee groups, as needed; monitor national casualty actuarial developments; hold regulator-only rate filing issues calls; and hold predictive analytic Book Club trainings. He said the two new charges proposed by the Task Force were adopted. Those charges are as follows: “D2. Review the completed work on artificial intelligence (AI) from other committee groups. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues in as far as these issues contain a Task Force component” and “With NAIC staff assistance, discuss guidance for the regulatory review of tree-based models and generalized additive models (GAM) used in rate filings.” Mr. Slavich said the Property and Casualty Insurance (C) Committee adopted the following new charge for the Statistical Data (C) Working Group: “Implement the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Insurance Database Report (Auto Report) and Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report).” Based on the Working Group’s 2021 research findings, the Committee decided to request that the Working Group move forward with implementation.

   Mr. Slavich said leadership of the Task Force’s working groups were reappointed. Ms. Krylova is the chair of the Actuarial Opinion (C) Working Group, and Ms. Fisk is the vice chair. Ms. Darby is the chair of the Statistical Data (C) Working Group, and Mr. Chou is the vice chair.

2. **Adopted the Report of the Actuarial Opinion (C) Working Group**

   Ms. Krylova said the Actuarial Opinion (C) Working Group is planning to submit a proposal to the Blanks (E) Working Group to change the Property/Casualty (P/C) Statement of Actuarial Opinion (SAO) instructions. She said the plan is to: 1) remove the paragraph about the continuing education (CE) logs, given the related project has concluded; 2) add guidance for situations where the parent board reviews the Appointed Actuary’s qualification
documentation for all the member companies; and 3) clarify the signature block requirements. The Working Group will meet March 1 to consider adoption of the proposal.

Ms. Krylova made a motion, seconded by Ms. Lederer, to adopt the report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

3. Adopted the Report of the Statistical Data (C) Working Group

Ms. Darby said the Statistical Data (C) Working Group released the Auto Report to the public, and the Homeowners Report is being considered for adoption by the Task Force.

Ms. Darby said the Working Group met to discuss its new charge. The Working Group decided to include the accelerated average premium every year for the Homeowners Report. Ms. Darby said this will result in the production of two reports in 2022 but only one report in subsequent years. Also, due to its data collection requirements, the Homeowners Report for California will include detailed premium and exposure data one year and then summary information the next year. The Working Group will continue to discuss expedited reporting for the Auto Report.

Ms. Darby made a motion, seconded by Mr. Chou, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

4. Discussed Project #2019-29: Retroactive Reinsurance Exception

Two comment letters were received regarding Project #2019-29 (Attachment Two-A). Mr. Chou and Joseph Sieverling (Reinsurance Association of America—RAA) summarized their comments. The Task Force will continue discussing this issue on its March 8 call. Ralph Blanchard (Travelers) said his initial concerns on this issue are related to risk-based capital (RBC) implications. Derek Freihaut (American Academy of Actuaries—Academy) said the Committee on Property and Liability Financial Reporting (COPLFR) discussed the proposal and had no concerns.

5. Discussed the Regulatory Review of Random Forest Rate Models

Two comment letters were received regarding Sam Kloese’s (NAIC) proposed glossary entries and information items concerning the regulatory review of random forest models (Attachment Two-B). David Heppen (Risk & Regulatory Consulting LLC) highlighted his comments. Mike Woods (Allstate) said his comments are detailed in nature.

Mr. Slavich said the Task Force needs to decide how to use the documents. He said at a minimum, the documents can be used by the NAIC rate model review team as it reviews random forest models upon states’ requests. Regarding publication, he said the Task Force could post any final product on its website and/or attach the work to the Regulatory Review of Predictive Models white paper. He said there would be no plan to modify any already-adopted white paper components but only a plan to attach random forest information to the white paper. Some Task Force members supported the idea to attach the additional glossary words and random forest information items to the already-adopted white paper, so long as the existing white paper is not open for modification. No one expressed opposition.

Mr. Slavich asked NAIC staff to review the comment letters and propose changes for Task Force discussion for its March 8 call.
6. **Discussed Other Matters**

Kris DeFrain (NAIC) said Roberto Perez (NAIC) will be demonstrating the shared model database in early March. Any state insurance regulator can attend.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/PROPERTY%20and%20CASUALTY%20INS%20(C)%20COMMITTEE/Casualty%20Actuarial%20and%20Statistical%20(C)%20TF/02-08%20min.docx
To: Kris DeFrain
From: Wanchin Chou, Chief Actuary
Date: January 20, 2022
Subject: Comment on Schedule P Reporting for Retroactive Reinsurance Accounting Exceptions

Thank you for the opportunity to comment on the proposed solutions to the problem of the mismatch between SSAP 62R and the Schedule P instructions as they pertain to the treatment of intercompany reinsurance arrangements.

Slide 18 points out that the Schedule P Instructions for intercompany pooling direct the company to record premiums and losses according to the pooling percentage and to restate the history if a change is made retroactively. SSAP 62R allows recording premiums and losses in this manner only if there is no surplus gain. In general, such pooling agreements result in some change in surplus. We find the current Schedule P instructions allow for valuable information regarding loss development and premium volume changes, and so we support the proposal to add intercompany pooling to the exceptions listed in SSAP 62R, paragraph 36.

Slide 20 points out that Schedule P are silent regarding treatment for the exceptions listed in SSAP 62R, paragraphs 36c and 36d. We support adding Schedule P instructions for the exceptions listed in SSAP62R, paragraphs 36c and 3d, including specifying a method for allocating premium to prior years.

We do not support adding a Schedule P line of business (one of the “Other Possible Actions” listed on slide 22) since this would include a mixture of insurance lines of business and claim ages. Such a mixture would not be useful in monitoring underwriting results.

Resolving the differences between SSAP 62R and Schedule P will make our system of accounting more uniform and transparent and benefit the public as a whole.
Via Electronic Mail

Commissioner Grace Arnold, Chair
Casualty Actuarial and Statistical Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Ms. Kris DeFrain
Director, Research and Actuarial
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Comments on December 7, 2021 Draft Report on Retroactive Reinsurance Reporting

Dear Commissioner Arnold and Ms. DeFrain:

The Reinsurance Association of America (RAA), headquartered in Washington, D.C., is the leading trade association of property and casualty reinsurers doing business in the United States. The RAA is committed to promoting a regulatory environment that ensures the industry remains globally competitive and financially robust. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross border basis.

The RAA appreciates the opportunity to comment on the draft report, Schedule P Reporting for Retroactive Reinsurance Accounting Exceptions (the report), presented to the Casualty Actuarial and Statistical Task Force (CASTF) on December 7, 2021. First, we appreciate the comprehensiveness of the report and congratulate the members of the subgroup and NAIC staff for providing a thorough review of the current accounting and reporting implications of the paragraph 36 exceptions in SSAP No. 62R. Our brief comments have been informed by only one RAA member since the comment period encompassed both the annual reinsurance renewal season and year-end reporting. Nevertheless, we wished to provide these comments now, even though we may have more to add as this project develops.

**Retroactive Reinsurance Exception – Paragraph 36d**
This issue arose at the NAIC because of a diversity in practice that was noted by COPLFR in its May 2019, letter to the CASTF and Statutory Accounting Principles Working Group (SAPWG). In that letter, COPLFR describes two loss portfolio transfer (LPT) reinsurance transactions among affiliates that were reported differently in Schedule P. Company A reported the ceded LPT premium in the current calendar year of Schedule P, while Company G allocated the ceded LPT...
premium to prior years on Schedule P. These transactions were accounted for as prospective reinsurance under the Paragraph 36d. exception of SSAP No. 62R. In RAA’s view, there are two issues to note regarding this situation:

1. We agree with the report (page 20) that under current guidance there will be distortions in Schedule P when applying prospective accounting to retroactive reinsurance.
2. We also agree with the report (page 19) that the Schedule P instructions are clear that ceded premium in the above should be reported in the current calendar year on Schedule P.

Therefore, it appears that Company G simply did not follow the existing Schedule P instructions. Perhaps, this was a permitted practice or alternatively, the Company G concluded that this reporting was “better” because it distorted Schedule P to a lesser degree.

**Response to Subgroup Proposal**

Regarding the specific proposal in the report on page 20, the RAA does not believe that adding additional instructions to Schedule P for paragraphs 36c and 36d is strictly necessary. There is already specific guidance for the 36d exception, and in general, each of the exceptions listed in SSAP No. 62R already have clear guidance as to how the elements to the transaction should be treated in the financial statements; as premiums, losses, etc. Further, there already is clear guidance as to how to treat premiums or losses on Schedule P. For example – if consideration is treated as premium, one should follow the guidance on Sch P for Premiums, which currently does not provide for allocation of premium to related AY.

This does not solve the original and ongoing issue of distortions in the Schedule P data. These issues are not new and have existed for a very long time. It seems to us that in order to address that issue, a very comprehensive review of Schedule P reporting guidance may be necessary. For example, if allocating premium is viewed as preferable to the current guidance, then the current guidance on Schedule P should provide for the allocation of premium to AY for all items that can vary (other examples include reinstatement premium adjustments; audit premiums; retrospective rating provisions), and any such change should apply to direct, assumed and ceded premiums. This is a broader issue than retroactive reinsurance. The guidance, if provided, may list retroactive as one of the areas that might cause need for allocation of material amounts, but should not be the only type of transaction considered.

Thank you for the opportunity to provide these comments. We look forward to continued discussion of these issues at future meetings.

Sincerely,

Joseph B. Sieverling
Senior Vice President
February 4, 2022

Kris DeFrain, FCAS, MAAA, CPCU
Director, Research and Actuarial Services
National Association of Insurance Commissioners Central Office

Re: Best Practices for Regulatory Review of Random Forests

Dear Ms. DeFrain,

Thank you for the opportunity to comment on changes to the white paper “Regulatory Review of Predictive Models” that will address Random Forest models.

Below are suggested revisions to the white paper. Revisions are shown in blue font.

Section A.3.d

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<tbody>
<tr>
<td>A.3.d</td>
<td>Determine how missing data was handled.</td>
<td>1</td>
<td>This is most relevant for variables that have been “scrubbed” or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or “not available” values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats. The modeler should describe the way the tree fitting process handled missing values. The modeler should specify if missing values are treated before running the tree model or if they are allowed to be handled by the tree model. When creating predictions on new datasets (such as hold out datasets), tree-based models may have different approaches for handling missing data or categorical levels not encountered in the</td>
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training data for a predictor variable. The modeler should specify the process utilized when this occurs.

Comments: We suggest revising section A.3.d to expand the commentary on situations where the handling of missing value may be relevant.

Section B.1.h

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<tr>
<td>B.1.h</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.</td>
<td>3</td>
<td>The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected. Minimum data volume constraints can be applied to a tree-based model, such that the trees will not create a split that would result in terminal nodes with volume below a set amount. The modeler should comment on how the threshold was chosen.</td>
</tr>
<tr>
<td>B.1.j</td>
<td>If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.</td>
<td>2</td>
<td>If there was no minimum data volume threshold applied to the trees, or if the threshold was very small, obtain an explanation of any post modeling adjustments the modeler made to address the credibility considerations and how the adjustments were applied.</td>
</tr>
<tr>
<td>New B.3.4</td>
<td>Obtain parameters that determined the volume of data in each tree node and a narrative of how parameters were chosen.</td>
<td>1</td>
<td>Minimum data volume constraints can be applied to a tree-based model, such that the trees will not create a split that would result in terminal nodes with volume below a set amount. The modeler should comment on how the threshold was chosen. If there was no minimum data volume threshold applied to the trees, or if the threshold was exceedingly small, obtain an explanation of any post modeling adjustments the modeler made to address the credibility considerations and how the adjustments were applied.</td>
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</table>
C.4.a Determine what, if any, consideration was given to the credibility of the output data.

The regulator should determine at what level of granularity credibility is applied. If modeling was by coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model. The company should comment on the minimum data volume requirement at each node before splitting.

Comments:

We recommend that the comment on “minimum data volume” be removed from B.1.h and create a new section B.3.4 requesting that the minimum data volume in a leaf be provided as a level 1 request due to the basic nature of this information.

We also recommend removing section B.1.j and adding the commentary of B.1.j to the newly created B.3.4 section on the minimum data volume hyperparameter.

C.4.a contains discussion of data volume and we believe commentary on data volume can be removed from C.4.a since it is discussed in other sections.

Section B.3.a

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<td>B.3.a</td>
<td>Obtain a complete data dictionary, including the names, types, definitions, and rationales for each variable.</td>
<td>1</td>
<td>Types of variables might be continuous, discrete, Boolean, etc. Tree based models do not have offset or control variables, as all variables are treated the same way in the trees. Identify any variable used as an offset or control in the random forest model and the offset factor that was applied for each level of the offset variable. For any variable(s) intended to function as a control or offset, obtain an explanation of its purpose and impact. Also, for any use of interaction between variables, obtain an explanation of its rationale and impact.</td>
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</table>

Comments:

Offsets and control variables can apply to tree-based models. Offsets may be applied to the starting prediction for a given record before a tree-based model is built. With proper
treatment, control variables can also exist in tree-based models if there are variables used in the model building process that are not part of the final rating plan.

## Section B.3.d

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<tr>
<td>B.3.d</td>
<td>Obtain plots describing the relationship between each predictor variable and the target variable. Obtain a rational explanation for why an increase in the observed relationship between each predictor variable should increase or decrease and the target variable (frequency, severity, loss costs, expenses, or any element or characteristic being predicted).</td>
<td>1</td>
<td>Partial dependence plots, accumulated local effects plots, or shapley plots will help improve model interpretability. The plots should be accompanied by commentary on why the visualized relationship is may be reasonable for variables of concern. Considering possible causation may be relevant, but proving causation is neither practical nor expected. If no rational explanation can be provided, greater scrutiny may be appropriate. For example, the regulator should look for unfamiliar predictor variables and, if found, the regulator should seek to understand the connection relationship that variable has to increasing or decreasing the target variable. The regulator should also consider that interpretability plots for tree-based models need to be reviewed with other considerations in mind. For example, partial dependence calculations assume independence with other variables in the model.</td>
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**Comments:**

We suggest removing the request that every plot be accompanied by commentary in the initial filing. Given that a loss model is built for each loss type and each model will contain tens of variables, this would require commentary on several hundred plots. We believe that asking for commentary on plots related to variables of concern would be more appropriate.

We also suggest adding some commentary to illustrate that each type of interpretability plot is imperfect and no plot should be completely relied upon.
### Section B.3.f

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<tr>
<td>B.3.f</td>
<td>Obtain variable importance plots. Obtain a description of how variable importance was calculated.</td>
<td>1</td>
<td>Variable Importance Plots for tree-based methods highlight which variables contributed most to the model. There are multiple ways to calculate variable importance, and variable importance can be used to create an intuitive understanding of model operation. Variables with the lowest importance measures should be prioritized when reviewing predictor variables for significance. Credibility can be addressed through proper hyperparameter selection. Variables with highest importance should be prioritized when reviewing the model for appropriateness. Variables with lower importance may be evaluated objectively through their correlation with other variables in the model, and subjectively through how they may be interacting with other variables in the model to identify a subset of risks.</td>
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**Comments:**

We recommend changing the focus on low importance variables. In tree-based models, carefully selected hyperparameters should prevent the model from splitting erroneously on non-credible variables. For example, the minimum leaf count or minimum improvement threshold for a split should demonstrate sufficient credibility for the segment being identified. This commentary may erroneously guide a model reviewer to request the removal of a variable that demonstrates material signal through complex interactions with other variables.

### Section B.4.e

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<tr>
<td>B.4.e</td>
<td>Obtain evidence that the model fits the training data well and for</td>
<td>2</td>
<td>The regulator should ask for the company to provide exhibits or plots that show the fitted average makes sense when compared to the observed average for variables of interest. Regulators would ideally review this comparison for every variable, but time constraints may</td>
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Limit the focus to just variables of interest. Variables of interest should include those with a low importance measure according to diagnostic tests, variables without an intuitive relationship to loss, or variables that may be a proxy for a protected class attribute. Variables of interest should include those with a high or medium importance measure according to diagnostic tests. Variables with low importance or without an intuitive relationship to loss may be evaluated objectively through their correlation with other variables in the model, and subjectively through how they may be interacting with other variables in the model to identify a subset of risks.

**Comments:**

We recommend changing the focus from variables with low importance to variables of high and medium importance. Variables of low importance provide low predictive power to the model and are therefore only mildly affecting any segment. Variables with low importance may only be meaningful in the tails of their distribution, and goodness of fit for most of the variable's range may be immaterial. Variables with lower importance may be better evaluated objectively through their correlation with other variables in the model, and subjectively through how they may be interacting with other variables in the model to identify a subset of risks.

**Section B.4.h**

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<tr>
<td>B.4.h</td>
<td>Obtain a narrative on how potential concerns with overfitting were addressed.</td>
<td>2</td>
<td>Tree based models such as Random Forest models are notorious for over-fitting. The company should provide a narrative on how overfitting was addressed. The company should provide lift charts on training data and testing data that is separate from the training data.</td>
</tr>
<tr>
<td>New B.3.5</td>
<td>Obtain a narrative of the process to select all hyperparameters for the Random Forest. Detail how this process addressed potential</td>
<td>2</td>
<td>Hyperparameter tuning can be done in a variety of ways. The rigor of the tuning process should reflect the risk of overfitting on the specific dataset.</td>
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Comments:

Overfitting in tree-based models should be addressed through the hyperparameter selection process. We recommend that B.4.h request only a one-way lift chart against holdout data to demonstrate that the model is not overfit, and that an additional section B.3.5 be added to request a narrative of the hyperparameter tuning process and how this has addressed overfitting.

Section B.4.j

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<tr>
<td>B.4.j</td>
<td>Obtain 5-10 sample records with corresponding output from the model for those records.</td>
<td>2 4</td>
<td>The company should provide 5-10 sample records with corresponding input variable values, the prediction from each component tree in the model, and the final ensemble model prediction. The company should describe how the final model prediction aggregates the individual tree model predictions.</td>
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Comments:

We suggest changing the level of importance of this item to level 4. A narrative describing how the predictions of each tree are combined for a final model prediction is essential information and is already requested in section B.2.e. However, we do not feel the request for sample records and sample calculations is part of a normal model review unless there are concerns about the model.

Section C.10.d

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<tr>
<td>C.10.d</td>
<td>Obtain complete documentation of all component trees and how the individual predictions are aggregated together into a final prediction.</td>
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<tr>
<td>1 4</td>
<td>The company should provide either tree diagrams for each component tree or comprehensive if-else statements that would replicate the logic of the trees. The company should state how the individual component tree predictions are combined into a final prediction.</td>
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**Comments:**

We suggest changing the level of importance of this item to level 4. We do not feel the request for each tree is part of a regular model review unless there are concerns about the model. Tree diagrams are also of limited usefulness by a reviewer since there are generally hundreds of trees in one model and it is unlikely that a reviewer would have the time to review each tree.

**General Comments**

We recommend additional commentary to clarify that this guidance is for Random Forests and may not be appropriate for all other types of tree-based models. For example, while examining individual trees for a Random Forest may be enlightening, examining individual trees for a Gradient Boosting Machine (GBM) is much less intuitive as each tree’s interpretation depends on the results of the possibly substantial number of trees before it. Other such differences exist and are out of scope for this commentary. We also recommend that the committee provide additional guidance specific to other types of tree-based models such as GBMs to avoid potential misapplication of this guidance on other tree-based models.

Once again, thank you for the opportunity to comment.

**Allstate Property & Casualty Actuarial Modeling Department**

For any questions, please contact:

Mike Woods, FCAS, CSPA, MAAA
Allstate Insurance Company

mike.woods@allstate.com
From: "Heppen, Dave"
Date: February 4, 2022 at 4:49:26 PM CST
To: "DeFrain, Kris"
Subject: RE: CASTF Exposure - Review of Random Forest Models

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Kris,

We wanted to provide you with the following comments on this exposure:

1. We thought the additional guidance on Random Forests was very well done, and we particularly thought items B.3.1-B.3.3, B.3.f, B.4.h, and B.4.k were helpful.

2. Regarding item B.2.a, we suggest adding guidance along the lines below:

   The narrative should include a description of each hyperparameter, document the values of the hyper parameters, specify the implication of using a higher or lower value for each hyper parameter, and discuss any sensitivity testing completed on the hyper parameters and observations from the sensitivity analysis.

3. Regarding consistency between the Appendix and the glossary, “pruning” is defined in the glossary but does not appear to be covered in the Appendix. We believe this term would fit well with B.4.h on overfitting; this could be accomplished with language along the lines below:

   If pruning was utilized to address overfitting, the narrative should provide commentary on the pruning process.

Thank you for the opportunity to comment on this!

Thanks,
Dave

David Heppen, FCAS, MAAA
Partner
Risk & Regulatory Consulting, LLC
20 Batterson Park Road / Suite 380 / Farmington, CT 06032
D: 610.247.8019 | E: dave.heppen@riskreg.com
Casualty Actuarial and Statistical (C) Task Force
E-Vote
January 24, 2022

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Jan. 24, 2022. The following Task Force members participated: Mike Kreidler, Chair, represented by Eric Slavich (WA); Grace Arnold, Vice Chair, represented by Phil Vigliaturo (MN); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Chlora Lindley-Myers and Cynthia Amann (MO); Troy Downing represented by Mari Kindberg (MT); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Andrew R. Stolfi represented by David Dahl (OR); Cassie Brown represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and Allan L. McVey and Juanita Wimmer (WV).

1. **Adopted the Competition Report**

The Task Force conducted an e-vote to consider adoption of the *2020 Competition Database Report* (Competition Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/PROPERTY%20and%20CASUALTY%20INS%20(C)%20COMMITTEE/Casualty%20Actuarial%20and%20Statistical%20(TF)/01-24%20CASTF%20Evote%20Comp%20min.docx
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Jan. 10, 2022. The following Task Force members participated: Jim L. Ridling represented by Daniel Davis (AL); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Robert Baron (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Kevin Conley (NC); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Russell Toal represented by Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Raymond G. Farmer represented by Will Davis (SC); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey and Juanita Wimmer (WV).

1. **Adopted the Auto Report**


Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/2022%20NAIC%20Meetings/Spring%20National%20Meeting/Committee%20Meetings/PROPERTY%20and%20CASUALTY%20INS%20(C)%20COMMITTEE/Casualty%20Actuarial%20and%20Statistical%20(C)%20TF/01-10%20CASTF%20Evote%20Auto%20min.docx
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Jan. 18, Feb. 1, and March 1, 2022. The following Working Group members participated: Anna Krylova, Chair (NM); Miriam Fisk, Vice Chair, and Rebecca Armon (TX); Amy Waldhauer (CT); David Christhilf (DC); Chantel Long and Judy Mottar (IL); Sandra Darby (ME); Julie Lederer (MO); Gordon Hay (NE); Tom Botsko (OH); Kate Yang (OK); and Kevin Clark, James Di Santo, and Michael McKenney (PA).

1. **Adopted a Proposal for the P/C SAO Instructions**

Ms. Krylova proposed revised 2022 Property/Casualty (P/C) Statement of Actuarial Opinion (SAO), P/C Actuarial Opinion Summary, and Title Statement of Actuarial Opinion instructions as a starting point for discussion during the Jan. 18 meeting (Attachment Five-A). Mr. Hay submitted additional proposed changes for the discussion (Attachment Five-B).

During its Feb. 1 meeting, the Working Group agreed to four changes to the P/C SAO instructions and decided to postpone any additional changes because more discussion and consultation would be needed, and there was no more time for deliberation in order to have an exposure and meet the Blanks (E) Working Group’s March 4 deadline.

The first change in the P/C SAO instructions is in Section 1. Guidance on continuing education (CE) logs is no longer required because the Casualty Actuarial and Statistical (C) Task Force’s CE log project will not be reoccurring, so the paragraph on the topic was removed. Ms. Krylova noted that actuaries will refer to their respective societies for guidance on CE logs.

The second change is also in Section 1. The change is to provide additional guidance on documentation of the board review of qualification documentation (QD) for companies that are part of a group whose parent board reviews QD on behalf of all subsidiaries. Guidance on this question was requested by the industry, and the Working Group consulted the Financial Examiners Handbook (E) Technical Group on the appropriate response.

The third change is in Section 3. An additional requirement has been added in the IDENTIFICATION paragraph for Appointed Actuaries to confirm that QD has been provided to the Board of Directors. This statement in the IDENTIFICATION paragraph will assist state insurance regulators in determining whether this requirement has been met.

The fourth change is in Section 8 and provides clarification that the signature block requirements apply to the SAO only. The actuarial report should reproduce the same information, though not necessarily in the same format. It has been reported that Appointed Actuaries often provide the required information in a slightly different format within the actuarial report, necessitating financial examiners to create meaningless findings/objections just because the information does not follow the exact format. The Working Group members agree that the prescribed format is applicable to the actuarial opinion only and that the format in the actuarial report may vary.

With a Blanks (E) Working Group deadline of March 4 looming, the Actuarial Opinion (C) Working Group’s chair exposed the amended proposed instructions for the P/C Statement of Actuarial Opinion for a 25-day public
comment period ending Feb. 27. No comments were received, and no additional comments were made during the Working Group’s March 1 meeting.

Ms. Lederer made a motion, seconded by Mr. Christhilf, to adopt the 2022 P/C SAO instructions and refer them to the Blanks (E) Working Group for consideration (Attachment Five-C). The motion passed unanimously.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.
1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Property and Casualty.

Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).
b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).
c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

If subject to the U.S. Qualification Standards, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the U.S. Qualification Standards for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

In accordance with the CAS and SOA’s continuing education review procedures, an Appointed Actuary who is subject to the U.S. Qualification Standards and selected for review shall submit a log of their continuing education in a form determined by the CAS and SOA. The log shall include categorization of continuing education approved for use by the Casualty Actuarial and Statistical Task Force. As agreed with the actuarial organizations, the CAS and SOA will provide an annual consolidated report to the NAIC identifying the types and subject matter of continuing education being obtained by Appointed Actuaries. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall follow the review procedures for the organization in which they submitted their attestation.

The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their appointment, and on an annual basis thereafter, directly or through company management. The documentation should include brief biographical information and a description of how the definition of “Qualified Actuary” is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document the company’s review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.
If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former Appointed Actuary’s satisfaction and those not resolved to the former Appointed Actuary’s satisfaction. The letter should include a description of the disagreement and the nature of its resolution (or that it was not resolved). Within this same ten (10) business days, the Insurer shall in writing also request such former Appointed Actuary to furnish a letter addressed to the Insurer stating whether the Appointed Actuary agrees with the statements contained in the Insurer’s letter and, if not, stating the reasons for which he or she does not agree. The former Appointed Actuary shall provide a written response to the insurer within ten (10) business days of such request, and the Insurer shall furnish such responsive letter from the former Appointed Actuary to the domiciliary commissioner together with its own responses.

The Appointed Actuary must report to the Board of Directors each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors and identify the manner of presentation (e.g., webinar, in-person presentation, written). A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

The Actuarial Opinion and the supporting Actuarial Report and workpapers should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including, but not limited to, ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.

1A. Definitions

“Appointed Actuary” is a Qualified Actuary (or individual otherwise approved by the domiciliary commissioner) appointed by the Board of Directors in accordance with Section 1 of these instructions.

“Board of Directors” can include the designated Board of Directors, its equivalent or an appropriate committee directly reporting to the Board of Directors.

“Qualified Actuary” is a person who:

(i) Meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualifications Standards), promulgated by the American Academy of Actuaries (Academy):

(ii) Has obtained and maintains an Accepted Actuarial Designation; and

(iii) Is a member of a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.

An exception to parts (i) and (ii) of this definition would be an actuary evaluated by the Academy’s Casualty Practice Council and determined to be a Qualified Actuary for particular lines of business and business activities.
“Accepted Actuarial Designation” in item (ii) of the definition of a Qualified Actuary, is an actuarial designation accepted as meeting or exceeding the NAIC’s Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (published on the NAIC website). The following actuarial designations, with any noted conditions, are accepted as meeting or exceeding basic education minimum standards:

(i) Fellow of the CAS (FCAS) – Condition: basic education must include Exam 6 – Regulation and Financial Reporting (United States);

(ii) Associate of the CAS (ACAS) – Conditions: basic education must include Exam 6 – Regulation and Financial Reporting (United States) and Exam 7 – Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management;

(iii) Fellow of the SOA (FSA) – Conditions: basic education must include completion of the general insurance track, including the following optional exams: the United States’ version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.

The table below provides some allowable exam substitutions for (i), (ii) and (iii) in the definition of “Accepted Actuarial Designation:” Noting that CAS exams have changed over time, exceptions for (i) and (ii) provide for FCAS/ACAS designations achieved before an exam was created (e.g. CAS Exam 6-US) or with an earlier version of an exam or exam topic (e.g., 2010 CAS Exam 6 instead of the current CAS Exam 7 Section A). FCAS/ACAS qualified under the 2018 and prior Statement of Actuarial Opinion instructions can use the noted substitution rules to achieve qualification under the new instructions by demonstrating basic and/or continuing education of the required topics including material in CAS Exam 6 (US) and section A of CAS Exam 7 (in the May 2019 CAS syllabus). Exceptions for (iii) for an FSA are also included in the table. The SOA exams completed in the general insurance track in 2019 and prior should be supplemented with continuing education and experience to meet basic education requirements in the U.S. Qualification Standards. For purpose of these instructions only, the table also includes specific exams from other organizations that are accepted as substitutes.

<table>
<thead>
<tr>
<th>Exception for (i), (ii), or (iii)</th>
<th>Exam: Exam Substitution Allowed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) and (ii) CAS Exam 6 (US)</td>
<td>1. Any CAS version of a U.S. P/C statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 (US) in 2011.</td>
</tr>
<tr>
<td></td>
<td>2. An FCAS or ACAS earned prior to 2021 who did not pass CAS Exam 6 (US) or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 6 (US) provided the Appointed Actuary explains in his/her qualification documentation how knowledge of U.S. financial reporting and regulation was obtained.</td>
</tr>
<tr>
<td></td>
<td>3. SOA FREU (US) Exam</td>
</tr>
<tr>
<td>(ii) CAS Exam 7</td>
<td>1. Any CAS version of an exam including advanced P/C reserving administered prior to creation of Exam 7 in 2011.</td>
</tr>
<tr>
<td></td>
<td>2. An ACAS earned prior to 2021 who did not pass CAS Exam 7 or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 7 provided the Appointed Actuary explains in his/her qualification documentation how knowledge of the additional reserving topics in CAS Exam 7 (Section A) in the May 2019 syllabus was obtained.</td>
</tr>
<tr>
<td></td>
<td>3. SOA Advanced Topics Exam (Note: The ERM portion of Exam 7 is not needed to meet NAIC educational standards, therefore SOA ERM Exam is not needed for the substitution for this purpose.)</td>
</tr>
<tr>
<td>(iii) SOA FREU (US) Exam</td>
<td>1. CAS Exam 6 (US)</td>
</tr>
<tr>
<td>(iii) SOA Advanced Topics Exam</td>
<td>1. CAS Exam 7</td>
</tr>
<tr>
<td></td>
<td>2. Any CAS version of an exam containing the advanced techniques to estimate policy liabilities (i.e., advanced reserving).</td>
</tr>
</tbody>
</table>

*Note: These exam substitutions only apply to these instructions and are not applicable for CAS or SOA exam waivers.
“Insurer” or “Company” means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

“Actuarial Report” means a document or other presentation prepared as a formal means of conveying to the state regulatory authority and the Board of Directors the Appointed Actuary’s professional conclusions and recommendations of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the Appointed Actuary’s opinion or findings, and of documenting the analysis underlying the opinion. The required content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

“Property and Casualty (P&C) Long Duration Contracts” refers to contracts (excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts) that fulfill both of the following conditions: (1) the contract term is greater than or equal to 13 months; and (2) the insurer can neither cancel the contract nor increase the premium during the contract term. These contracts are subject to the three tests of SSAP No. 65—Property and Casualty Contracts of the NAIC Accounting Practices and Procedures Manual.

“Accident and Health (A&H) Long Duration Contracts” refers to A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required. See Schedule H instructions for a description of categories of contract reserves, as well as policy features that give rise to contract reserves. Two specific examples of contracts that typically require contract reserves are long-term care and disability income insurance.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.
Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent (1%) of the insurer’s capital and surplus reflected in the insurer’s latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer’s direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer’s latest quarterly statements filed with its domiciliary commissioner.

1C. Reporting Requirements for Pooled Companies

For each company in the pool, the Appointed Actuary shall include a description of the pool, identification of the lead company and a listing of all companies in the pool, their state of domicile and their respective pooling percentages.

Exhibits A and B for each company in the pool should represent the company’s share of the pool and should reconcile to the financial statement for that company.

The following paragraph applies to companies that have a 0% share of the pool (no reported Schedule P data). The company shall submit an Actuarial Opinion that reads similar to that provided for the lead company. For example, the IRIS ratio and risk of material adverse deviation discussions, and other relevant comments shall relate to the risks of the lead company in the pool. The Exhibit B responses to question 5 should be $0 and to question 6 should be “not applicable.” Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the 0% companies in their data capture).

2. The Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary’s work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary’s relationship to the Company, qualifications for acting as Appointed Actuary and date of appointment and specify that the appointment was made by the Board of Directors.

If the Appointed Actuary was approved by the Academy to be a “Qualified Actuary,” with or without limitation, or if the Appointed Actuary is not a Qualified Actuary but was approved by the domiciliary commissioner, the company must attach, each year, the approval letter and reference such in the identification paragraph.

4. The SCOPE paragraph should contain a sentence such as the following:

“I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date.”

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.
The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

“In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by [officer name and title at the Company]. I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P, Part 1 of the Company’s current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary.”

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration:

“In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of [state of domicile].
B. Are computed in accordance with accepted actuarial standards.
C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.”

If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts or Other Loss Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:

D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or [insert Other Loss Reserve item on which the Appointed Actuary is expressing an opinion] of the Company under the terms of its contracts and agreements.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards.

If the Appointed Actuary has made use of the analysis of another actuary not within the Appointed Actuary’s control (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name, credential and affiliation within the OPINION paragraph. If the Appointed Actuary has made use of the work of a non-actuary (such as for modeling) for a material portion of the reserves, that individual must be identified by name and affiliation and a description of the type of analysis performed must be provided.

A Statement of Actuarial Opinion should be made in accordance with one of the following sections (1 through 5). The Appointed Actuary must explicitly identify in Exhibit B which type applies.

1. Determination of Reasonable Provision. When the carried reserve amount is within the Appointed Actuary’s range of reasonable reserve estimates, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

2. Determination of Deficient or Inadequate Provision. When the carried reserve amount is less than the minimum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the minimum amount that the Appointed Actuary believes is reasonable.

3. Determination of Redundant or Excessive Provision. When the carried reserve amount is greater than the maximum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the maximum amount that the Appointed Actuary believes is reasonable.
4. **Qualified Opinion.** When, in the Appointed Actuary’s opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items, the Appointed Actuary should issue a qualified Statement of Actuarial Opinion. The Appointed Actuary should disclose the item (or items) to which the qualification relates, the reason(s) for the qualification and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, except for the item (or items) to which the qualification relates. The Appointed Actuary is not required to issue a qualified opinion if the Appointed Actuary reasonably believes that the item (or items) in question are not likely to be material.

5. **No Opinion.** The Appointed Actuary’s ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the Appointed Actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

   A. **Company-Specific Risk Factors**
   
   The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the Appointed Actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

   B. **Risk of Material Adverse Deviation**
   
   The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.

   C. **Other Disclosures in Exhibit B**
   
   RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

   D. **Reinsurance**
   
   RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.
   
   The Appointed Actuary’s comments on reinsurance collectability should address any uncertainty associated with including potentially uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the Appointed Actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary’s comments do not imply an opinion on the financial condition of any reinsurer.

Financial reinsurance refers to contracts referenced in SSAP No. 62R in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

E. IRIS Ratios

If the Company’s reserves will create exceptional values under the NAIC IRIS Tests for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

F. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for regulatory examination for seven (7) years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Actuarial Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to Company management, the Board of Directors, the regulator or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.

Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in the NAIC Accounting Practices and Procedures Manual requires a company with over 10,000 in force lives covered by long-term care (LTC) insurance contracts as of the valuation date to perform a stand-alone asset adequacy analysis for its in force long-term care (LTC) contracts. The Actuarial Report and workpapers summarizing the results, assumptions and testing procedures for the asset adequacy testing of LTC business must be in compliance with AG 51 requirements. When referring to AG 51, the term “Actuarial Memorandum” is synonymous with Actuarial Report and workpapers.

The Actuarial Report should contain disclosure of all reserve amounts associated with A&H Long Duration Contracts reported by the Company; the reserve amounts in the Actuarial Report should tie to the Annual Statement.
The Actuarial Report must also include:

A. A description of the Appointed Actuary’s relationship to the Company, with clear presentation of the Appointed Actuary’s role in advising the Board of Directors and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board of Directors and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

B. An exhibit that ties to the Annual Statement and compares the Appointed Actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary’s conclusions include the Appointed Actuary’s point estimate(s), range(s) of reasonable estimates or both.

C. An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary’s analysis, to the Annual Statement Schedule P line of business reporting. An explanation should be provided for any material differences.

D. An exhibit or appendix showing the change in the Appointed Actuary’s estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. The exhibit or appendix should illustrate the changes on a net basis but should also include the changes on a gross basis, if relevant. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

E. Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

F. Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, and how these factors were addressed in prior and current analyses.

8. Both the Actuarial Opinion and the Actuarial Report should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the respective dates when the Actuarial Opinion was rendered and the Actuarial Report finalized. The signature and date should appear in the following format:

________________________
Signature of Appointed Actuary

________________________
Printed name of Appointed Actuary

________________________
Employer’s name

________________________
Address of Appointed Actuary

________________________
Telephone number of Appointed Actuary

________________________
Email address of Appointed Actuary

________________________
Date opinion was rendered

9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Actuarial Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Actuarial Opinion shall be considered to be in error if the Actuarial Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Actuarial Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification is required when discovery is made between the issuance of the Actuarial Opinion and Dec. 31 of that year. Notification should include a summary of such findings.
If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended Actuarial Opinion submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended Actuarial Opinion has been finalized.

No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

**Exhibit A: SCOPE**

**DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)</td>
<td>$ ________</td>
</tr>
<tr>
<td>2. Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)</td>
<td>$ ________</td>
</tr>
<tr>
<td>3. Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)</td>
<td>$ ________</td>
</tr>
<tr>
<td>4. Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)</td>
<td>$ ________</td>
</tr>
<tr>
<td>5. The Page 3 write-in item reserve, “Retroactive Reinsurance Reserve Assumed”</td>
<td>$ ________</td>
</tr>
<tr>
<td>6. Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>

**Premium Reserves:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Reserve for Direct and Assumed Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ ________</td>
</tr>
<tr>
<td>8. Reserve for Net Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ ________</td>
</tr>
<tr>
<td>9. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>
Exhibit B: DISCLOSURES
DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

1. Name of the Appointed Actuary
   Last _______ First _______ Mid _______

2. The Appointed Actuary’s relationship to the Company
   Enter E or C based upon the following:
   E if an Employee of the Company or Group
   C if a Consultant

3. The Appointed Actuary’s Accepted Actuarial Designation
   (indicated by the letter code):
   F if a Fellow of the Casualty Actuarial Society (FCAS)
   A if an Associate of the Casualty Actuarial Society (ACAS)
   S if a Fellow of the Society of Actuaries (FSA) through the General Insurance track
   M if the actuary does not have an Accepted Actuarial Designation but is approved by the Academy’s Casualty Practice Council.
   O for Other

4. Type of Opinion, as identified in the OPINION paragraph.
   Enter R, I, E, Q, or N based upon the following:
   R if Reasonable
   I if Inadequate or Deficient Provision
   E if Excessive or Redundant Provision
   Q if Qualified. Use Q when part of the OPINION is Qualified.
   N if No Opinion

5. Materiality Standard expressed in U.S. dollars (used to Answer Question #6) $ _______

6. Are there significant risks that could result in Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]

7. Statutory Surplus (Liabilities, Surplus and Other Funds page, Col 1, Line 37) $ _______

8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $ _______

9. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P
   9.1 Nontabular Discount [Notes, Line 32B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 1, 2, 3, & 4 $ _______
   9.2 Tabular Discount [Notes, Line 32A23, (Amounts 1 & 2)], Electronic Filing Col 1 & 2 $ _______

10. The net reserves for losses and loss adjustment expenses for the Company’s share of voluntary and involuntary underwriting pools’ and associations’ unpaid losses and loss adjustment expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines $ _______
11. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines *

11.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 33A03D, ending net asbestos reserves for current year) Electronic Filing Col 5 $ _______

11.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 33D03D, ending net environmental reserves for current year), Electronic Filing Col 5 $ _______

12. The total claims made extended loss and loss adjustment expense, and unearned premium reserves (Greater than or equal to Schedule P Interrogatories)

12.1 Amount reported as loss and loss adjustment expense reserves $ _______

12.2 Amount reported as unearned premium reserves $ _______

13. The net reserves for the A&H Long Duration Contracts that the Company carries on the following lines on the Liabilities, Surplus and Other Funds page:

13.1 Losses $ _______

13.2 Loss Adjustment Expenses $ _______

13.3 Unearned Premium $ _______

13.4 Write-In (list separately, adding additional lines as needed, and identify (e.g., “Premium Deficiency Reserves”, “Contract Reserves other than Premium Deficiency Reserves” or “AG 51 Reserves”)) $ _______

14. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ _______

* The reserves disclosed in item 11 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor’s Pollution Liability, Consultant’s Environmental Liability, and Pollution and Remediation Legal Liability.
ACTUARIAL OPINION SUMMARY SUPPLEMENT

1. For all Companies that are required by their domiciliary state to submit a confidential document entitled Actuarial Opinion Summary (AOS), such document shall be filed with the domiciliary state by March 15 (or by a later date otherwise specified by the domiciliary state). This AOS shall be submitted to a non-domiciliary state within 15 days of request, but no earlier than March 15, provided that the requesting state can demonstrate, through the existence of law or some similar means, that it is able to preserve the confidentiality of the document.

2. The AOS should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including but not limited to ASOP No. 23, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.

3. Exemptions for filing the AOS are the same as those for filing the Statement of Actuarial Opinion.

4. The AOS contains significant proprietary information. It is expected that the AOS be held confidential; it is not intended for public inspection. The AOS should not be filed with the NAIC and should be kept separate from any copy of the Statement of Actuarial Opinion (Actuarial Opinion) in order to maintain confidentiality of the AOS. The AOS can contain a statement that refers to the Actuarial Opinion and the date of that opinion.

5. The AOS should be signed and dated by the Appointed Actuary who signed the Actuarial Opinion and shall include at least the following:

   A. The Appointed Actuary’s range of reasonable estimates for loss and loss adjustment expense reserves, net and gross of reinsurance, when calculated;

   B. The Appointed Actuary’s point estimates for loss and loss adjustment expense reserves, net and gross of reinsurance, when calculated;

   C. The Company’s carried loss and loss adjustment expense reserves, net and gross of reinsurance;

   D. The difference between the Company’s carried reserves and the Appointed Actuary’s estimates calculated in A and B, net and gross of reinsurance; and

   E. Where there has been one-year adverse development in excess of 5% of the prior year-end’s policyholders’ surplus as measured by Schedule P, Part 2 Summary in three (3) or more of the past five (5) calendar years, an explicit description of the reserve elements or management decisions that were the major contributors.

6. The AOS for a pooled Company (as referenced in paragraph 1C of the instructions for the Actuarial Opinion) shall include a statement that the Company is a xx% pool participant. For a non-0% Company, the information provided for paragraph 5 should be numbers after the Company’s share of the pool has been applied; specifically, the point or range comparison should be for each statutory Company and should not be for the pool in total. For any 0% pool participant, the information provided for paragraph 5 should be that of the lead company.

7. The net and gross reserve values reported by the Appointed Actuary in the AOS should reconcile to the corresponding values reported in the Insurer’s Annual Statement, the Appointed Actuary’s Actuarial Opinion and the Actuarial Report. If not, the Appointed Actuary shall provide an explanation of the difference.
8. The Insurer required to furnish an AOS shall require its Appointed Actuary to notify its Board of Directors in writing within five (5) business days after any determination by the Appointed Actuary that the AOS submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The AOS shall be considered to be in error if the AOS would have not been issued or would have been materially altered had the correct data or other information been used. The AOS shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification shall be required when discovery is made between the issuance of the AOS and Dec. 31 of that year. Notification should include a summary of such findings.

If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the AOS, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended AOS to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended AOS submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended AOS has been finalized.

9. No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.
ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement, the statement of a Qualified Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion) setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Title.

The Qualified Actuary must be appointed by the Board of Directors or its equivalent, or by a committee of the Board, by December 31 of the calendar year for which the opinion is rendered. Upon initial appointment (or “retention”), the Company shall notify the domiciliary commissioner within five business days of the appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).

b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

c. A statement that the person meets the requirements of a Qualified Actuary.

Once this notification is furnished, no further notice is required with respect to this person unless the actuary ceases to be appointed or retained or ceases to meet the requirements of a Qualified Actuary.

If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former actuary’s satisfaction and those not resolved to the former actuary’s satisfaction. The letter should include a description of the disagreements and the nature of its resolution (or that it was not resolved). The Insurer shall also request in writing such former actuary to furnish a letter addressed to the Insurer stating whether the actuary agrees with the statements contained in Insurer’s letter and, if not, stating the reasons for which he or she does not agree; and the Insurer shall furnish such responsive letter from the former actuary to the domiciliary commissioner together with its own.

The Appointed Actuary must report to the Board of Directors or the Audit Committee each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors or the Audit Committee and that the Actuarial Opinion and the Actuarial Report were made available. A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

The Actuarial Opinion and the supporting Actuarial Report and workpapers, should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including but not limited to ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.
1A. Definitions

“Qualified Actuary” is a person who is either:

(i) A member in good standing of the Casualty Actuarial Society; or

(ii) A member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries.

“Insurer” or “Company” means a reporting entity authorized to write title insurance under the laws of any state and who files on the Title Blank.

“Actuarial Report” means a document or other presentation, prepared as a formal means of conveying to the state regulatory authority and the Board of Directors, or its equivalent, the actuary’s professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the actuary’s opinion or findings and of documenting the analysis underlying the opinion. The expected content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

1B. Exemptions

An insurer who intends to file for one of the exemptions under this section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if the exemption is deemed inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.
Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption.

Financial hardship is presumed to exist if the projected reasonable cost of the opinion would exceed the lesser of:

(i) One percent (1%) of the insurer’s capital and surplus reflected in the insurer’s latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer’s direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer’s latest quarterly statements filed with its domiciliary commissioner.

2. The Statement of Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary’s work; an OPINION paragraph expressing his or her opinion with respect to such subjects and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary’s relationship to the Company, qualifications for acting as Appointed Actuary, and date of appointment, and specify that the appointment was made by the Board of Directors (or its equivalent) or by a committee of the Board. A member of the American Academy of Actuaries qualifying under paragraph 1A(ii) must attach, each year, a copy of the approval letter from the Academy.

These instructions require that a Qualified Actuary prepare the Actuarial Opinion. If a person who does not meet the definition of a Qualified Actuary has been approved by the insurance regulatory official of the domiciliary state, the Company must attach, each year, a letter from that official stating that the individual meets the state’s requirements for rendering the Actuarial Opinion.

4. The SCOPE paragraph should contain a sentence such as the following:

“I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date.”

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

The Appointed Actuary should state that the items in the SCOPE paragraph, on which he or she is expressing an opinion, reflect the Disclosure items (8 through 14) in Exhibit B.

The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

“In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by __________ (name, affiliation and relation to Company). I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P, Parts 1 and 2 of the Company’s current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary.”
5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration:

“In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of (state of domicile).
B. Are computed in accordance with accepted actuarial standards.
C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.”

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards.

If the actuary has made use of the work of another actuary (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name and affiliation within the OPINION paragraph.

A Statement of Actuarial Opinion should be made in accordance with one of the following sections (a through e). The actuary must explicitly identify in Exhibit B which type applies.

a. Determination of Reasonable Provision. When the carried reserve amount is within the actuary’s range of reasonable reserve estimates, the actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

b. Determination of Deficient or Inadequate Provision. When the carried reserve amount is less than the minimum amount that the actuary believes is reasonable, the actuary should issue a statement of actuarial opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the actuary should disclose the minimum amount that the actuary believes is reasonable.

c. Determination of Redundant or Excessive Provision. When the carried reserve amount is greater than the maximum amount that the actuary believes is reasonable, the actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the actuary should disclose the maximum amount that the actuary believes is reasonable.

d. Qualified Opinion. When, in the actuary’s opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified Statement of Actuarial Opinion. The actuary should disclose the item (or items) to which the qualification relates, the reasons for the qualification, and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the stated reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, except for the item (or items) to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item (or items) in question are not likely to be material.

e. No Opinion. The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.
6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

a. Risk of Material Adverse Deviation.

The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard with respect to the relevant characteristics of the Company. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.

b. Other Disclosures in Exhibit B

RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

If the Company’s reserves will cause the ratio of One-Year or Two-Year Known Claims Reserve Development (shown in Schedule P, Part 3) to the respective prior year’s Policyholders’ Surplus to be greater than 20%, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the exceptional reserve development.

c. Reinsurance

RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.

The Appointed Actuary’s comments on reinsurance collectability should address any uncertainty associated with including potentially-uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service, and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary’s comments do not imply an opinion on the financial condition of any reinsurer.


Financial reinsurance refers to contracts referenced in SSAP No. 62R—Property and Casualty Reinsurance of the Accounting Practices and Procedures Manual in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

d. Reserve Development

If the Company’s reserves will cause the ratio of One-Year or Two-Year Reserve Development (shown in Schedule P, Part 2) to the respective prior year’s Policyholders’ Surplus to be greater than 20%, the Appointed actuary must include RELEVANT COMMENT on the factors that led to the exceptional reserve development.
e. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly-appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for examination for seven years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to company management, the Board of Directors, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.

The Actuarial Report must also include:

- A description of the Appointed Actuary’s relationship to the Company, with clear presentation of the Appointed Actuary’s role in advising the Board and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

- An exhibit that ties to the Annual Statement and compares the Appointed Actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary’s conclusions include the Appointed Actuary’s point estimate(s), range(s) of reasonable estimates or both.

- An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary’s analysis, to the Annual Statement Schedule P.

- An exhibit or appendix showing the change in the Appointed Actuary’s estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. If the Appointed Actuary is newly-appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

- Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

- Extended comments on factors that led to exceptional reserve development, as defined in 6C and 6D, and how these factors were addressed in prior and current analyses.
8. The statement should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the date when the Opinion was rendered. The signature and date should appear in the following format:

___________________________________
Signature of Appointed Actuary
Printed name of Appointed actuary
Employer’s name
Address of Appointed Actuary
Telephone number of Appointed Actuary
Email address of Appointed Actuary
Date opinion was rendered

9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Opinion shall be considered to be in error if the Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected.

Notification shall be required for any such determination made between the issuance of the Actuarial Opinion and the balance sheet date for which the next Actuarial Opinion will be issued. The notification should include a summary of such findings and an amended Actuarial Opinion.

An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the summary and the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification a copy of the summary and amended Actuarial Opinion being furnished to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that the submitted Actuarial Opinion should no longer be relied upon or such other notification recommended by the actuary’s attorney.

If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the actuary and the Company should undertake as quickly as is reasonably practical those procedures necessary for the Appointed Actuary to make the determination discussed above. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the actuary should proceed with the notification discussed above.

No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibit A and Exhibit B are to be filed in both print and data capture format.
## Exhibit A: SCOPE

### DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMAT

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpaid Losses and Loss Adjustment Expenses (Schedule P, Part 1, Total Column 24 or 34 if discounting is allowable under state law)</td>
<td>$ ________</td>
</tr>
<tr>
<td>2. Unpaid Losses and Loss Adjustment Expenses - Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Columns 17, 18, 20, 21, and 23, Line 12 x 1000)</td>
<td>$ ________</td>
</tr>
<tr>
<td>3. Other items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>

## Exhibit B: DISCLOSURES

### DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMAT

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Name of the Appointed Actuary
2. The Appointed Actuary’s relationship to the Company.
   Enter E or C based upon the following:
   - E - If an Employee of the Company or Group
   - C - If a Consultant
3. The Appointed Actuary has the following designation (indicated by the letter code):
   - F - If a Fellow of the Casualty Actuarial Society (FCAS)
   - A - If an Associate of the Casualty Actuarial Society (ACAS)
   - M - If not a member of the Casualty Actuarial Society, but a Member of the American Academy of Actuaries (MAAA) approved by the Casualty Practice Council, as documented with the attached approval letter.
   - O - For Other
4. Type of Opinion, as identified in the OPINION paragraph. Enter R, I, E, Q, or N based upon the following:
   R - If Reasonable
   I - If Inadequate or Deficient Provision
   E - If Excessive or Redundant Provision
   Q - If Qualified (use Q when part of the OPINION is Qualified)
   N - If No Opinion

5. Materiality Standard expressed in U.S. dollars (used to answer question #6) $ __________

6. Are there significant risks that could result in Material Adverse Deviation? __________

7. Statutory Surplus (Liabilities, Surplus, and Other Funds Page, Line 32) $ __________

8. Known claims reserve (Liabilities, Surplus, and Other Funds Page, Line 1) $ __________

9. Statutory premium reserve (Liabilities, Surplus, and Other Funds Page, Line 2) $ __________

10. Aggregate of other reserves required by law (Liabilities, Surplus, and Other Funds Page, Line 3) $ __________

11. Supplemental reserve (Liabilities, Surplus, and Other Funds Page, Line 4) $ __________

12. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P $ __________

13. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P $ __________

14. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ __________
Remove the two sentences starting with “The log shall include categorization of CE approved for use by CAST…” to eliminate the reference to the CE Log study.

Add deadline for submission of QD to the Board: “at least one month prior…”

Add language about documenting review of QD at the level of the holding company structure that is responsible for overseeing insurance operations. (language from FEHTG+CT/Michelle’s proposal)

Add reference to ASOP 56 (Modeling), 1 (Introductory ASOP), 20 (Discounting of PC Unpaid Claim Estimates) and 21 (Responding to or Assisting Auditors or Examiners in Connection with Financial Audits, Financial Reviews, and Financial Examinations)

Add assertion that the qualification documentation was provided to the BOD, “directly or through Company Management.”

Michelle made a point that hardly any actuarial reports follow this format exactly. Usually this information is provided in various spots throughout the report. Do we want to word this language just to ask that this information is included, but not mandate the format and location?

What exactly are the actuary’s “conclusions”? Are they each prescribed SAO assertion, esp. that the carried amounts on Exhibit A meet state legal requirements, are based on or consistent with reserves based on good actuarial work, and make a provision that’s reasonable for P0Y?

Do we all expect the appointed actuary to use basic data and reasonable methods/assumptions to arrive at his/her indicated amount and/or range of reasonable amounts? And then expect a “Reasonable” SAO if the carried amounts are materially consistent with those “actuary’s conclusions?”

Is this really about the signature block? I see infrequent deviations in signature blocks and discourage the deviation.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 4, Actuarial communications. Okay.

The Actuarial Report must contain both narrative and technical components separate from each other.

The narrative component should provide sufficient detail to clearly explain the findings, recommendations and conclusions, as well as their significance.

The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work.

The narrative component should include an analysis of the basic data (e.g., loss triangle) to the conclusions.

The technical component must show the analysis from the basic data (e.g., loss triangle) to the actuary’s conclusions.

The Actuarial Report must contain separate narrative and technical components.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>Changes to Existing Reporting [ ]</td>
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| Property/Casualty [ X ] |
| Health [ ] |
| Separate Accounts [ ] |
| Protected Cell [ ] |
| Health (Life Supplement) [ ] |

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Changes and clarifying guidance in Sections 1, 3, and 8 of the Actuarial Opinion Instructions. Please see the attached red-line document for identification of each change.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Proposed changes include some clean-up and clarifications in the P/C Statement of Actuarial Opinion Instructions. Changes were adopted by Actuarial Opinion (C) Working Group on 3/1/2022.

Section 1:
- Guidance on continuing education (CE) logs is no longer required because the Casualty Actuarial and Statistical (C) Task Force’s CE Log project will not be reoccurring. Actuaries will refer to their respective societies for guidance on CE Logs.
- Additional guidance is provided on documentation of the board review of Qualification Documentation (QD) for companies that are part of a group whose parent board reviews QD on behalf of all subsidiaries. Guidance on this question has been requested by the industry and the Working Group has consulted the Financial Examination Handbook (E) Technical Group on the appropriate response.

Section 3: An additional requirement is added in the IDENTIFICATION paragraph for Appointed Actuaries to confirm that qualification documentation has been provided to the Board of Directors. This statement in the IDENTIFICATION paragraph will assist regulators in determining whether this requirement has been met.
Section 8: Clarification that the signature block requirements apply to the Statement of Actuarial Opinion only. The Actuarial Report should reproduce the same information, though not necessarily in the same format. It has been reported that Appointed Actuaries often provide the required information in a slightly different format within the Actuarial Report, necessitating Financial Examiners to create meaningless findings/objections just because the information doesn’t follow the exact format. The Working Group members agree that the prescribed format is applicable to the Actuarial Opinion only and the format in the Actuarial Report may vary.

** This section must be completed on all forms. Revised 7/18/2018
ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled “Statement of Actuarial Opinion” (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the Annual Statement Instructions – Property and Casualty.

Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

a. Name and title (and, in the case of a consulting actuary, the name of the firm).

b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

If subject to the U.S. Qualification Standards, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the U.S. Qualification Standards for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

In accordance with the CAS and SOA’s continuing education review procedures, an Appointed Actuary who is subject to the U.S. Qualification Standards and selected for review shall submit a log of their continuing education in a form determined by the CAS and SOA. The log shall include categorization of continuing education approved for use by the Casualty Actuarial and Statistical Task Force. As agreed with the actuarial organizations, the CAS and SOA will provide an annual consolidated report to the NAIC identifying the types and subject matter of continuing education being obtained by Appointed Actuaries. An Appointed Actuary subject to the U.S. Qualification Standards and not a member of the CAS or SOA shall follow the review procedures for the organization in which they submitted their attestation.

The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their appointment, and on an annual basis thereafter, directly or through company management. The documentation should include brief biographical information and a description of how the definition of “Qualified Actuary” is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document the company’s review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. It is generally expected that the review of the Appointed Actuary’s qualification documentation should take place at the level within a holding company structure that is responsible for overseeing insurance operations. If a statutory entity is a subsidiary or a non-lead pool member with an Appointed Actuary whose qualifications were reviewed by the pool lead or principal’s Board, the statutory entity’s Board can satisfy the review requirement by acknowledging the parent Board’s review. This can be done by noting in the meeting minutes the name of the principal or lead entity and the date the parent Board reviewed the qualification documentation, or by attaching a copy of the parent Board’s meeting minutes reflecting their review of the qualification documentation. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.
If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former Appointed Actuary’s satisfaction and those not resolved to the former Appointed Actuary’s satisfaction. The letter should include a description of the disagreement and the nature of its resolution (or that it was not resolved). Within this same ten (10) business days, the Insurer shall in writing also request such former Appointed Actuary to furnish a letter addressed to the Insurer stating whether the Appointed Actuary agrees with the statements contained in the Insurer’s letter and, if not, stating the reasons for which he or she does not agree. The former Appointed Actuary shall provide a written response to the insurer within ten (10) business days of such request, and the Insurer shall furnish such responsive letter from the former Appointed Actuary to the domiciliary commissioner together with its own responses.

The Appointed Actuary must report to the Board of Directors each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors and identify the manner of presentation (e.g., webinar, in-person presentation, written). A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

The Actuarial Opinion and the supporting Actuarial Report and workpapers should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including, but not limited to, ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.

1A. Definitions

“Appointed Actuary” is a Qualified Actuary (or individual otherwise approved by the domiciliary commissioner) appointed by the Board of Directors in accordance with Section 1 of these instructions.

“Board of Directors” can include the designated Board of Directors, its equivalent or an appropriate committee directly reporting to the Board of Directors.

“Qualified Actuary” is a person who:

(i) Meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualifications Standards), promulgated by the American Academy of Actuaries (Academy):

(ii) Has obtained and maintains an Accepted Actuarial Designation; and

(iii) Is a member of a professional actuarial association that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.

An exception to parts (i) and (ii) of this definition would be an actuary evaluated by the Academy’s Casualty Practice Council and determined to be a Qualified Actuary for particular lines of business and business activities.
“Accepted Actuarial Designation” in item (ii) of the definition of a Qualified Actuary, is an actuarial designation accepted as meeting or exceeding the NAIC’s Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (published on the NAIC website). The following actuarial designations, with any noted conditions, are accepted as meeting or exceeding basic education minimum standards:

(i) Fellow of the CAS (FCAS) – Condition: basic education must include Exam 6 – Regulation and Financial Reporting (United States);

(ii) Associate of the CAS (ACAS) – Conditions: basic education must include Exam 6 – Regulation and Financial Reporting (United States) and Exam 7 – Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management;

(iii) Fellow of the SOA (FSA) – Conditions: basic education must include completion of the general insurance track, including the following optional exams: the United States’ version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.

The table below provides some allowable exam substitutions for (i), (ii) and (iii) in the definition of “Accepted Actuarial Designation:” Noting that CAS exams have changed over time, exceptions for (i) and (ii) provide for FCAS/ACAS designations achieved before an exam was created (e.g. CAS Exam 6-US) or with an earlier version of an exam or exam topic (e.g., 2010 CAS Exam 6 instead of the current CAS Exam 7 Section A). FCAS/ACAS qualified under the 2018 and prior Statement of Actuarial Opinion instructions can use the noted substitution rules to achieve qualification under the new instructions by demonstrating basic and/or continuing education of the required topics including material in CAS Exam 6 (US) and section A of CAS Exam 7 (in the May 2019 CAS syllabus). Exceptions for (iii) for an FSA are also included in the table.

The SOA exams completed in the general insurance track in 2019 and prior should be supplemented with continuing education and experience to meet basic education requirements in the U.S. Qualification Standards. For purpose of these instructions only, the table also includes specific exams from other organizations that are accepted as substitutes.

<table>
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<tr>
<th>Exception for (i), (ii), or (iii)</th>
<th>Exam:</th>
<th>Exam Substitution Allowed*</th>
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<tr>
<td>(i) and (ii) CAS Exam 6 (US)</td>
<td>1. Any CAS version of a U.S. P/C statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 (US) in 2011.</td>
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<td>2. An FCAS or ACAS earned prior to 2021 who did not pass CAS Exam 6 (US) or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 6 (US) provided the Appointed Actuary explains in his/her qualification documentation how knowledge of U.S. financial reporting and regulation was obtained.</td>
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<td>3. SOA FREU (US) Exam</td>
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<td>(ii) CAS Exam 7</td>
<td>1. Any CAS version of an exam including advanced P/C reserving administered prior to creation of Exam 7 in 2011.</td>
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<td></td>
<td>2. An ACAS earned prior to 2021 who did not pass CAS Exam 7 or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 7 provided the Appointed Actuary explains in his/her qualification documentation how knowledge of the additional reserving topics in CAS Exam 7 (Section A) in the May 2019 syllabus was obtained.</td>
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<td>3. SOA Advanced Topics Exam (Note: The ERM portion of Exam 7 is not needed to meet NAIC educational standards, therefore SOA ERM Exam is not needed for the substitution for this purpose.)</td>
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<tr>
<td>(iii) SOA FREU (US) Exam</td>
<td>1. Any CAS version of a U.S. statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 in 2011.</td>
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<tr>
<td>(iii) SOA Advanced Topics Exam</td>
<td>1. CAS Exam 7</td>
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<tr>
<td></td>
<td>2. Any CAS version of an exam containing the advanced techniques to estimate policy liabilities (i.e., advanced reserving).</td>
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*Note: These exam substitutions only apply to these instructions and are not applicable for CAS or SOA exam waivers.
“Insurer” or “Company” means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

“Actuarial Report” means a document or other presentation prepared as a formal means of conveying to the state regulatory authority and the Board of Directors the Appointed Actuary’s professional conclusions and recommendations of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the Appointed Actuary’s opinion or findings, and of documenting the analysis underlying the opinion. The required content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

“Property and Casualty (P&C) Long Duration Contracts” refers to contracts (excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts) that fulfill both of the following conditions: (1) the contract term is greater than or equal to 13 months; and (2) the insurer can neither cancel the contract nor increase the premium during the contract term. These contracts are subject to the three tests of SSAP No. 65—Property and Casualty Contracts of the NAIC Accounting Practices and Procedures Manual.

“Accident and Health (A&H) Long Duration Contracts” refers to A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required. See Schedule H instructions for a description of categories of contract reserves, as well as policy features that give rise to contract reserves. Two specific examples of contracts that typically require contract reserves are long-term care and disability income insurance.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.
Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent (1%) of the insurer’s capital and surplus reflected in the insurer’s latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer’s direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer’s latest quarterly statements filed with its domiciliary commissioner.

1C. Reporting Requirements for Pooled Companies

For each company in the pool, the Appointed Actuary shall include a description of the pool, identification of the lead company and a listing of all companies in the pool, their state of domicile and their respective pooling percentages.

Exhibits A and B for each company in the pool should represent the company’s share of the pool and should reconcile to the financial statement for that company.

The following paragraph applies to companies that have a 0% share of the pool (no reported Schedule P data). The company shall submit an Actuarial Opinion that reads similar to that provided for the lead company. For example, the IRIS ratio and risk of material adverse deviation discussions, and other relevant comments shall relate to the risks of the lead company in the pool. The Exhibit B responses to question 5 should be $0 and to question 6 should be “not applicable.” Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the 0% companies in their data capture).

2. The Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary’s work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary’s relationship to the Company, qualifications for acting as Appointed Actuary and date of appointment and specify that the appointment was made by the Board of Directors. Additionally, the IDENTIFICATION paragraph should include a statement asserting that the Appointed Actuary has complied with the requirement to provide qualification documentation to the Board of Directors, either directly or through company management.

If the Appointed Actuary was approved by the Academy to be a “Qualified Actuary,” with or without limitation, or if the Appointed Actuary is not a Qualified Actuary but was approved by the domiciliary commissioner, the company must attach, each year, the approval letter and reference such in the identification paragraph.

4. The SCOPE paragraph should contain a sentence such as the following:

“I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date.”

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.
The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

“In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by __________ (officer name and title at the Company). I evaluated that data for reasonableness and consistency. I also reconciled that data to Schedule P, Part 1 of the Company’s current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary.”

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration:

“In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of (state of domicile).
B. Are computed in accordance with accepted actuarial standards.
C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.”

If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts or Other Loss Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:

D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or <insert Other Loss Reserve item on which the Appointed Actuary is expressing an Opinion> of the Company under the terms of its contracts and agreements.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards.

If the Appointed Actuary has made use of the analysis of another actuary not within the Appointed Actuary’s control (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name, credential and affiliation within the OPINION paragraph. If the Appointed Actuary has made use of the work of a non-actuary (such as for modeling) for a material portion of the reserves, that individual must be identified by name and affiliation and a description of the type of analysis performed must be provided.

A Statement of Actuarial Opinion should be made in accordance with one of the following sections (1 through 5). The Appointed Actuary must explicitly identify in Exhibit B which type applies.

1. Determination of Reasonable Provision. When the carried reserve amount is within the Appointed Actuary’s range of reasonable reserve estimates, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

2. Determination of Deficient or Inadequate Provision. When the carried reserve amount is less than the minimum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the minimum amount that the Appointed Actuary believes is reasonable.

3. Determination of Redundant or Excessive Provision. When the carried reserve amount is greater than the maximum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the maximum amount that the Appointed Actuary believes is reasonable.
4. **Qualified Opinion.** When, in the Appointed Actuary’s opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items, the Appointed Actuary should issue a qualified Statement of Actuarial Opinion. The Appointed Actuary should disclose the item (or items) to which the qualification relates, the reason(s) for the qualification and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, **except for** the item (or items) to which the qualification relates. The Appointed Actuary is not required to issue a qualified opinion if the Appointed Actuary reasonably believes that the item (or items) in question are not likely to be material.

5. **No Opinion.** The Appointed Actuary’s ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the Appointed Actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

   A. **Company-Specific Risk Factors**

      The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the Appointed Actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

   B. **Risk of Material Adverse Deviation**

      The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.

   C. **Other Disclosures in Exhibit B**

      RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

   D. **Reinsurance**

      RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.

      The Appointed Actuary’s comments on reinsurance collectability should address any uncertainty associated with including potentially uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the Appointed Actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary’s comments do not imply an opinion on the financial condition of any reinsurer.

Financial reinsurance refers to contracts referenced in SSAP No. 62R in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

E. IRIS Ratios

If the Company’s reserves will create exceptional values under the NAIC IRIS Tests for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

F. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for regulatory examination for seven (7) years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Actuarial Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to Company management, the Board of Directors, the regulator or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.

Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in the NAIC Accounting Practices and Procedures Manual requires a company with over 10,000 in force lives covered by long-term care (LTC) insurance contracts as of the valuation date to perform a stand-alone asset adequacy analysis for its in force long-term care (LTC) contracts. The Actuarial Report and workpapers summarizing the results, assumptions and testing procedures for the asset adequacy testing of LTC business must be in compliance with AG 51 requirements. When referring to AG 51, the term “Actuarial Memorandum” is synonymous with Actuarial Report and workpapers.

The Actuarial Report should contain disclosure of all reserve amounts associated with A&H Long Duration Contracts reported by the Company; the reserve amounts in the Actuarial Report should tie to the Annual Statement.
The Actuarial Report must also include:

A. A description of the Appointed Actuary’s relationship to the Company, with clear presentation of the Appointed Actuary’s role in advising the Board of Directors and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board of Directors and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

B. An exhibit that ties to the Annual Statement and compares the Appointed Actuary’s conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed Actuary’s conclusions include the Appointed Actuary’s point estimate(s), range(s) of reasonable estimates or both.

C. An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary’s analysis, to the Annual Statement Schedule P line of business reporting. An explanation should be provided for any material differences.

D. An exhibit or appendix showing the change in the Appointed Actuary’s estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. The exhibit or appendix should illustrate the changes on a net basis but should also include the changes on a gross basis, if relevant. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

E. Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

F. Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Policyholders’ Surplus, Two-Year Reserve Development to Policyholders’ Surplus or Estimated Current Reserve Deficiency to Policyholders’ Surplus, and how these factors were addressed in prior and current analyses.

8. The Actuarial Opinion and the Actuarial Report should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the respective dates when the Actuarial Opinion was rendered and the Actuarial Report finalized. The signature and date should appear in the following format:

__________________________
Signature of Appointed Actuary

__________________________
Printed name of Appointed Actuary

__________________________
Employer’s name

__________________________
Address of Appointed Actuary

__________________________
Telephone number of Appointed Actuary

__________________________
Email address of Appointed Actuary

__________________________
Date opinion was rendered

The same information should be reproduced within the Actuarial Report, along with the date the Actuarial Report was finalized.

9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Actuarial Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Actuarial Opinion shall be considered to be in error if the Actuarial Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Actuarial Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification is required when discovery is made between the issuance of the Actuarial Opinion and Dec. 31 of that year. Notification should include a summary of such findings.
If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended Actuarial Opinion submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended Actuarial Opinion has been finalized.

No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

### Exhibit A: SCOPE

**DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS**

<table>
<thead>
<tr>
<th>Loss and Loss Adjustment Expense Reserves:</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)</td>
<td>$ ________</td>
</tr>
<tr>
<td>2. Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)</td>
<td>$ ________</td>
</tr>
<tr>
<td>3. Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)</td>
<td>$ ________</td>
</tr>
<tr>
<td>4. Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)</td>
<td>$ ________</td>
</tr>
<tr>
<td>5. The Page 3 write-in item reserve, “Retroactive Reinsurance Reserve Assumed”</td>
<td>$ ________</td>
</tr>
<tr>
<td>6. Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Premium Reserves:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Reserve for Direct and Assumed Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ ________</td>
</tr>
<tr>
<td>8. Reserve for Net Unearned Premiums for P&amp;C Long Duration Contracts</td>
<td>$ ________</td>
</tr>
<tr>
<td>9. Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>
Exhibit B: DISCLOSURES
DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

1. Name of the Appointed Actuary
   Last _______ First _______ Mid _______

2. The Appointed Actuary’s relationship to the Company
   Enter E or C based upon the following:
   E if an Employee of the Company or Group
   C if a Consultant

3. The Appointed Actuary’s Accepted Actuarial Designation (indicated by the letter code):
   F if a Fellow of the Casualty Actuarial Society (FCAS)
   A if an Associate of the Casualty Actuarial Society (ACAS)
   S if a Fellow of the Society of Actuaries (FSA) through the General Insurance track
   M if the actuary does not have an Accepted Actuarial Designation but is approved by the Academy’s Casualty Practice Council.
   O for Other

4. Type of Opinion, as identified in the OPINION paragraph.
   Enter R, I, E, Q, or N based upon the following:
   R if Reasonable
   I if Inadequate or Deficient Provision
   E if Excessive or Redundant Provision
   Q if Qualified. Use Q when part of the OPINION is Qualified.
   N if No Opinion

5. Materiality Standard expressed in U.S. dollars (used to Answer Question #6) $ _______

6. Are there significant risks that could result in Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]

7. Statutory Surplus (Liabilities, Surplus and Other Funds page, Col 1, Line 37) $ _______

8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $ _______

9. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P
   9.1 Nontabular Discount [Notes, Line 32B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 1, 2, 3, & 4 $ _______
   9.2 Tabular Discount [Notes, Line 32A23, (Amounts 1 & 2)], Electronic Filing Col 1 & 2 $ _______

10. The net reserves for losses and loss adjustment expenses for the Company’s share of voluntary and involuntary underwriting pools’ and associations’ unpaid losses and loss adjustment expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines $ _______
11. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines *

11.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 33A03D, ending net asbestos reserves for current year) Electronic Filing Col 5 $ ________

11.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 33D03D, ending net environmental reserves for current year), Electronic Filing Col 5 $ ________

12. The total claims made extended loss and loss adjustment expense, and unearned premium reserves (Greater than or equal to Schedule P Interrogatories)

12.1 Amount reported as loss and loss adjustment expense reserves $ ________

12.2 Amount reported as unearned premium reserves $ ________

13. The net reserves for the A&H Long Duration Contracts that the Company carries on the following lines on the Liabilities, Surplus and Other Funds page:

13.1 Losses $ ________

13.2 Loss Adjustment Expenses $ ________

13.3 Unearned Premium $ ________

13.4 Write-In (list separately, adding additional lines as needed, and identify (e.g., “Premium Deficiency Reserves”, “Contract Reserves other than Premium Deficiency Reserves” or “AG 51 Reserves”)) $ ________

14. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ ________

* The reserves disclosed in item 11 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor’s Pollution Liability, Consultant’s Environmental Liability, and Pollution and Remediation Legal Liability.

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Jan. 27, 2022. The following Working Group members participated: Sandra Darby, Chair (ME); Wanchin Chou, Vice Chair, and Qing He (CT); Cynthia Amann (MO); Christian Citarella (NH); Alexander Vajda (NY); Tom Botsko (OH); Andrew Schallhorn (OK); David Dahl (OR); and Brian Ryder (TX). Also participating were: Luciano Gobbo (CA); Randy Jacobson (HI); Anthony Bredel (IL); Nichole Torblaa (LA); Regan Hess (MT); and Chris Aufenthie (ND).

1. **Discussed Suggested Changes to NAIC Statistical Reports**

Ms. Darby said Arthur Schwartz (NC) submitted potential changes to the *Competition Database Report* (Competition Report), the *Auto Database Report* (Auto Report), and the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report).

Ms. Darby said for the Competition Report, there were questions about the market share data. She said it was unclear whether these suggestions were a replacement or a supplement for the current report. Mr. Botsko said he would like to know why certain columns were eliminated in this spreadsheet.

Ms. Darby said for the Auto Report, the submitting statistical agents would need to clarify if they can provide the data by metropolitan statistical area (MSA). She said it is unclear what the data source would be for elements like median car value and median per capita income.

Ms. Darby said for the Homeowners Report, it is unclear what the data source would be for median home value and what the difference is between new homes and all homes. She said mobile home coverage may not be able to be broken out and reported separately as requested.

Ms. Darby said she would compile a list of questions about these proposed changes to send to Mr. Schwartz. She said these suggestions would be discussed on a future call for Mr. Schwartz to address the questions.

2. **Discussed the Timeline of Data Collection for NAIC Statistical Reports**

Ms. Darby said the Working Group has a charge from the Casualty Actuarial and Statistical (C) Task Force to adopt a faster timeline for the publication of auto insurance and homeowners insurance average premiums. She said the Auto Report could not include loss and claims data on a sped-up timeline, and the Homeowners Report would not include California detailed data every year, as that data is collected by the California Department of Insurance (DOI) only every other year. Mr. Citarella said the Working Group should consider adopting a sped-up timeline for the Homeowners Report. He said if California data can only be collected every other year, then the report should still be published, and it can include California data in the years that it is available. Mr. Gobbo said California can provide high level information every year, but it can only provide the homeowners data by insurance range every other year.

Libby Crews (NAIC) said the Working Group would need to produce two reports in one year to catch up to the desired timeline.
Due to this change, Mr. Chou asked for a longer exposure period to review the reports when they are completed for the year.

Mr. Chou made a motion, seconded by Mr. Citarella, to speed up the timeline of the Homeowners Report by collecting data from the most recent data year and collect two years of data in 2022 to catch up to the new timeline. The motion passed unanimously.

Ms. Darby said a sped-up timeline for the Auto Report would not include loss and claims data, as that cannot be collected on a faster timeline.

Birny Birnbaum (Center for Economic Justice—CEJ) said more recent average premium data can be added to the report along with historical loss information. Ms. Darby asked if the more recent average premium data should be added to the report as an appendix. Mr. Birnbaum said the information should not be in an appendix. He said the report would just have one more recent year of average premium data than the loss data. Mr. Dahl said it would be better to have the more recent premium information in a separate table so that readers are not trying to compare premium and loss information for different years.

Mr. Citarella asked if NAIC staff could provide mock-ups of the more recent average premium data added into the current tables and added as a separate table.

3. Discussed Initiating a Review of the Statistical Handbook

Ms. Darby said the Working Group should begin a review of the Statistical Handbook (Handbook). She said the Handbook has not been updated since 2012. She asked any Working Group member that would like to lead the review of a section of the Handbook to reach out. She said the Working Group would work on updating the Handbook throughout the year.

Having no further business, the Statistical Data (C) Working Group adjourned.
APPENDIX B-RF – INFORMATION ELEMENTS AND GUIDANCE FOR A REGULATOR TO MEET BEST PRACTICES’ OBJECTIVES (WHEN REVIEWING RANDOM FORESTS)

This appendix identifies the information a state insurance regulator may need to review a Random Forest predictive model used by an insurer to support a personal automobile or home insurance rating plan. The list is lengthy but not exhaustive. It is not intended to limit the authority of a regulator to request additional information in support of the model or filed rating plan. Nor is every item on the list intended to be a requirement for every filing. However, the items listed should help guide a regulator to sufficient information that helps determine if the rating plan meets state-specific filing and legal requirements. Documentation of the design and operational details of the model will help ensure the business continuity and transparency of the models used. Documentation should be sufficiently detailed and complete to enable a qualified third party to form a sound judgment on the suitability of the model for the intended purpose. The theory, assumptions, methodologies, software, and empirical bases should be explained, as well as the data used in developing and implementing the model. Relevant testing and ongoing performance testing need to be documented. Key model limitations and overrides need to be pointed out so that stakeholders understand the circumstances under which the model does not work effectively. End-user documentation should be provided and key reports using the model results described. Major changes to the model need to be documented and shared with regulators in a timely and appropriate manner. Information technology (IT) controls should be in place, such as a record of versions, change control, and access to the model.

Many information elements listed below are probably confidential, proprietary, or trade secret and should be treated as such, in accordance with state laws and/or regulations. Regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. For example, some proprietary models may have contractual terms (with the insurer) that prevent disclosure to the public. Without clear necessity, exposing this data to additional dissemination may compromise the model’s protection. Although the list of information is long, the insurer should already have internal documentation on the model for more than half of the information listed. The remaining items on the list require either minimal analysis (approximately 25%) or deeper analysis to generate for a regulator (approximately 25%).

The “Level of Importance to the Regulator’s Review” is a ranking of information a regulator may need to review which is based on the following level criteria:

Level 1 – This information is necessary to begin the review of a predictive model. These data elements pertain to basic information about the type and structure of the model, the data and variables used, the assumptions made, and the goodness of fit. Ideally, this information would be included in the filing documentation with the initial submission of a filing made based on a predictive model.

Level 2 – This information is necessary to continue the review of all but the most basic models, such as those based only on the filer’s internal data and only including variables that are in the filed rating plan. These data elements provide more detailed information about the model and address questions arising from review of the information in Level 1. Insurers concerned with speed to market may also want to include this information in the filing documentation.

Level 3 – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on review of the information in Level 1 and Level 2. These data elements address even more detailed aspects of the model. This information does not necessarily need to be included with the initial submission, unless specifically requested by a particular state, as it is typically requested only if the reviewer has concerns that the model may not comply with state laws and/or regulations.

Level 4 – This information is necessary to continue the review of a model where concerns have been raised and not resolved based on the information in Level 1, Level 2, and Level 3. This most granular level of detail is addressing

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2 There are some models that are made public by the vendor and would not result in a hindrance of the model’s protection.
the basic building blocks of the model and does not necessarily need to be included by the filer with the initial submission, unless specifically requested by a particular state. It is typically requested only if the reviewer has serious concerns that the model may produce rates or rating factors that are excessive, inadequate, and/or unfairly discriminatory.

Appendix B-RF is focused on Random Forest models and should not be referenced in the review of other model types. Random Forest models are a tree-based approach with many significant differences from GLMs. This Appendix B-RF is intended to provide state guidance for the review of rate filings based on Random Forest models.
## A. SELECTING MODEL INPUT

<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1. Available Data Sources | Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model). | 1 | Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets.

Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes.

Note: Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh. |

<p>| | Reconcile aggregated insurance data underlying the model with available external insurance reports. | 4 | Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer’s data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer’s data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to the Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>2</td>
<td>Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should explain why any states were excluded from the countrywide data. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur. The company should provide a demonstration that the model fits well on the specific state or surrounding region.</td>
</tr>
</tbody>
</table>

2. Sub-Models

<p>| A.2.a   | Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models. | 3 | Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. Random Forest models handle redundant variables by splitting on only one of the variables within each component tree. By contrast, GLMs struggle with redundant variables as they try to include redundant variables simultaneously. However, best actuarial practice is to keep models as parsimonious as possible and only include additional variables that contribute significant additional predictive power. |
| A.2.b   | Determine if the sub-model was previously approved (or accepted) by the regulatory agency. | 1 | If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model’s review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review. Note: A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model’s indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful. |</p>
<table>
<thead>
<tr>
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<th>Level of Importance to the Regulator’s Review</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2.c</td>
<td>Determine if the sub-model output was used as input to the Random Forest; obtain the vendor name, as well as the name and version of the sub-model.</td>
<td>1</td>
<td>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</td>
</tr>
<tr>
<td>A.2.d</td>
<td>If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.</td>
<td>1</td>
<td>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</td>
</tr>
<tr>
<td>A.2.e</td>
<td>Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.</td>
<td>1</td>
<td>If a weather-based sub-model is input to the Random Forest under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</td>
</tr>
<tr>
<td>Section</td>
<td>Information Element</td>
<td>Level of Importance to the Regulator’s Review</td>
<td>Comments</td>
</tr>
<tr>
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</tr>
<tr>
<td>A.2.f</td>
<td>If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.</td>
<td>1</td>
<td>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</td>
</tr>
<tr>
<td>3. Adjustments to Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.3.a</td>
<td>Determine if premium, exposure, loss, or expense data were adjusted (e.g., on-leveled, developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.</td>
<td>2</td>
<td>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance. Premium should be brought to current rate level if the target variable is calculated with a premium metric, such as loss ratio. Premium can be brought to current rate level with the extension of exposures method or the parallelogram method. Note that the premium must be on-leveled at a granular variable level for each variable included in the new model if the parallelogram method is used. Statewide on-level factors by coverage are typically sufficient for statewide rate indication development but not sufficient for models that determine rates by variable level.</td>
</tr>
<tr>
<td>A.3.b</td>
<td>Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.</td>
<td>1</td>
<td>Pre-modeling binning may be unnecessary in a random forest model. The tree model will naturally segment numerical values in the splitting process of the trees. However, if the insurer does bin variables before modeling, the reason should be understood.</td>
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<td><strong>A.3.c</strong></td>
<td>Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.</td>
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<td>This is most relevant for variables that have been “scrubbed” or adjusted. Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it. It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.</td>
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<tr>
<td>A.3.d</td>
<td>Determine how missing data was handled.</td>
<td>1</td>
<td>This is most relevant for variables that have been “scrubbed” or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or “not available” values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats. The modeler should describe the way the tree fitting process handled missing values. The modeler should specify if missing values are treated before running the tree model or if they are allowed to be handled by the tree model. When creating predictions on new datasets (such as hold out datasets), tree-based models may have different approaches for handling missing data or categorical levels not encountered in the training data for a predictor variable. The modeler should specify the process utilized when this occurs.</td>
</tr>
<tr>
<td>A.3.e</td>
<td>If duplicate records exist, determine how they were handled.</td>
<td>1</td>
<td>Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer’s response, the regulator should ask for the filer’s materiality standard.</td>
</tr>
<tr>
<td>A.3.f</td>
<td>Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.</td>
<td>3</td>
<td></td>
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<tr>
<td>4. Data Organization</td>
<td>Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.</td>
<td>2</td>
<td>This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.</td>
</tr>
<tr>
<td>A.4.b</td>
<td>Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.</td>
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<td>2</td>
<td>An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, the company should provide support and a rational explanation for their use.</td>
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<tr>
<td>A.4.c</td>
<td>Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
<td>1</td>
<td>“None” or “N/A” may be an appropriate response.</td>
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### B. BUILDING THE MODEL

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<tbody>
<tr>
<td>1.</td>
<td>1. High-Level Narrative for Building the Model</td>
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<tr>
<td>B.1.a</td>
<td>Identify the type of model underlying the rate filing (e.g., Random Forest, GLM, decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.). Understand the model’s role in the rating system and provide the reasons why that type of model is an appropriate choice for that role.</td>
<td>1</td>
<td>It is important to understand if the model in question is a Random Forest and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage. <strong>Note:</strong> If the model is not a Random Forest, the information elements in this white paper may not apply in their entirety.</td>
</tr>
<tr>
<td>B.1.b</td>
<td>Identify the software used for model development. Obtain the name of the software vendor/developer, software product, and a software version reference used in model development.</td>
<td>3</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a “contact” in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</td>
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<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.</td>
<td>1</td>
<td>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset. The discussion of training, test, and/or validation datasets is a separate discussion from the % of observations (rows of data) or % of features (columns of data) used within each tree. These splits are based on hyperparameters and are commented on in other sections.</td>
</tr>
<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan.</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
<tr>
<td>B.1.e</td>
<td>Obtain a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
<td>1</td>
<td>A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the “raw” data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.</td>
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<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td>Candidate variables are the variables used as input to the modeling process. Certain variables may not end up used in the final model if none of the component trees of the model split on the variable. The narrative regarding the candidate variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making</td>
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the decisions regarding candidate variable selection. The modeler should comment on the use of automated feature selection algorithms to choose candidate predictor variables and explain how potential overfitting that can arise from these techniques was addressed.
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<tr>
<td>B.1.h</td>
<td>In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.</td>
<td>3</td>
<td>The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected.</td>
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<tr>
<td>B.1.i</td>
<td>Determine if model input data was segmented in any way (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.</td>
<td>1</td>
<td>The regulator would use this to follow the logic of the modeling process.</td>
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<tr>
<td>2. Medium-Level Narrative for Building the Model</td>
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<tr>
<td>B.2.a</td>
<td>At crucial points in model development, if selections were made among alternatives regarding model assumptions, techniques, or hyperparameters, obtain a narrative on the judgment used to make those selections.</td>
<td>2</td>
<td>Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.</td>
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<tr>
<td>B.2.b</td>
<td>If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.</td>
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<tr>
<td>B.2.d</td>
<td>Identify which distribution was used for the model (e.g., Regression based on Poisson, Gamma, Logistic, or Tweedie are common choices). Obtain an explanation of why the distribution was chosen. Certain distribution assumptions will involve numerical parameters, for example regression with a Tweedie assumed distribution will have a p power value. Obtain the specific numerical parameters associated with the distribution.</td>
<td>1</td>
<td>Tree-based methods combine predictions from multiple component trees and aggregate them into a final prediction for each observation. Common methods for combining random forest model predictions include the arithmetic or geometric mean of all the component trees.</td>
</tr>
<tr>
<td>B.2.e</td>
<td>Obtain a narrative on how the predictions from the component trees are combined to arrive at a final model prediction.</td>
<td>2</td>
<td></td>
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<tr>
<td>B.2.f</td>
<td>If there were data situations in which weights were used, obtain an explanation of how and why they were used.</td>
<td>3</td>
<td>Investigate whether identical records were combined to build the model.</td>
</tr>
<tr>
<td>B.3.1</td>
<td>Obtain the number of component trees comprising the Random Forest model. Obtain a narrative on how this number was chosen.</td>
<td>1</td>
<td>Random Forest models should contain enough trees to reduce error to an acceptable level. Random forest models should balance this with the concept of parsimony. A model with fewer trees that achieves relatively similar reduction in error is preferable to a model with more trees. Checking the error on a test dataset or out of bag error for different numbers of trees can reveal at what value the error on test data starts to level off. Modelers might rely on early stopping rules within modeling software to arrive at the final number of trees. The narrative on the number of trees should discuss the stopping criterion, which defines what condition is met when the model stopped adding more trees.</td>
</tr>
<tr>
<td>B.3.2</td>
<td>Obtain the sampling parameters that apply to both the percent of observations used in each component tree and the number of features tested for each split within each tree. Obtain a narrative on how the sampling parameters were selected.</td>
<td>1</td>
<td>Random forest models often sample both the observations (typically rows of modeling data) with replacement and sample the features (typically columns of modeling data) This means that each tree has a bootstrapped dataset. The company should discuss the bagging fraction (a.k.a. sample size) applied to observations (typically rows of data). This is often expressed as a percent. For example: perhaps each tree is based on a bootstrapped sample which is 50% of the original dataset. The company should discuss the number of features</td>
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<td>B.3.3 Obtain the maximum depth that applies to the component trees in the model. Obtain a narrative on how this number was chosen.</td>
<td>The depth of a tree is the number of splits that are allowed to occur between the root node and the terminal nodes. This number can be set explicitly in modeling software or may be implicitly set if the company applies a splitting constraint, such as a minimum observations per node. Maximum tree depths of 8 or higher are considered extremely high.</td>
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<tr>
<td>B.3.4 Obtain parameters that determined the volume of data in each tree node and a narrative of how parameters were chosen.</td>
<td>Minimum data volume constraints can be applied to a tree-based model, such that the trees will not create a split that would result in terminal nodes with volume below a set amount. The modeler should comment on how the threshold was chosen. If there was no minimum data volume threshold applied to the trees, or if the threshold was exceedingly small, obtain an explanation of any post-modeling adjustments the modeler made to address the credibility considerations and how the adjustments were applied.</td>
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<tr>
<td>B.3.5 Obtain a narrative of the process to select all hyperparameters for the Random Forest. Detail how this process addressed potential overfitting in the model.</td>
<td>The narrative should include a description of each hyperparameter, document the values of the hyperparameters, specify the implication of using a higher or lower value for each hyperparameter, and discuss any sensitivity testing completed on the hyperparameters and observations from the sensitivity analysis. Hyperparameter tuning can be done in a variety of ways. The rigor of the tuning process should reflect the risk of overfitting on the specific dataset.</td>
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<tr>
<td>3. Predictor Variables</td>
<td>Obtain a complete data dictionary, including the names, types, definitions, and rationales for each variable.</td>
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<tr>
<td>B.3.a</td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
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</tr>
<tr>
<td>B.3.c</td>
<td>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</td>
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<tr>
<td>B.3.d</td>
<td>Obtain plots describing the relationship between each predictor variable and the target variable. Obtain a rational explanation for the observed relationship between each predictor variable and the target variable (frequency, severity, loss costs, expenses, or any element or characteristic being predicted).</td>
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seek to understand the relationship that variable has to the target variable.

The regulator should also consider that interpretability plots for tree-based models need to be reviewed with other considerations in mind. For example, partial dependence calculations assume independence with other variables in the model.
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<tr>
<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.</td>
<td>2</td>
<td>Variable Importance Plots for tree-based methods highlight which variables contributed most to the model. There are multiple ways to calculate variable importance. Variables with the lowest importance measures should be prioritized when identifying variables that may not be contributing significantly to the model. Variables may have a low importance measure due to high correlation with other variables, but may still prove useful if they interact with other variables to identify unique subsets of risks. Variables with the highest importance measures should be prioritized when determining which variables have the largest impact on predictions.</td>
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<tr>
<td>B.3.f</td>
<td>Obtain variable importance plots. Obtain a description of how variable importance was calculated.</td>
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### 4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures

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<tr>
<td>B.4.a</td>
<td>Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model’s projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data.</td>
<td>1</td>
<td>For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk. <strong>Note:</strong> It may be useful to consider geographic stability measures for territories within the state.</td>
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<tr>
<td>B.4.e</td>
<td>Obtain evidence that the model fits the training data well by variable and for the overall model.</td>
<td>2</td>
<td>The regulator should ask for the company to provide exhibits or plots that show the fitted average makes sense when compared to the observed average for variables of interest. Regulators would ideally review this comparison for every variable, but time constraints may limit the focus to just variables of interest. Variables of interest should include those with a high importance measure (which will have the most material impact on rates), those with a low importance measure (which may not be contributing significantly to the model), variables without an intuitive relationship to loss, or variables that may be proxies for a protected class attribute.</td>
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<td>B.4.g</td>
<td>Obtain a description how the model was tested for stability over time.</td>
<td>2</td>
<td>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</td>
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<tr>
<td>B.4.h</td>
<td>Obtain a narrative on how potential concerns with overfitting were addressed.</td>
<td>2</td>
<td>Tree-based models such as Random Forest models are notorious for overfitting. The company should provide a narrative on how overfitting was addressed. The company should provide a lift chart on training data used to fit the model and a lift chart on testing data which was not used to fit the model. If pruning was utilized to address overfitting, the narrative should provide commentary on the pruning process.</td>
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<td>B.4.i</td>
<td>Obtain support demonstrating that the Random Forest assumptions are appropriate.</td>
<td>3</td>
<td>A visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular Random Forest work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</td>
</tr>
<tr>
<td>B.4.j</td>
<td>Obtain 5-10 sample records with corresponding output from the model for those records.</td>
<td>2</td>
<td>The company should provide comprehensive documentation of the rating algorithm such that a rate can be reproduced for any theoretical risk. The company should demonstrate the comprehensiveness of the documentation by providing 5-10 sample records with corresponding input variable values and the final model prediction. The company should describe how the final model prediction aggregates the individual tree model predictions. The company should describe how to use other filing exhibits to reproduce the final model prediction for each sample record.</td>
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<tr>
<td>B.4.k</td>
<td>Obtain a deviance analysis by number of trees.</td>
<td>2</td>
<td>The company should provide a plot showing that the deviance of the overall model decreases after each iteration (each additional tree).</td>
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<td>5. “Old Model” Versus “New Model”</td>
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<tr>
<td>B.5.a</td>
<td>Obtain an explanation of why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.</td>
<td>2</td>
<td>The regulator should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change.</td>
</tr>
<tr>
<td>B.5.b</td>
<td>Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.</td>
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<td>This information element requests a comparison of the Lorenz curve and Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan’s predictive ability. One example of a comparison might be sufficient. <strong>Note:</strong> This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, “Generalized Linear Models for Insurance Rating.”</td>
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<th>B.5.c</th>
<th>Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.</th>
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<td>One example of a comparison might be sufficient. <strong>Note:</strong> “Not applicable” is an acceptable response.</td>
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<tr>
<td>B.5.d</td>
<td>If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model as candidate variables. Obtain an explanation of why these variables were dropped from the new model. Obtain a list of all new predictor variables in the new model that were not in the prior old model.</td>
<td>2</td>
<td>It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.</td>
</tr>
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</table>

6. Modeler Software

| B.6.a   | Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model. | 4 | The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model. |
### C. THE FILED RATING PLAN

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<tbody>
<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
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<tr>
<td>C.1.a</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.</td>
<td>1</td>
<td>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.b</td>
<td>Obtain an explanation of how the model was used to adjust the filed rating algorithm.</td>
<td>1</td>
<td>The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
</tr>
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| **2. Relevance of Variables and Relationship to Risk of Loss** | **C.2.a** Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced. | 2 | The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model visualization plots (such as partial dependence plots, accumulated local effects plots, or Shapley plots) should be consistent with the expected direction of the relationship.  
**Note:** This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated. |
| **3. Comparison of Model Outputs to Current and Selected Rating Factors** | **C.3.b** Obtain documentation and support for all calculations, judgments, or adjustments that connect the model’s indicated values to the selected rates filed in the rating plan. | 1 | The documentation should include explanations for the necessity of any such adjustments and each significant difference between the model’s indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived.  
**Note:** This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another. |
<p>| | <strong>C.3.c</strong> For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures. | 2 | The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals. |</p>
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<tr>
<td>4.</td>
<td><strong>Responses to Data, Credibility, and Granularity Issues</strong></td>
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<tr>
<td>C.4.a</td>
<td>Determine what, if any, consideration was given to the credibility of the output data.</td>
<td>2</td>
<td>The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril to model.</td>
</tr>
<tr>
<td>C.4.b</td>
<td>If the rating plan is less granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.</td>
</tr>
<tr>
<td>C.4.c</td>
<td>If the rating plan is more granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Definitions of Rating Variables</strong></td>
<td></td>
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<tr>
<td>C.5.a</td>
<td>Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.</td>
<td>2</td>
<td>If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Supporting Data</strong></td>
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<tr>
<td>C.6.a</td>
<td>Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.</td>
<td>4</td>
<td>For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.</td>
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<td>7. Consumer Impacts</td>
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<td>C.7.a</td>
<td>Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.</td>
<td>4</td>
<td>These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.</td>
</tr>
<tr>
<td>C.7.b</td>
<td>Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.</td>
<td>3</td>
<td>One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s average fitted model prediction. Look for significant variation between the average fitted model predictions for adjacent rating variable levels and evaluate if such variation is reasonable and credible.</td>
</tr>
<tr>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.</td>
<td>2</td>
<td>Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.</td>
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<tr>
<td>C.7.d</td>
<td>Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.</td>
<td>2</td>
<td>The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan. While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated. See Appendix D for an example of a disruption analysis.</td>
</tr>
<tr>
<td>C.7.e</td>
<td>Obtain exposure distributions for the model’s output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.</td>
<td>3</td>
<td>See Appendix D for an example of an exposure distribution.</td>
</tr>
<tr>
<td>C.7.f</td>
<td>Identify policy characteristics, used as input to a model or sub-model, that remain “static” over a policy’s lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as “static,” yet change over time.</td>
<td>3</td>
<td>Some examples of “static” policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on “static” variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile. A few examples of “non-static” policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</td>
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<td>C.7.g</td>
<td>Obtain a means to calculate the rate charged a consumer.</td>
<td>3</td>
<td>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. <strong>Note:</strong> This information may be proprietary. For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model’s output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</td>
</tr>
<tr>
<td>C.7.h</td>
<td>In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.</td>
<td>1</td>
<td>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it. The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</td>
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8. **Accurate Translation of Model into a Rating Plan**

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<tr>
<td>C.8.a</td>
<td>Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan’s manual, in fact, reflects the model output and any adjustments made to the model output.</td>
<td>1</td>
<td>The regulator can review the rating plan’s manual to see that modeled output is properly reflected in the manual’s rules, rates, factors, etc.</td>
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### 9. Efficient and Effective Review of Rate Filing

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<tr>
<td>C.9.a</td>
<td>Establish procedures to efficiently review rate filings and models contained therein.</td>
<td>1</td>
<td>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing. The regulator should review the state’s rate filing review process and procedures to ensure that they are fair and efficient.</td>
</tr>
<tr>
<td>C.9.b</td>
<td>Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.</td>
<td>1</td>
<td>This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.</td>
</tr>
<tr>
<td>C.9.c</td>
<td>Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.</td>
<td>1</td>
<td>The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.</td>
</tr>
<tr>
<td>C.10.d</td>
<td>Obtain complete documentation that would allow future audits of model predictions.</td>
<td>1</td>
<td>The company should provide comprehensive documentation of the rating algorithm such that a rate can be reproduced for any theoretical risk. Comprehensive documentation could be provided as one of the following: a complete set of tree diagrams, a set of if-else logic statements that represents the trees, or a table showing every possible combination of risk characteristics and the final prediction.</td>
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RANDOM FOREST GLOSSARY OF TERMS

**Accumulated Local Effects Plots:** A type of interpretability plot. Accumulated Local Effects plots calculate smaller, incremental changes in the feature effects. ALE shows the expected and centered effects of a variable.

**Bagged Trees:** An ensemble of trees where each tree is based on a “bootstrap aggregated” sample.

**Branch:** A connection on a decision tree between a parent node and a child node. A relationship based on a predictor variable is checked at each node, determining which branch applies.

**Candidate Variables:** The variables specified by the modeler to be used within the full model. The random variable selection by a random forest means that component trees might only use a subset of these variables in each tree.

**Child Node:** The node below a parent node. The child node is the result of a split that occurs based on a predictor variable. The node above the child node, which is where the split occurred resulting in the creation of the child nodes, is called the parent note. There is 1 parent node for every child node. The root node is the only node which is not a child node.

**Component Tree:** An individual tree within an approach based on an ensemble of trees such as random forest or gradient boosting machine.

**Deviance:** A measure of model fit. Deviance is based on the difference between the log-likelihood of the saturated model and the log-likelihood of the proposed model being evaluated. Smaller values of deviance demonstrate that a model’s predictions fit closer to actual. Deviance on training data will always decrease as model complexity increases.

**Hyperparameter:** A model hyperparameter is a model setting specified by the modeler that is external to the model and whose value cannot be estimated from data.

**Node:** A point on a decision tree. Nodes are either root nodes (the top node), leaf nodes (a terminal node at which point no further splitting occurs), or an internal node which appears in the middle of the tree while splitting is still taking place.

**Out-of-Bag Error:** Error calculated for observations based on the trees that did not include them in the set of training observations. Out-of-Bag Error is calculable when bootstrapping is used to generate different datasets for each component tree in an ensemble tree method.

**Parent Node:** The node above a child node. The parent node is where a split occurs based on a predictor variable. The nodes below the parent node, which are a direct result of the parent node’s split, are called child nodes. There are typically 2 child nodes for every parent node. Terminal nodes cannot be parent nodes.

**Partial Dependence Plots:** A type of interpretability plot. The partial dependence plot computes the marginal effect of a given variable on the prediction.

**Pruning:** The process of scaling back a tree to reduce its complexity. This results in trees with fewer branches and terminal nodes appearing higher on the tree. Pruning is more common on models built on a single decision tree rather than on ensemble models such as random forests or Gradient Boosting Machines.

**Random Forest:** An ensemble of trees where each tree is based on a bootstrap aggregated sample and each split is based on a random sample of the candidate variables.

**Root node:** The first (top) node in a decision tree. This node contains the entire set of data used by the tree as no splits have occurred yet.
Shapley Additive Explanation Plots: A type of interpretability plot. Shapley plots investigate the effect of including a variable in the model by the order in which it is added. The Shapley value represents the amount the variable of interest contributes to the prediction.

Splitting: The process of dividing a node into two or more sub-nodes, starting from the root node. Splitting occurs at every node up until the terminal (leaf) nodes when the stopping criterion is met.

Stopping Criterion: A criterion applied to the splitting process that informs the node when it is ineligible to split any further. Volume of data is often used as a stopping criterion, such that each leaf node is based on at least a pre-determined amount of data.

Terminal Node: An end node containing no child nodes, because the node has met the stopping criterion. The terminal node is associated with a prediction for one of the component trees. The terminal node is also known as a “leaf” node, the resulting endpoint of a decision tree.

Tree-Based Model: A model that can be represented as a decision tree or a collection of decision trees.

Tree Depth: The maximum number of splits between the root node and a leaf node for a tree.

Variable Importance: A measure of how the variables (a.k.a. features) contribute to the overall model. There are multiple ways to measure variable importance.
SURPLUS LINES (C) TASK FORCE

The Surplus Lines (C) Task Force did not meet at the Spring National Meeting.
TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force April 5, 2022, Minutes
Title Insurance (C) Task Force
Kansas City, Missouri
April 5, 2022

The Title Insurance (C) Task Force met in Kansas City, MO, April 5, 2022. The following Task Force members participated: Eric Dunning, Chair, and Connie Van Slyke (NE); Michael S. Pieciak, Vice Chair, represented by Kevin Gaffney (VT); Jim L. Ridling represented by Jimmy Gunn and Reyn Norman (AL); Michael Conway represented by Peg Brown (CO); David Altmaier represented by Anoush Brangaccio (FL); Vicki Schmidt represented by Craig VanAalst (KS); James J. Donelon represented by Warren Byrd (LA); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Marjorie Thompson (MO); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); Judith L. French represented by Michelle Brugh Rafeld (OH); Glen Mulready (OK); Michael Humphreys represented by Shannen Logue and Sebastian Conforto (PA); Elizabeth Kelleher Dwyer represented by Brian Werbeloff (RI); Larry D. Deiter represented by Frank Marnell (SD); and Scott A. White represented by Mike Beavers and Chuck Myers (VA). Also participating was: Mike Kreidler represented by Michael Walker (WA).

1. **Adopted its 2021 Fall National Meeting Minutes**

   Director Dunning said the Task Force met Nov. 16, 2021. During this meeting, the Task Force took the following action: 1) adopted its Oct. 19, 2021, minutes; 2) adopted its 2022 proposed charges; 3) heard a presentation from AM Best on how the robust housing market drove historic title industry performance; 4) heard a presentation from the American Land Title Association (ALTA) on changes to its homeowners policy and endorsements.

   Mr. Gaffney made a motion, seconded by Ms. Biehn, to adopt the Task Force’s Nov. 16, 2021, minutes (see NAIC Proceedings – Fall 2021, Title Insurance (C) Task Force). The motion passed unanimously.

2. **Received a Report on How Cyber Wire Fraud Cases Referred by Title Agents are Handled at the VBI**

   Mr. Myers stated that the Virginia Bureau of Insurance (VBI) is one of the regulatory authorities under the Virginia State Corporation Commission (SCC). Virginia has 356,000 active title agents, 1.6 appointments, and almost 9,000 title appointments. A settlement agent who wants to do real estate closings on property located in Virginia can be licensed as a title agent and registered with the VBI as a real estate settlement agent. According to the Federal Bureau of Investigation (FBI) internet crime report, internet crimes have risen considerably over each of the last five years. There has been an average of 552,000 complaints per year received by the FBI Internet Crime Complaint Center (IC3). The IC3’s primary functions are to provide a central hub to alert the public to threats; host a victim reporting portal; partner with private sector and local, state, federal, and international agencies; increase victim reporting via outreach; and host a remote access database for all law enforcement. In 2021 alone, there were 847,000 complaints with losses of $6.9 billion reported to the IC3.

   Virginia is the ninth top state by victim losses. The increase in settlement agent fraud is linked to the strong rise in real estate transactions in the state recently. In just four northern Virginia counties during 2021, 27,000 homes were sold for $19 billion in 19 days. Multiple parties are involved in a real estate transaction, including the buyer, seller, relator, mortgage lender, and mortgage broker. This provides many opportunities for fraudsters, especially considering that as many as four out of five people are still using unsecured emails. When a compromise occurs, the consumer should first contact their financial institution to attempt to get the stolen assets frozen or recalled. Complaints should then be filed by the financial institution and the consumer with the IC3. The IC3’s Recovery Asset Team (RAT) then assists FBI field offices with the possible freezing of funds for victims.
The VBI usually becomes involved after receiving a complaint from the consumer. In one specific case, the consumer felt the settlement agent should have responded to their confirmation of the email wire. After investigating, the VBI found that the reason for the lack of response was that the confirmation email also went to the fraudster’s email address. Business email fraudsters commonly make a slight, and therefore possibly unnoticeable, change to a valid email address. VA Code § 38.2-625 Notice to Commissioner requires an agent or agency to report if they have a cyber breach to the commissioner. In this case, the agency was out just over $1 million because the fraudster was about to gain access to their entire system and transfer funds out from not just the agency, but the lawyer that owned the agency. All the money was returned to the consumers through either errors and omissions coverage, loans or personal money tied to the agency. In a different case, $154,000 was wired to pay off a loan. The financial institution was valid, but the beneficiary was not. The account was traced to San Francisco, CA, where it had then been wired again to Indiana, and the agency was able to recover $82,000. The balance was submitted as an errors and omissions claim. Under VA Code § 55.1-1004 Duties of Settlement Agents, a settlement agent must have an errors and omissions or malpractice insurance policy providing a minimum of $250,000 in coverage, a blanket fidelity bond or employee dishonesty insurance policy covering persons employed by the settlement agent providing a minimum of $100,000 in coverage, and a surety bond of no less than $200,000.

3. **Heard a Presentation on CPL Language**

Paul Hammann (First American Title Insurance Company and ALTA) stated that the 2021 closing protection letter (CPL) was adopted by ALTA and became effective on April 2, 2021. It is a revision to the 2018 CPL, which was a revision to the 2015 CPL. The ALTA CPL sets standard and best practices and serves as a model. Most jurisdictions still use the 2015 CPL, which does not contain the new exclusions. The 2021 CPL expressly covers lenders, purchasers, or lessees. Elsewhere in the CPL, the borrower in any refinance transaction is covered under the definition of “you” and “your.” If there is only a loan closing, the borrowers are automatically afforded coverage under the definition of “you” and “your” in the letter. For residential deals, the borrower is automatically covered. The CPL covers losses that are solely caused by a failure of the issuing agent or approved attorney to comply with the insureds written closing instructions that relate to: 1) the disbursement of funds necessary to establish the status of the title to the land; 2) the validity, enforceability, or priority of the lien of the insured mortgage; or 3) obtaining any document, specifically required by the insured, but only to the extent that failure to obtain it adversely affects the status of the title or validity, enforceability, or priority of the lien of the insured mortgage. The CPL also covers losses from fraud, theft, dishonesty, or misappropriation by the issuing agent or approved attorney in handling your funds or documents in connection with the closing, but only to the extent that it affects the status of the title or validity, enforceability, or priority of the lien of the insured mortgage on the title. There are three types of authorizing laws. The CPL may be issued to the seller, buyer, and lender, as is done in Alabama, Arizona, Arkansas, Georgia, Louisiana, Nevada, and Utah. The CPL may be issued to the buyer and lender with the seller allowed but not mandatory. The CPL may be issued to the buyer and lender, where the seller is not included, as is done in the ALTA CPL and some states. Title underwriters are limited to the issuance of title insurance. CPLs are an exception to the monoline limitations.

State-specific requirements include: 1) Notice of Availability (Alabama, Arizona, Arkansas, Colorado, Missouri, and Ohio); 2) the CPL must be issued to the buyer, borrower, lender, and seller on residential transactions (Indiana); 3) the CPL must be issued to the buyer, lender, or seller on residential transactions and may be issued to the buyer, lender, or seller in other transactions (Missouri); 4) the CPL must be offered to any lender, borrower, or seller and any applicant for title insurance (Ohio); 5) the CPL must be issued to proposed insureds (Nebraska); 6) the CPL must be issued to the proposed insured residential lender and may be issued to other proposed insureds (Rhode Island); and 7) the CPL may be issued to the lender or purchaser/seller (Texas).
The 2021 ALTA CPL requirements are as follows:

1. The Company issues or is contractually obligated to issue a Policy for Your protection in connection with the Real Estate Transaction.

2. You are to be:
   A. A lender secured by the Insured Mortgage on the Title to the Land.
   B. A purchaser or lessee of the Title to the Land.

3. The aggregate of all Funds You transmit to the Issuing Agent or Approved Attorney for the Real Estate Transaction does not exceed $_____________.

4. Your loss is solely caused by:
   A. A failure of the Issuing Agent or Approved Attorney to comply with Your written closing instructions that relate to:
      i. The disbursement of Funds necessary to establish the status of the Title to the Land.
      ii. The validity, enforceability, or priority of the lien of the Insured Mortgage.
      iii. Obtaining any document, specifically required by You, but only to the extent that the failure to obtain the document adversely affects the status of the Title to the Land or the validity, enforceability, or priority of the lien of the Insured Mortgage on the Title to the Land.
   B. Fraud, theft, dishonesty, or misappropriation by the Issuing Agent or Approved Attorney in handling Your Funds or documents in connection with the closing, but only to the extent that the fraud, theft, dishonesty, or misappropriation adversely affects the status of the Title to the Land or the validity, enforceability, or priority of the lien of the Insured Mortgage on the Title to the Land.

For Requirements 1 and 2, the ALTA CPL specifies that the protection is extended to either a secured lender or purchaser/lessee of the Title. In contrast, the Ohio Closing Protection Coverage (CPC) Ohio Title Insurance Rating Bureau (OTIRB) specifies either a lender secured by a mortgage or a listed “Covered Party” with an interest in the land. Ohio allows the seller to be a “Covered Party.” The Missouri CPL also allows for sellers to be covered and a separate Seller’s CPL to be utilized. Texas ICS: T-51 covers purchasers and sellers, and T-50 covers lenders.

For Requirement 3, the ALTA CPL specifies the defined maximum amount of funds that are to be transmitted to the entity handling the real estate transaction as a requirement. In contrast, the Ohio CPC OTIRB has no such requirement but limits liability to the amount of funds due to or paid for the covered party. The Missouri CPL limits liability to $5 million for buyers, lessees, and lenders; the alternate version facilitates insertion by the underwriter of the higher or lower amount tailored to the actual transaction. The Texas ICS T-51 (for buyer/seller) only insures above the first $500,000 of the loss for sellers and buyers, and no maximum is specified (deductible concept). For Requirement 4, the ALTA CPL specifies that the indemnity for fraud, theft, dishonesty, or misappropriation must adversely affect the status of the title or lien of the insured mortgage on the title. In contrast, the Ohio CPC OTIRB specifies, “theft, misappropriation, fraud or any other failure,” without the requirement for an effect on the title or lender’s lien. The Missouri CPL specifically includes any “theft or fraud” in the purchaser’s deposited earnest money or settlement funds, and there is no reference to affect the Title or lender’s lien. Texas provides protection for “fraud or dishonesty” of the Issuing Agent in handling seller/purchaser funds and protection for “fraud or dishonesty” of the lender, as it affects the status of the title or validity, enforceability, and priority of the mortgage lien.

The ALTA CPL excludes: 1) certain closing instructions; 2) loss of funds due to bank issues; 3) mechanic’s and materialmen’s liens; 4) certain defects, liens, encumbrances, and adverse claims connected with the Real Estate Transaction; and 5) “fraud, theft, dishonesty, misappropriation, and negligence” by the CPL recipient, its employees, agent, attorney, or broker. In contrast, in Ohio, failure to comply with inconsistent closing instructions is not excluded. There is also no exclusion of “other matters in connection with the real estate transaction.” Although fraud, theft, dishonesty, misappropriation, and negligence are not directly addressed in the Ohio CPC, “matters” created, suffered, assumed, or agreed to by the CPC recipient and your agents/employees are excluded.
Missouri has no express exclusion for mechanics’ liens but does address fraud, dishonesty, or negligence by your employee, agent, attorney, or broker and “matters” created, suffered, assumed, or agreed to or known are excluded. The Texas T-51 for the Buyer or Seller excludes “fraud, dishonesty, or negligence” by the letter recipient; its employee; agent; or attorney; and like Ohio and Missouri, “any matters created, suffered, assumed, or agreed to by or known to you.” The Texas T-50 for the Lender excludes: 1) “fraud, dishonesty, or negligence” by the letter recipient, its employee, agent, attorney, or broker; 2) “any matters created, suffered, assumed, or agreed to by or known to you,” like Ohio and Missouri; and 3) no liability for loss from negligence, fraud, or bad faith of any party other than the issuing agent.

Additionally, ALTA provides exclusions not existing in the Ohio CPC, as Ohio does not state exclusion of loss resulting from: 1) failures of the issuing agent to determine the applicability of documents required by closing instructions; 2) laws regulating lending practices; 3) imposing credit risk retention and securitization standards; 4) construction disbursements; 5) an agent acting as a qualified intermediary for 1031 exchange; or 6) cyber or other fraud that is beyond the scope of the stated indemnification. The Missouri CPL is similar to the scope of the Ohio CPC exclusions. The scope of the Texas T-51 for consumer reimbursement is limited to settlement funds for fraud/dishonesty of the issuing agent, so many of ALTA’s CPL exclusions do not apply. There is greater reimbursement scope with the T-50 for lenders, so more exclusions apply.

Regarding liability exposure, liability for loss in Ohio is limited to the actual loss of funds and is no greater than the amount due to or paid on behalf of a covered party. There is no stated maximum amount and no expressly stated limit lender covered party to the owner of the secured indebtedness at the time of CPC payment. There is also no express cut off for payments under a title insurance policy. Missouri specifies that liability is the amount of settlement fund transmitted, but the default maximum is $5 million. It does not expressly limit the lender covered party to the owner of secured indebtedness at the time of the CPC payment, and there is no express cut off for payments under a title policy. In Texas, buyer/sellers effectively have a $500,000 deductible on a claim. For Lenders, there is no stated liability limit.

Regarding a limited agent, under the ALTA CPL, the issuing agent or approved attorney is not the insurer’s agent for closing/escrow, so closing/escrow is outside the scope of the agency. Agency is limited to policy issuance and there are exclusions for fraud, theft, dishonesty, misappropriation, or negligence of other parties to the transaction. There are also exclusions for creditworthiness claims and inadequate security. In contrast, the Ohio CPC does not include a statement as to the limitation of agency scope, but the loss events are narrowly expressed. Also, protection as to compliance with closing instructions is limited to the status of title or the validity, enforceability, or priority of the mortgage lien. Missouri is virtually the same. The Texas Lender T-50 has virtually the same language as the ALTA CPL. However, the Texas T-51 for Seller and Buyer have a very narrow scope protecting settlement/earnest money funds.

Regarding the jurisdiction and forum, the ALTA CPL provides protection when the real estate is in a specified state, the real estate has a choice of law and jurisdiction provision, and class action proceedings are not permitted. Additionally, demand for arbitration may be made by either party where the policy amount of insurance is up to $2 million and by mutual agreement for the policy amount of insurance over $2 million. There are not similar provisions stated in the Ohio CPC. The Missouri CPL provides protection only for real estate transactions in Missouri. The Texas T-50 (Lender) provides arbitration provisions that mirror those of the ALTA CPL. Unlike the T-50, the T-51 (Seller/Buyer) limits the corporate contact with the company to the principal place of business in Texas, thus leaving open the position that jurisdiction and choice of law are limited to Texas.

4. Received a Report on How CPLs are Used in Louisiana and Ohio from a Statutory and Regulatory Framework

Mr. Byrd stated that the CPL serves as a contract whereby a title insurer agrees to indemnify a lender or any other parties to a real estate transaction from any actual losses that arise due to any misconduct of the closing title
agent or the closing attorney. Some of the misconduct that is considered in the CPL includes, but is not limited to, fraud or dishonesty in the handling of funds or closing documents and the failure of the closing agent to follow written closing instructions. Written closing instructions could be as simple as the settlement agent being instructed to deposit certain funds in a specific account and then transfer those funds at a specific time to another account when the transaction is funded. If these instructions are not followed and there is a loss, the loss is covered under the CPL. In most instances, the title insurer that issues the closing protection is the same insurer that will issue either the owner’s policy or the lender’s policy in conjunction with the real estate transaction.

The relevant statute in Louisiana is R.S. 22:515 (C), which states that a title insurer may issue closing or settlement protection to a person who is a party to a transaction in which a title insurance policy is contemplated being issued. The closing or settlement protection shall conform to the terms of coverage and form of instrument as may be required by the department and may indemnify a person solely against loss of settlement funds because of the following acts of a settlement agent, title insurer’s named employee, or title insurance producer: a) theft or misappropriation of settlement funds; or b) failure to comply with instructions when agreed to by the settlement agent, employee, or title insurance producer. The premium charged by a title insurer for this coverage shall be submitted to and approved by the commissioner of insurance. Additionally, a title insurer shall not provide any other coverage, which purports to indemnify against improper acts or omissions of a person with regard to escrow or settlement service.

The written closing instructions should not be inconsistent with any instructions outlined in the title insurance policy’s commitment/binder documents. The fees (premium) assessed for the issuance of CPLs have been between $25 and $50. Courts have expressed varied opinions on whether the CPL is an insurance product. At the initial use of CPLs, title insurers did not charge a fee for the letter. Based upon La. R.S. 22:515 (C), the Louisiana legislature recognizes the CPL as providing some form of coverage, and the premium for the CPL must be approved by the commissioner of insurance. Louisiana is a prior approval state. Thus, the form, the letter itself, and the rate must be submitted to the insurance department for prior approval. The written notice of a claim must be received by the company within one year from the transmittal of the fund.

Ms. Rafeld stated that Ohio has had some issues with CPLs being offered. In 2007, at the height of title default locations in the marketplace, Ohio enacted closing protection legislation. The closing protection law requires title insurance companies or the agent to offer closing or settlement protection to all parties associated with the transaction. All CPLs issued are to indemnify the party who requested the protection against misappropriation, fraud, or any other failure to properly disperse settlement closing or escrow funds. Also included is any situation where the title agent fails to comply with written closing instructions. Ohio has found issues with the lack of coverage for injured parties from escrow agents mistakes or fraud. Additionally, past cases have found that some title agents do not always offer closing protection as they are required. In most of those cases, the issue became known through the investigation into an agent misappropriating settlement funds. The investigations revealed that the agents did not offer protection because they did not want the consumer to believe the theft of their money would even be a possibility during the real estate transaction. This raises the question of whether the offering of closing protection should be left to the individual in a position to steal the funds. Other concerns include the timing as to when closing protection coverage is offered in the way the coverage is described by title agents under the current process or methods. There is an extremely low acceptance rate by consumers.

Many within the agent community have expressed that they are not in favor of the mandate to offer closing protection coverage, as it makes them look bad in the eyes of the consumer. For this reason, the importance of closing protection is often downplayed by title agents. Another issue is some title underwriters doing business in the state have tried to exclude cyber theft events from CPL coverage. They have also been reluctant to reimburse consumers affected by business email compromise, believing it falls outside the CPL statute in Ohio. There needs to be education within the underwriter community when the CPL filings are being submitted to the OTIRB because of Ohio’s statute. The CPL is to indemnify a party from misappropriations, fraud, or any other failure to properly
disperse settlement funds. When an ALTA CPL is filed with the OTIRB, it has been necessary to tell the underwriter that Ohio’s interpretation of the law is that cyber theft events related to business email compromises are not to be excluded from CPL coverage.

5. **Held a Q&A Session on the Cyber Wire Fraud Report and Presentations**

Birny Birnbaum (Center for Economic Justice—CEJ) asked why CPLs are not covered by errors and omissions policies, thus alleviating the need for an additional fee for coverage under a CPL. Mr. Hammann stated that the fee associated with a CPL is to cover the costs of the CPL issuance, not a premium. The CPL fee is not charged in all jurisdictions.

Peter Kochenburger (University of Connecticut School of Law) urged state insurance regulators not to allow arbitration mandates. Class actions should be restricted to cases where evidence of their need is demonstrated.

6. **Discussed its 2022 Work Plan**

Director Dunning asked that in the interest of time, Task Force members, interested state insurance regulators, and interested parties review the work plan included as part of the materials and submit comments to Anne Obersteadt (NAIC) at aobersteadt@naic.org.

The work plan includes: 1) holding a regulator-only meeting with the Consumer Financial Protection Bureau (CFPB); 2) discussion on how the use and language of CPLs varies by state; 3) a presentation on the post-pandemic future of the title insurance industry; 4) a roundtable discussion on rate regulation; 5) a presentation from industry on complications that arise from the required use of plans by some states that include rules or forms tailored to other lines of insurance; and 6) a review of Section 15C of the *Title Insurers Model Act* (#628) to determine if there is a need to make a recommendation to remove the requirement for the on-site review of underwriting and claims practices.

Having no further business, the Title Insurance (C) Task Force adjourned.
WORKERS’ COMPENSATION (C) TASK FORCE

Workers’ Compensation (C) Task Force March 21, 2022, Minutes.................................................................................. 7-131
The Workers’ Compensation (C) Task Force met March 21, 2022. The following Task Force members participated: Alan McClain, Chair, and Jimmy Harris (AR); John F. King, Vice Chair (GA); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Jennifer Brown, Jimmy Gunn, Yada Horace, and Erick Wright (AL); Ricardo Lara represented by Yvonne Hauscarrriague, Giovanni Muzzarelli, and Sarah Ye (CA); Andrew N. Mais represented by George Bradner and Amy Waldhauer (CT); Trinidad Navarro represented by Lucretia Prince (DE); David Altmaier represented by Greg Jaynes (FL); Colin M. Hayashida represented by Kathleen Nakasone and Grant Shintaku (HI); Doug Ommen represented by Travis Grassel (IA); Dean L. Cameron represented by Katie Deaver, Michele MacKenzie, and Randy Pipal (ID); Vicki Schmidt represented by Julie Holmes and Craig VanAalst (KS); James J. Donelon represented by Warren Byrd and Tom Travis (LA); Gary D. Anderson represented by Caleb Huntington and Matthew Mancini (MA); Eric A. Cioppa represented by Brock Bubar, Sandra Darby, and Robert Wake (ME); Grace Arnold represented by Sandra Anderson, Tammy Lohmann, and Phil Vigliaturo (MN); Chlora Lindley-Myers represented by Jo LeDuc and Rebecca Shavers (MO); Mike Causey represented by Fred Fuller (NC); Marlene Caride represented by Mark McGill and Carl Sornson (NJ); Barbara D. Richardson represented by Erin Summers (NV); Michael Humphreys represented by Michael Mckenney and Eric Zhou (PA); Elizabeth Kelleher Dwyer represented by Beth Vollucci (RI); Raymond G. Farmer represented by Will Davis (SC); Larry D. Deiter (SD); Jon Pike represented by Tracy Klausmeier and Reed Stringham (UT); Michael S. Pieciak represented by Mary Block, Isabelle Turpin Keiser, Karla Nuissl, Pat Murray, and Marcia Violette (VT); and Allan L. McVey, Tonya Gillespie, Erin K. Hunter, and Juanita Wimmer (WV). Also participating were: Tom Zuppan (AZ); Kevin Dyke and Tina Nacy (MI); Mike Chaney (MS); Bob Biskupiak (MT); Connie Van Slyke (NE); Bogdanka Kurahovic and Jennifer Catechis (NM); Cuc Nguyen and Andrew Schallhorn (OK); Brian Hoffmeister (TN); Marianne Baker and Nicole Elliott (TX); Rebecca Nichols (VA); David Haushalter (WI); Danie Capps (WY).

1. Heard an Update on Federal Legislation

Brooke Stringer (NAIC) said the Democrats in the U.S. House of Representatives (House) are concerned by a decline in the adequacy of benefits provided to injured workers under the state-based workers’ compensation system. She said House Democrats believe the costs for disabling workplace injuries are being shifted to federal programs, such as Social Security disability insurance, due to reduced workers’ compensation coverage under state laws.

Ms. Stringer said that in an earlier version of the Build Back Better Act, the House Committee on Education and Labor included language and funding for the U.S. Department of Labor (DOL) Office of Workers’ Compensation Programs (OWCP) for “monitoring of state workers’ compensation programs.” The property/casualty (P/C) trade associations opposed this provision in the Build Back Better Act, and the specific reference was ultimately removed.

In November 2021, the House passed a $1.7 trillion Build Better Act. While the updated bill provides $121 million for the DOL’s OWCP activities, it did not include a specific reference to oversight of the state workers’ compensation programs, which was included in previous versions. The outcome of the bill in the U.S. Senate remains uncertain.

Ms. Stringer said last week during a markup at the House Committee on Education and Labor, ranking member Virginia Foxx (R-NC) offered an amendment to prohibit monitoring of the DOL on the adequacy of state workers’ compensation programs; this amendment was defeated along party lines.
Ms. Stringer said in December 2021, the Workforce Protections Subcommittee held a hearing on “Strengthening the Safety Net for Injured Workers,” which also touched on the DOL’s authority to reinstitute monitoring and reporting on state workers’ compensation programs. She said it is anticipated that there could be continued congressional oversight and that attention to this issue moving forward. Ms. Stringer said she will keep the Task Force informed of any updates.

Commissioner King asked Ms. Stringer to report back to the Task Force if she sees any movement in the Senate regarding the monitoring of workers’ compensation. He said state insurance regulators will want to talk to their congressional delegation in the event there is any movement toward the monitoring of workers’ compensation.

Commissioner McClain said the monitoring of workers’ compensation does go across all regulatory lines. He said adjudication and benefits are typically the responsibility of the workers’ compensation agencies in the various states and usually not within the departments of insurance (DOIs). Commissioner McClain said the impact of these items affects the rating and loss costs, and these are the items affecting the DOIs.

Commissioner McClain said there have been several reforms in the past 20 to 30 years, as well as mechanization and employers paying more attention to worker safety. The combination of these items has lowered the frequency and severity of accidents in the workplace, and has affected workers’ compensation rates in a positive way.

2. Heard an Update on Cannabis, Independent Contractor, and Single-Payer Health Insurance Legislation Regarding Workers’ Compensation

Susan Donegan (National Council on Compensation Insurance—NCCI) said there is huge crossover potential between state activities, especially in the legislatures, and what is going on in Congress. She said at the end of last year, the NCCI tracked more than 1,000 state and federal bills.

Ms. Donegan said there were approximately 164 of these bills enacted. She said another 182 bills enacted were COVID-19-related.

Ms. Donegan said approximately 350 workers’ compensation regulations were proposed throughout the states and of those, approximately 162 were adopted. Ms. Donegan said many of these regulations were COVID-19-related. She said legislatures were looking at extensions of presumptions or making permanent laws about infectious or contagious diseases that may happen in the future, whether they include a pandemic or not.

Ms. Donegan said there have been COVID-19 vaccination-related bills being introduced during the current legislative sessions. These bills are generally falling into two categories. The first category is a private right of action against employers regarding certain injuries or death occurring from receiving a mandated vaccination as a condition of employment. She said there were approximately 12 states that have been looking at this issue. To date, some of these bills have died, and some of these bills are still in committee.

Ms. Donegan said state and federal cannabis-related legislation has the potential to intersect. She said there have been inconsistencies between state and federal laws regarding cannabis, including items such as the criminal justice impact on current law, expungements, and criminal records related to cannabis.

Ms. Donegan said one bill that has seen a lot of activity federally is the SAFE Banking Act. This Act has passed in the House six times, but the Senate has remained opposed to passing a stand-alone measure for cannabis and the banking sector. Ms. Donegan said this bill will need to pass the Senate if it is going to help businesses unable to open a bank account or obtain loans at a reasonable rate. She said 23 state governors (19 Democrats and four Republicans) have sent a letter to Congress urging the passage of the SAFE Banking Act.
Ms. Donegan said a broader proposal, “The Cannabis Administration and Opportunity Act,” was not introduced, but it unveiled in July 2021. This Act would remove cannabis from the list of controlled substances, which would empower states to implement their own cannabis laws. This Act would also provide access for insurance services to cannabis-related businesses. Ms. Donegan said there is some interest in using a broader approach than to simply focus on the banking sector.

Ms. Donegan said there are two cases currently on petition for a Writ of Certiorari to the U.S. Supreme Court in Minnesota. She said the issue is whether the Controlled Substances Act (CSA) preempts any order under a state workers’ compensation law, requiring an employer to reimburse an injured employee for the cost of buying medical cannabis to treat a work-related injury. Ms. Donegan said there is a mature split in the states’ supreme courts regarding whether preemption is valid. She said 11 states have said a preemption is valid, while 16 states have said preemption is not valid.

Ms. Donegan said there is a conflict between federal and state jurisdictions regarding cannabis. She said cannabis has been a Schedule I substance since 1970. Ms. Donegan said this complication, as well as the differing opinions regarding preemption, is confusing. She said she hopes that one day soon, there will be more continuity regarding medical cannabis legislation and regulations to alleviate insurers concerns regarding the risk to insure cannabis businesses.

Ms. Donegan said the NCCI has been watching federal activities and state level activities regarding who is an employee versus who is an independent contractor. She said South Dakota just signed a bill establishing a test for determining whether a delivery facilitation contractor is an independent contractor or an employee. Ms. Donegan said that there are several types of contractors and that states have different ways of describing this particular focus.

Ms. Donegan said in March 2021, the U.S. House of Representatives passed the “Protecting the Right to Organize Act.” This act focuses on the right to form and join unions. However, there are a couple of provisions in the Act that affect worker classification. Ms. Donegan said an independent contractor could be deemed an employee for purposes of federal law, which would allow unions to organize and then protect people who might have earlier been classified as an independent contractor. She said this bill has gone to the Senate. However, there has been no action in the Senate to date.

Ms. Donegan said earlier this month, a U.S. district court judge in the district of Eastern Texas ruled that the DOL violated the Administrative Procedures Act (APA) by delaying and then withdrawing the Trump administration rule that made it easier for businesses to classify workers as independent contractors. This invalidated the DOL’s actions and reinstated the Trump administration rule siding with the coalition of workforce Innovation, which represents the gig economy businesses such as Uber and Lyft. Ms. Donegan said the Biden administration has not yet indicated how it is going to respond to this ruling.

Ms. Donegan said the NCCI is following legislation regarding single payer health insurance, as this could be a game changer for workers’ compensation. She said it is unknown as to whether workers’ compensation would be included in a single-payer system or whether workers’ compensation would have its own carve out.

Ms. Donegan said health care reform is still getting some attention in Congress. In February, the representatives of the House Committee on Education and Labor held a hearing on health care reform titled “Exploring Pathways to Affordable, Universal Health Coverage.” She said it examined mechanisms to transition private health coverage to a federal system. Those who gathered discussed the considerations of a Medicare for all approach. Ms. Donegan said the Committee did not have any questions regarding the potential impacts to injured workers, nor was anything discussed regarding workers’ compensation presented in the hearing.
Ms. Donegan said there are approximately nine bills at the state level addressing some type of single payer mechanism, ranging from creating a study group to study a single payer system to how to finance a single payer system. She said four of the nine bills did not include workers’ compensation. However the remainder did reference workers’ compensation. Ms. Donegan said one of the questions needing answered regarding single payer legislation that includes workers’ compensation is how this would affect workers’ compensation.

Having no further business, the Workers’ Compensation (C) Task Force adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

Market Regulation and Consumer Affairs (D) Committee April 7, 2022, Minutes .................................................. 8-2
2022 Proposed Revised Charges (Attachment One)................................................................. 8-8
Market Regulation Certification (D) Working Group March 22, 2022, Minutes (Attachment Two) .............. 8-13
Market Analysis Procedures (D) Working Group March 3, 2022, Minutes (Attachment Three) ............... 8-15
Market Conduct Annual Statement Blanks (D) Working Group March 17, 2022, Minutes
(Attachment Four)......................................................................................................................... 8-18
Digital Claims Interrogatory Reporting Subject Matter Expert (SME) Proposal (Attachment Four-A) ...... 8-22
Market Conduct Examination Guidelines (D) Working Group March 10, 2022, Minutes
(Attachment Five)......................................................................................................................... 8-23
Privacy Protections (D) Working Group April 6, 2022, Minutes (Attachment Six) ...................................... 8-29
Privacy Protections (D) Working Group 2022 Work Plan (Attachment Six-A) ........................................ 8-33
The Market Regulation and Consumer Affairs (D) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Jon Pike, Chair (UT); Trinidad Navarro, Vice Chair (DE); Karima M. Woods (DC); Sharon P. Clark (KY); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning represented by Martin Swanson (NE); Russell Toal (NM); Barbara D. Richardson (NV); Michael Humphreys represented by David Buono (PA); Cassie Brown (TX); and Michael S. Pieciak represented by Karla Nuissl (VT). Also participating were: Michael Conway and Damion Hughes (CO); Doug Ommen (IA); Erica Weyhenmeyer (IL); Larry D. Deiter (SD); Katie Johnson and Rebecca Nichols (VA); and John Haworth (WA).

1. Adopted its 2021 Fall National Meeting Minutes

Superintendent Toal made a motion, seconded by Ms. Biehn, to adopt the Committee’s Dec. 15, 2021, minutes (see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee). The motion passed unanimously.

2. Adopted its 2022 Revised Charges

Commissioner Pike said when the Committee charges were adopted at the 2021 Fall National Meeting, it was noted that the Privacy Protections (D) Working Group might move under the Innovation, Cybersecurity, and Technology (H) Committee to better align the privacy protection discussions with the NAIC members’ discussions regarding the increased use of consumer data and innovations. He said the revised charges reflect this change in the reporting structure for the Working Group.

Commissioner Pike also said the Speed to Market (H) Working Group will move to the Market Regulation and Consumer Affairs (D) Committee because of the more technical efforts of the Working Group, which has been focusing on the updates to the product coding matrix (PCM) and Product Filing Review Handbook.

Commissioner Pike said the revised charges also include the Antifraud (D) Task Force’s revised charges that disbanded the Antifraud Education Enhancement (D) Working Group and moved the charge of the Working Group to the Task Force. He said the elimination of the Working Group should allow for the continuation of the education initiatives in a more streamlined manner.

Commissioner Ommen said he consulted with the vice chair of the Advisory Organization Examination Oversight (D) Working Group, and they agreed that the name of the Working Group should be shortened to the Advisory Organization (D) Working Group. He asked for a motion to shorten the name of the Working Group. Commissioner Richardson made a motion, seconded by Director Lindley-Myers, to rename the Advisory Organization Examination Oversight (D) Working Group to the Advisory Organization (D) Working Group. The motion passed unanimously.

Superintendent Toal made a motion, seconded by Commissioner Richardson, to adopt the Committee’s 2022 revised charges (Attachment One), including renaming the Advisory Organization Examination Oversight (D) Working Group. The motion passed unanimously.
3. **Adopted the Reports of its Task Forces and Working Groups**

   a. **Market Regulation Certification (D) Working Group**

   Superintendent Toal said the Market Regulation Certification (D) Working Group met March 22. He said since this was the first time the Working Group has met since late 2020, the Working Group reviewed the status of the Voluntary Market Regulation Certification Program.

   Superintendent Toal noted that the Working Group has three parts of the Voluntary Market Regulation Certification Program to complete this year. First, he said the certification requirements are finished, but the revisions suggested by the certification pilot states need to be adopted for inclusion in the Voluntary Market Regulation Certification Program. Second, the implementation plan for the Voluntary Market Regulation Certification Program needs to be brought up to date. Third, the Working Group needs to complete the scoring guidelines to enable jurisdictions to understand what is needed to be certified and uniformly self-evaluate themselves.

   Superintendent Toal said the Working Group heard a report from the small group of state insurance regulators working on the scoring matrix for the Voluntary Market Regulation Certification Program. He said they made progress in 2020 and will have a draft of the scoring matrix to the Working Group prior to the Summer National Meeting.

   b. **Antifraud (D) Task Force**

   Commissioner Navarro said the Antifraud (D) Task Force met March 28. He said the Task Force discussed a letter received concerning racial bias and discrimination potentially taking place. The Task Force heard comments from NAIC Consumer Representative Birny Birnbaum (Center for Economic Justice—CEJ) and will continue to monitor the topic and schedule additional discussions, if warranted.

   Commissioner Navarro said the Task Force adopted a recommendation to temporarily disband the Antifraud Education Enhancement (D) Working Group and move its current charge under the Task Force. As the Working Group’s last official action, the Task Force received an update from the Working Group. Commissioner Navarro said updated Investigator Safety Training Webinars for the state insurance regulators and private investigators will be held this year, and specific dates will be distributed once confirmed. He said Michelle Brugh Rafeld (OH) will continue her position as the Task Force’s education subject matter expert (SME) and work with the NAIC to develop additional advanced training throughout the year.

   Commissioner Navarro said the Task Force received an update from the Antifraud Technology (D) Working Group. He said the Working Group requested that state insurance regulator SMEs work with NAIC staff to create a template for industry to use when creating their Antifraud Plans. The Working Group will expose the final draft of the template for comment, and the Working Group will meet to discuss the comments and potentially adopt the template. Commissioner Navarro said once the template is adopted by the Working Group, it will be presented to the Task Force for consideration at the Summer National Meeting. He said the Working Group chair has continued to work with NAIC staff to redesign the Online Fraud Reporting System (OFRS). He said the OFRS industry section is currently in beta testing, and the NAIC is accepting suggestions to finalize the redesign.

   Commissioner Navarro said the Task Force received an update from the newly appointed Improper Marketing of Health Insurance (D) Working Group. He said the Working Group continues to meet monthly in regulator-to-regulator session, and it held its second open meeting April 4 at the Spring National Meeting. He said during the meeting, the Working Group discussed current issues being witnessed throughout the states, including enforcement actions taking place due to their continued efforts. He said the Working Group also heard from the
Coalition Against Insurance Fraud (CAIF) regarding the work it has completed specific to the improper marketing of insurance. He said the Working Group discussed the collaborative document on lead generators comprising potential fraudulent entities who are improperly marketing health insurance. The collaborative document was created to assist states and federal agencies to coordinate necessary actions to fight insurance fraud.

Lastly, Commissioner Navarro said the Task Force received a report on matters of national interest to the insurance fraud bureaus from the CAIF.

c. Market Information Systems (D) Task Force


Commissioner Conway said the Task Force also considered the report of the Market Information Systems Research and Development (D) Working Group regarding the incorporation of artificial intelligence (AI) in the NAIC market information systems (MIS). He said the report lays out five sequential steps needed to incorporate AI into the MIS, beginning with a full analysis of the current state of the data in the MIS and the data’s usefulness for AI analysis techniques. He said after hearing comments regarding the time and resources needed to implement all five of the report’s recommendations and a proposal to limit adoption to only the first two recommendations to assess the current quality of the market information data, the Task Force decided to continue its discussions and consideration of adoption at its next meeting.

Commissioner Conway said the Task Force also received reports from the Working Group on the status of current MIS projects and its analysis of the completeness, accuracy, and timeliness of the data in the MIS. He said the Task Force adopted both reports.

d. Producer Licensing (D) Task Force

Director Deiter said the Producer Licensing (D) Task Force has not met since the 2021 Fall National Meeting, but progress has been made on several important initiatives, and a call will be scheduled in late April or early May.

Director Deiter said the Task Force has continued its development of a uniform process for considering updates to the NAIC’s Uniform Applications. He said one of the main changes to the document is language that clarifies the coordination between the NAIC, the National Insurance Producer Registry (NIPR), and NAIC member jurisdictions, including any back-office system vendors, in assessing the cost and time needed to implement adopted changes to the Uniform Licensing Applications. He said the Task Force will accept a final round of comments and plans to consider the adoption of the Uniform Application Change Process during its next call. He said the Task Force will then begin the review of suggested changes to the Uniform Producer Licensing Application within the guidelines of the adopted process.

Director Deiter said there has been additional discussions regarding how states review 1033 waiver requests. He said the Federal Violent Crime Control and Law Enforcement Act of 1994 requires producer applicants who have been convicted of crimes involving dishonesty or breach of trust to obtain written consent or approval before engaging in the business of insurance. He noted that NAIC staff have been working with industry to clarify industry’s request to simplify the 1033 waiver process and bring a proposal to the Task Force.

Director Deiter said the Task Force has faced delays appointing working group chairs due to the resignation and lack of availability of producer licensing directors to chair the working groups. He said Richard Tozer (VA) has
agreed to chair the Uniform Education (D) Working Group, and he is working with Commissioner Clark, the vice chair of the Task Force, to identify a chair for the Producer Licensing Uniformity (D) Working Group.

Director Deiter said the Task Force will consider the formal appointment of a new Adjuster Licensing (D) Working Group during its next conference call. He said Rachel Chester (RI) agreed to move forward with leading initial discussions falling under the current Task Force charge to “monitor the state implementation of adjuster licensing reciprocity and uniformity and update, as necessary, NAIC adjuster licensing standards.”

e. Market Analysis Procedures (D) Working Group

Mr. Haworth said the Market Analysis Procedures (D) Working Group met March 23 and reviewed its charges for 2022. He said during 2022, the Working Group will focus on the MIS data to ensure it is effectively meeting the needs of market analysts and, if necessary, provide recommendations for enhancements and improvements. He also said in 2022, the Working Group will open discussions on the next line of business for the Market Conduct Annual Statement (MCAS). He encouraged all interested state insurance regulators, interested parties, and industry to provide suggestions for the Working Group to consider.

Mr. Haworth said the Working Group discussed the new standard MCAS ratios for the two newest lines of business in the MCAS; i.e., Short-Term Limited-Duration (STLD) Insurance and Travel Insurance. He said the ratios are exposed on the Working Group web page, and the Working Group will be voting on their adoption on its conference call.

Finally, Mr. Haworth said the Working Group adopted a motion to add the disability and lender-placed insurance MCAS data to the Market Analysis Review System (MARS). The Working Group forwarded the request to the Market Information Systems Research and Development (D) Working Group for its consideration. He said during the Market Information Systems Research and Development (D) Working Group’s discussion, it asked the Market Analysis Procedures (D) Working Group for additional details, and that will be on the agenda during its next meeting.

f. Market Conduct Annual Statement Blanks (D) Working Group

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group met March 17 and received an update regarding the Life MCAS draft edits for Accelerated Underwriting. She said the Accelerated Underwriting (A) Working Group adopted its draft paper. She said the MCAS Accelerated Underwriting SMEs has a meeting scheduled on April 13 to discuss a definition for the proposed Life MCAS Accelerated Underwriting proposal.

Ms. Weyhenmeyer said the Market Conduct Annual Statement Blanks (D) Working Group received an update regarding the Other Health MCAS draft. She said the SMEs working on the Other Health draft are finalizing the draft, and it is anticipated that the draft will be exposed in time for the Working Group to consider adoption prior to the June 1 deadline for edits to the 2023 MCAS reporting.

Ms. Weyhenmeyer said the Working Group discussed the proposed lawsuit definitions and placement of lawsuit data elements for the Homeowners MCAS and Private Passenger Auto (PPA) MCAS. The SMEs working on this issue have scheduled a call on April 12 to discuss outstanding questions and concerns prior to providing a draft proposal to the Working Group for public discussion.

Ms. Weyhenmeyer said the Working Group adopted the proposal for digital claims interrogatories for the Homeowners and PPA MCAS lines of business. She said the edits will be provided to the Committee, along with
any other MCAS edits that need to be considered prior to the Committee’s Aug.1 deadline for edits to the 2023 MCAS reporting.

Finally, Ms. Weyhenmeyer said the Working Group reviewed guidance regarding the new data element asking for the “Number of Lawsuits Closed with Consideration for the Consumer” on the Homeowners and PPA MCAS Lines of business.

g. Market Conduct Examination Guidelines (D) Working Group

Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group met March 10 and reviewed its 2022 charges and established priorities for 2022. First, the Working Group will develop a new, updated Chapter 24 of the Market Regulation Handbook on conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) examination in the Market Regulation Handbook. Mr. Hughes said at the end of 2021, the Working Group was asked to coordinate with the MHPAEA (B) Working Group to develop updates to the mental health parity-related chapter of the Market Regulation Handbook to ensure it reflects current MHPAEA parity compliance analysis requirements for non-quantitative treatment limits (NQTLs) and better align the chapter with established federal guidance related to mental health parity. He said the Market Conduct Examination Guidelines (D) Working Group’s vice chair, Ms. Weyhenmeyer, is the chair of the MHPAEA (B) Working Group, and the two working groups are already collaborating to address this request. He said as a result of that coordination, an updated MHPAEA chapter is forthcoming and will be distributed after the Spring National Meeting as a new exposure draft for the Market Conduct Examination Guidelines (D) Working Group’s consideration. Second, the Working Group will update Chapter 23—Conducting the Life and Annuity Examination of the Market Regulation Handbook to include revised guidance pertaining to the revisions to the Suitability in Annuity Transactions Model Regulation that were adopted by the NAIC in February 2020. Third, the Working Group will develop new travel insurance-related Standardized Data Requests (SDRs) to address in-force policies and claims.

Mr. Hughes said the Working Group will also move forward in 2022 with its charges to develop uniform market conduct procedural guidance; coordinate with the Innovation, Cybersecurity, and Technology (H) Committee; discuss the effectiveness of group supervision of market conduct risks; and discuss the role of market conduct examiners in reviewing insurers’ corporate governance.

Mr. Hughes said the Working Group also discussed draft revisions to Chapter 21—Conducting the Property and Casualty Examination of the Market Regulation Handbook regarding provisions from the Real Property Lender-Placed Insurance Model Act (#631) and to Chapter 20—General Examination Standards of the Market Regulation Handbook regarding provisions in the Insurance Holding Company System Regulatory Act (#440).

h. Speed to Market (H) Working Group

Ms. Nichols said the Speed to Market (H) Working Group leadership and NAIC staff support met March 10 to discuss the Working Group’s goals and plans for 2022. She said a Working Group call is scheduled for April 20 to discuss its 2022 goals. Ms. Nichols said the Working Group will: 1) hear an update on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project; 2) hear a status update on edits to the Product Filing Review Handbook; and 3) discuss the annual review of the PCM and Uniform Transmittal Document suggestions.

i. Advisory Organization (D) Working Group

Commissioner Ommen said the Advisory Organization (D) Working Group met March 22. He noted that because the Working Group’s charge is to oversee the regularly scheduled examinations of advisory organizations, the Working Group always meets in closed regulator-only session.
Commissioner Ommen said in addition to receiving updates on exams currently in progress and the most recent company responses to their annual self-evaluations, the Working Group began consideration of advisory organizations that primarily provide telematics and other services heavily reliant in the use of big data technology to insurers. He said this is beyond the standard loss cost and actuarial type services that most advisory organizations provide for their members. He said this year, the Working Group is considering the examination standards that should be in place to effectively regulate these entities. He noted that there are currently a couple states that participate in the Working Group who are conducting examinations of these organizations, and the Working Group will be reviewing and discussing the results of these examinations as it works on examination standards.

Mr. Birnbaum asked whether the development of the standards would be on open conference calls so interested parties could participate. Commissioner Ommen said the development would initially be closed, but once a framework of standards is developed, it would likely move to the Market Conduct Examination Guidelines (D) Working Group for completion. Mr. Birnbaum also asked whether the results of advisory organization examinations could be made public. Commissioner Ommen said the decision to make examination reports public belongs to the jurisdictions participating in the examination, not the Advisory Organization (D) Working Group.

j. Privacy Protections (D) Working Group

Ms. Johnson said the Privacy Protections (D) Working Group met March 23 and March 9 in regulator-only session. She said state insurance regulator SMEs conducted their initial drafting via email and then met March 29 and April 4 following the Working Group’s meeting.

Ms. Johnson said the Working Group adopted its 2021 Fall National Meeting minutes and heard updates by Jennifer McAdam (NAIC) on state privacy legislation and Brooke Stringer (NAIC) on federal privacy legislation.

Ms. Johnson said the Working Group also discussed comments received on the exposure draft of the Working Group’s work plan, which was exposed March 23 for a seven-day public comment period that ended on March 30. She said the Working Group adopted the 2022 work plan during its April 4 meeting.


Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products or Services

1. The Market Regulation and Consumer Affairs (D) Committee will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
   C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
   D. Oversee the activities of the Antifraud (D) Task Force.
   E. Oversee the activities of the Market Information Systems (D) Task Force.
   F. Oversee the activities of the Producer Licensing (D) Task Force.
   G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update, as needed.

2. The Advisory Organization Examination Oversight (D) Working Group will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
   A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

4. The **Market Analysis Procedures (D) Working Group** will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
   B. Discuss other market data collection issues and make recommendations, as necessary.
   C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).

5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
   A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
   A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
   B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
   C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
   D. Develop uniform market conduct procedural guidance (e.g., a library, depository, or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
   E. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
   F. Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
   G. Discuss the role of market conduct examiners in reviewing insurers’ corporate governance as outlined in the NAIC’s *Corporate Governance Annual Disclosure Model Act (#305)* and *Corporate Governance Annual Disclosure Model Regulation (#306)*.

7. The **Market Regulation Certification (D) Working Group** will:
   A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states’ compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The **Privacy Protections (D) Working Group** will:
   A. Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the *NAIC Insurance Information and Privacy Protection Model Act (#670)* and the *Privacy of Consumer Financial and Health Information Regulation (#672)*.
8. The Speed to Market (D) Working Group will:
   A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented
to the Working Group by the SERFF Advisory Board (SAB), likely originating from the SERFF Product
Steering Committee (PSC). Upon approval and acquisition of any needed funding, direct the SAB to
implement the project. Receive periodic reports from the SAB, as needed.
   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the
Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive
(EX) Committee.
   C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market
operational efficiencies related to product filing needs, efficiencies, and effective consumer protection.
   This includes the following activities:
   i. Provide a forum to gather information from the states and the industry regarding tools, policies, and
resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency
issues for state insurance regulators and the industry, particularly regarding uniformity.
   ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that
provide a tool to measure the success of the speed to market modernization efforts, as measured by
nationwide and individual state speed to market compliance, with an emphasis on monitoring state
regulatory and insurer responsibilities for speed to market for insurance products.
   iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal
document (UTD) on an annual basis, including the review, approval, and notification of changes.
Monitor, assist with, and report on state implementation of any PCM changes.
   iv. Facilitate the review and revision of the Product Filing Review Handbook, which contains an overview
of all the operational efficiency tools and describes best practices for industry filers and state
reviewers regarding the rate and form filing and review process. Develop and implement a
communication plan to inform the states about the Product Filing Review Handbook.
   D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and
enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner
at each national meeting. Receive periodic reports from NAIC staff, as needed.
   E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission
(Compact):
   i. Provide support to the Compact as the speed to market vehicle for asset-based insurance products,
encouraging the states’ participation in, and the industry’s usage of, the Compact.
   ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

D Cmte Rev Charges
2022 Proposed Revised Charges

ANTIFRAUD (D) TASK FORCE

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring, and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintaining and improving electronic databases regarding fraudulent insurance activities; 2) disseminating the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) providing a liaison function between state insurance regulators, law enforcement (federal, state, local, and international), and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces, and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

Ongoing Support of NAIC Programs, Products or Services

1. The Antifraud (D) Task Force will:
   A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
   B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
   C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
   D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
   E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
   F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
   G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
   H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
   I. **Evaluate and recommend methods to track national fraud trends.**
   J. **Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2022 Fall National Meeting.**

2. The Antifraud Education Enhancement (D) Working Group will:
   A. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2022...
3.2. The Antifraud Technology (D) Working Group will:
   A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by 2022 Fall National Meeting.
   B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2022 Fall National Meeting.

4.3. The Improper Marketing of Health Insurance (D) Working Group will:
   A. Coordinate with state insurance regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.
   B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

NAIC Support Staff: Greg Welker/Lois E. Alexander

Antifraud TF Charges
Market Regulation Certification (D) Working Group
Virtual Meeting
March 22, 2022

The Market Regulation Certification (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 22, 2022. The following Working Group members participated: John Haworth, Vice Chair (WA); Lori K. Wing-Heier (AK); Crystal Phelps (AR); Erica Weyhenmeyer (IL); Dawna Kokosinski (MD); Chlora Lindley-Myers (MO); Tracy Biehn (NC); Edwin Pugsley (NH); Ralph Boeckman and Erin Porter (NJ); Landon Hubbard (OK); Colette Hittner (OR); Michael Bailes (SC); Julie Fairbanks (VA); Karla Nuissl (VT); Theresa Miller (WV); and Bill Cole (WY).

1. **Reviewed its 2022 Charges and Current Status of the Voluntary Market Regulation Certification Program**

   Mr. Haworth said the Working Group did not meet in 2021 while the Market Regulation and Consumer Affairs (D) Committee considered next steps for the Voluntary Market Regulation Certification Program. He said the 2022 chair of the Committee, Commissioner Jon Pike (UT), asked Superintendent Russell Toal (NM) if he would serve as Working Group chair in 2022, and Superintendent Toal agreed to do so. Mr. Haworth said he agreed to serve as Working Group vice chair.

   Mr. Haworth said there is only one charge for the Working Group and that is to develop a formal market regulation certification proposal for consideration by the NAIC membership. He said the charge has five sections.

   First, Mr. Haworth said the Working Group is to develop the certification standards that it would expect a state’s insurance department should meet. He said this, for the most part, has been achieved. He said there are 12 requirements in the certification program covering staffing, use of the NAIC market information systems, participation in Market Regulation and Consumer Affairs (D) Committee working groups, participation in the Market Conduct Annual Statement (MCAS), collaboration with other departments, and the ability to enforce compliance of regulated entities to market conduct laws and regulations. Mr. Haworth noted that in 2017 and 2018, the Working Group oversaw a pilot program of 18 states that worked to apply the certification standards to the market regulation divisions of their insurance departments. He said the volunteers brought the assessments and recommendations to the Working Group. In 2019 and 2020, the Working Group met to consider the recommendations and incorporated many of them in the certification program. He said these revisions can be found on the Working Group’s web page.

   Second, Mr. Haworth said the Working Group was tasked with developing an implementation plan for the certification program. He said this has also been finished, but because a few years have passed since it was drafted, the implementation plan is now out of date and needs to be brought back up to date. He said the Working Group will be considering the implementation plan in a meeting later in 2022 and will have it completed before the Fall National Meeting.

   Third, Mr. Haworth said the Working Group will develop a process for measuring a jurisdiction’s compliance to the standards. He said the Working Group was actively working on the scoring matrix for measuring the compliance to the standards. He said a current version of the scoring matrix is on the Working Group’s web page.

   Fourth, Mr. Haworth said the Working Group needs to create a process for future revisions to the certification standards. He said this was completed with the implementation plan and consists of a single paragraph at the end.
of the implementation plan. He said when the Working Group reviews the implementation plan, it will take a look at the revision process to see if it needs improvement or if it is good as is.

Finally, Mr. Haworth said the Working Group is tasked with assisting jurisdictions in achieving certification once a certification program is approved and an implementation plan is in place.

2. **Heard an Update on the Certification Program Scoring Matrix**

Mr. Haworth said the Certification Program Scoring Matrix drafting group met March 9 to resume its work on a draft for a scoring matrix to enable jurisdictions to do self-assessments and provide a framework for scoring jurisdictions seeking certification under the Voluntary Market Regulation Certification Program.

Mr. Haworth said the scoring matrix classifies each part of each requirement as mandatory, primary, or secondary, and the drafting group is currently assigning point values to each part. He said a color-coded draft of the scoring matrix without the point values can be found in the exposure drafts on the Working Group’s web page. He said questions coded as red are mandatory; questions coded as yellow are primary; and questions coded as green are secondary. He said a jurisdiction scoring 70% of the maximum possible points would pass the certification assessment. He noted, however, that if one of the mandatory parts is missed, the jurisdiction would not pass the certification assessment even if it scored more than 70%. Mr. Haworth said the drafting group will have the draft ready for the Working Group’s consideration prior to the Summer National Meeting.

3. **Discussed Other Matters**

Mr. Haworth said the goal of the Working Group is to have the Voluntary Market Regulation Certification Program, the implementation plan, and the scoring matrix to the Market Regulation and Consumer Affairs (D) Committee by the Fall National Meeting. He asked that comments be sent to Randy Helder (NAIC) by April 15 on any portion of the certification program.

Having no further business, the Market Regulation Certification (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 3, 2022. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Kurt Swan (CT); Frank Pyle (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Dawn Kokosinski (MD); Timothy Schott (ME); Jill Huisken (MI); Cynthia Amann, Teresa Kroll, and Jo LeDuc (MO); Paul Hanson (MN); Martin Swanson and Reva Vandevoorde (NE); Edwin Pugsley (NH); Ralph Boeckman (NJ); Guy Self (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Brett Bache (RI); Glynda Daniels (SC); Tracy Klausmeier (UT); Will Felvey (VA); Isabelle Turpin Keiser (VT); and Theresa Miller (WV).

1. **Adopted its 2021 Fall National Meeting Minutes**

Mr. Haworth said the Working Group met Nov. 18, 2021, and took the following action: 1) adopted its 2021 Summer National Meeting minutes; 2) discussed market analysis training; 3) discussed the proposed standard ratios for the travel insurance and short-term, limited-duration (STLD) insurance Market Conduct Annual Statement (MCAS) blanks; and 3) discussed the market analysis tools in i-Site+ that will be replaced with enhanced tools and dashboards.

Ms. Weyhenmeyer made a motion, seconded by Ms. Rebholz, to adopt the Working Group’s Nov. 18, 2021, minutes (see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Seven). The motion passed unanimously.

2. **Reviewed its Charges for 2022**

Mr. Haworth said the Working Group’s charges for 2022 have not changed. He said the charges are deliberately broad and could encompass numerous activities. He encouraged everyone to consider what tasks may be important for the Working Group to consider and address in 2022.

Mr. Haworth said the first charge is “to recommend changes to the market analysis framework based over the last five years, including the current set of Level 1 and Level 2 questions.” He said the charge is the reason agenda item 4 was added to the agenda for this meeting. He said he had received a request for the Working Group to consider adding the MCAS data from lender-placed insurance and disability insurance into the Market Analysis Review System (MARS) Level 1 data set. He said he is recommending the Working Group submit a Uniform System Enhancement Request (USER) form to the Market Information Systems Research and Development (D) Working Group to prioritize the request.

Mr. Haworth said the Working Group’s second charge is “to discuss market data collection issues and make recommendations, as necessary.” He said the charge is the reason the Working Group schedules at least one or two discussions regarding the latest MCAS filings and any issues that analysts are encountering with them. He said the charge also covers the Complaints Database System (CDS), the Regulatory Information Retrieval System (RIRS), the Market Action Tracking System (MATS), the Market Analysis Prioritization Tool (MAPT), and other databases.

Mr. Haworth noted that the Market Information Systems Research and Development (D) Working Group annually reports on the completeness, accuracy, and timeliness of the data in the market information systems.
suggested that when the report is ready, the Market Analysis Procedures (D) Working Group should review and provide feedback, as the market analysis experts, to the Market Information Systems Research and Development (D) Working Group and the Market Information Systems (D) Task Force on ways to address the concerns arising from the metrics report.

Mr. Haworth said the third charge is to consider recommendations for new lines of business for the MCAS. He said the most recent recommendations were in November 2019 to add other health insurance to the MCAS and in March 2020 to add travel insurance to the MCAS. He said the Working Group did not make any recommendations in 2021, and he recommended that the Working Group consider which, if any, lines of business, need to be added to the MCAS.

Mr. Haworth said any requests for agenda items relating to the Working Group charges should be sent to Randy Helder (NAIC).

3. Discussed Standard Ratios for the Travel and STLD MCAS Blanks

Mr. Haworth said the proposed standard ratios for the travel and STLD MCAS blanks were originally exposed for the Working Group’s Nov. 18, 2021, meeting, and the Working Group asked for volunteers to review them, make edits and bring them back to the Working Group.

Mr. Haworth said there are five proposed ratios for travel insurance and 11 ratios for STLD. He said along with the proposed ratios, the drafting group made two suggestions for new data elements.

Mr. Haworth said the first suggestion is a new element for the travel MCAS blank of “policies in-force during the period” to assist in analyzing complaint trends from year to year and from company to company. He said the second new data element is for the STLD blank and is the “dollar amount of claims paid during the reporting period.”

Mr. Haworth said the Working Group will consider the new data elements separate from the ratios.

Lisa Brown (American Property Casualty Insurers Association—APCIA) said the APCIA supports the five new ratios for the travel insurance MCAS blank and the new data elements. She said the date element of “policies in-force during the period” is a better comparison to the number of complaints. She thanked state insurance regulators that participated in the drafting of the ratios and said industry appreciated the open dialogue.

Duke de Haas (Allianz) also thanked state insurance regulators for the work put into developing the ratios. He agreed that “policies in-force” is a better denominator for the complaints ratio and is more consistent with the other lines of business.

Mr. Haworth said the proposed ratios are posted on the Working Group web page and asked that comments on the ratios and data elements be sent to Mr. Helder by April 15. He said it is important to get these adopted in time for next year’s MCAS data collection.

4. Discussed Market Analysis Tools and Data Elements

Mr. Haworth said this agenda item addresses the Working Group’s first charge to “recommend changes to the market analysis framework based over the last five years, including the current set of Level 1 and Level 2 questions.” He said he plans to continue this agenda item throughout the year.
Mr. Haworth said he would like to make a recommendation that the Working Group submit a USER form to the Market Information Systems Research and Development (D) Working Group to incorporate the disability insurance and lender-place insurance MCAS data into the MARS Level 1 set of questions.

Ms. LeDuc made a motion, seconded by Mr. Pyle, to add the disability insurance and lender-place insurance MCAS data into the MARS. The motion passed unanimously.

5. Discussed Other Matters

Birny Birnbaum (Center for Economic Justice—CEJ) noted that the proposed standard ratios for travel insurance do not include a ratio to measure cancellations. He said this is inconsistent with the other MCAS lines of business. He said there is no purpose to have a data element capturing the number of cancellations if no ratio is developed regarding cancellations. He noted the travel insurance MCAS blank does not have the appropriate data elements to create a denominator for a good cancellation ratio. Ms. Brown noted that was why industry proposed the addition of the data element of “policies in-force during the period,” but she also noted that most cancellations are consumer initiated and that a ratio to measure cancellations would not be of much value since state insurance regulators would already know the number of cancellations. Mr. Birnbaum said a high cancellation ratio compared with other companies would tell state insurance regulators there may be marketing issues with the reporting company.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.
Market Conduct Annual Statement Blanks (D) Working Group
Virtual Meeting
March 17, 2022

The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 17, 2022. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Rebecca Rebholz, Chair, Vice Chair (WI); Maria Ailor and Cheryl Hawley (AZ); Scott Woods (FL); Paula Shamburger (GA); Brenda Johnson (KS); Lori Cunningham (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Jill Huiskens (MI); Teresa Kroll and Jo LeDuc (MO); Martin Swanson (NE); Guy Self (OH); Jeff Arnold (PA); Michael Bailes (SC); Tony Dorschner (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); Melissa Gerachis (VA); and Jason Carr (WA).

1. **Adopted its Nov. 22, 2021, Minutes**

The Working Group met Nov. 22, 2021, and took the following action: 1) adopted its July 28, 2021, minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) received a proposal from the subject matter expert (SME) group on lawsuit definitions and placement of the lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS; and 5) received a proposal from the SME group on reporting of the digital claims interrogatory question.

Ms. Rebholz made a motion, seconded by Ms. Moran, to adopt the Working Group’s Nov. 22, 2021, minutes (*see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Eight*). The motion passed unanimously.

2. **Received an Update on the Life MCAS Draft Edits for AU**

Ms. Weyhenmeyer stated that the March 4 draft of AU in the life insurance educational paper, which was drafted by the Accelerated Underwriting (A) Working Group, was exposed for a two-week public comment period ending March 18. The draft can be found on the Accelerated Underwriting (A) Working Group’s web page for anyone who would like to review it.

Ms. Weyhenmeyer stated the Accelerated Underwriting (A) Working Group is meeting March 24 in lieu of the Spring National Meeting to: 1) discuss comments received; and 2) consider adoption of the educational paper. Upon adoption, the Working Group plans forward it to the Life Insurance and Annuities (A) Committee for consideration of adoption at the Spring National Meeting. She stated if the draft paper is adopted on March 24, the Market Conduct Annual Statement Blanks (D) Working Group will be reconvening the AU SME group that worked on the life MCAS updates related to AU. The SME group will be tasked with reviewing the definition of AU adopted by the Accelerated Underwriting (A) Working Group to determine if it is appropriate for use with MCAS reporting of AU. She stated if these things happen and are completed before the Market Conduct Annual Statement Blanks (D) Working Group’s meeting in April, then the AU edits will again be exposed to the Working Group along with an updated definition. Then the Working Group can consider the edits during its May meeting.

3. **Received an Update on the Other Health Draft Group**

Randy Helder (NAIC) stated the Other Health Drafting Group is being led by Mary Kay Rodriguez (WI) and that meetings have been taking place weekly for the last few months, with about 20 people in attendance, including...
state insurance regulators, consumer representatives, and industry members. He stated drafts are being posted regularly on the Market Conduct Annual Statement Blanks (D) Working Group web page for review and that any questions can be forwarded to him.

Mr. Helder stated that the Drafting Group began its work by identifying the other health lines to be included in the blank. The other health lines agreed upon are: 1) Health - Accident Only; 2) Health - Accidental Death and Dismemberment; 3) Health - Specified Disease - Limited Benefit; 4) Health – Hospital/Other Indemnity; and 5) Health – Hospital/Surgical/Medical Expense. He stated each of these are divided into individual policies that are sold through associations and policies that are sold through employer groups. The drafting group used the adopted short-term, limited-duration (STLD) MCAS blank as a starting point for developing the data elements and definitions. It eliminated the non-relevant data points and added some data elements that are more appropriate for the other health products. He stated the data elements are divided into five sections: 1) interrogatories; 2) policy/certificate administration; 3) claims administration; 4) consumer complaints and lawsuits; and 5) marketing and sales.

Mr. Helder stated the data elements are close to conclusion and that another meeting will take place for a review of some additional definitions. The goal is for this to be completed by the end of April for the Working Group’s review.

4. **Adopted the Proposal for Digital Claims Interrogatories for the Homeowner and PPA MCAS Lines of Business**

Ms. Weyhenmeyer stated the proposal for digital claims interrogatories for the homeowner and PPA MCAS lines of business is included in attachment two of the meeting materials. She stated this proposal was first presented to the Working Group last November, and that during last year’s June 30, 2021, Working Group meeting, the Working Group voted to include an interrogatory within the home and auto MCAS blanks to capture third-party vendors providing third-party data and algorithms used in the digital claims process. The wording approved during the June 30 meeting included “and for each vendor, identify the vendor’s specific role in the digital claim process.” The SME group was tasked with reviewing this interrogatory and to make recommendations of how third-party vendor data should be reported.

Ms. Weyhenmeyer stated the proposal shows the requirement to identify vendor roles is removed, allowing single-element capture of names of third-party vendors, similar to the capture of names of managing general agents (MGAs) and third-party administrators (TPAs). A public comment period was allowed for review of this proposal, and no comments were received.

Ms. Rebholz made a motion, seconded by Ms. Gerachis, to adopt the proposal for the auto and home digital claims Interrogatories that will be included in the 2023 MCAS reporting, to be collected in 2024 (Attachment Four-A). The motion passed unanimously.

5. **Discussed the Proposed Lawsuit Definitions and Placement of Lawsuit Data Elements for the Homeowners and Auto MCAS**

Ms. Weyhenmeyer stated the proposal for lawsuit definitions and placement of lawsuit data elements for the homeowners and auto MCAS is included in the meeting materials. She stated this was first presented to the Working Group in November 2021 and that the materials include a description and redline version, followed by a clean version of the proposal. Ms. Weyhenmeyer stated the proposal simplifies the lawsuit reporting and its definition as much as possible. The SME group proposes the following for the home and PPA MCAS lawsuit reporting: 1) removal of the lawsuit data elements from the claims reporting section; 2) creation of a new reporting section for the lawsuit data elements; 3) reporting the lawsuit data elements by claims coverage type.
as has been done in the past; 4) adding reporting for “non-claim related lawsuits”; and 5) updating the definition of lawsuits to accommodate the new reporting structure.

Ms. Weyhenmeyer stated the proposed definition is similar to the definition used for other MCAS lines of business, which was done for consistency. She stated a few of the simplifications to the definition could be made to the definition in other lines of business if the Working Group finds that it would be useful. In November, the SME group also proposed the addition of an interrogatory to capture comments for the newly added lawsuit section.

Lisa Brown (American Property Casualty Insurance Association—APCIA) submitted comments for review, which were also part of the meeting materials. Ms. Brown stated she participated in the SME group for this. She stated the proposed definition says: “include only lawsuits brought by an applicant for insurance, a policyholder or claimant as a plaintiff against the reporting insurer or its agent as a defendant.” She stated that “agent” should be defined if it is going to be used as a term in the definition because it was unclear to many of their members if that is referring to an agent as an insurance producer or a third-party that has an agency relationship based on the definition of agency. Ms. Brown stated the definition also states: “If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits.” She stated there needs to be clarification on how these should be reported as there may be multiple policies issued by multiple insurers. Ms. Brown stated they support the language proposed for arbitration, mediation, and appraisal, but ask that it be amended to exclude appraisal matters filed in a court of law and interpleader actions filed by a company. She stated that in Michigan, there seems to be a lot of suits brought by a medical provider for payment under personal injury protection (PIP) and asked if those suits would be counted since medical provider may not fall into the category of policyholder, applicant, or claimant. She also asked if a Pennsylvania writ of summons would be considered a lawsuit under this definition.

Ms. Brown stated the APCIA recognizes the need to expand collection of lawsuit data for both claims-related and non-claims related lawsuits but asks that the coverage breakout for claims-related lawsuit data be deleted and the reasons for this request. Ms. Huiskens stated Michigan is not ready to decide on proposed language with the way it is written now. Ms. Brown stated their request would be that under what to exclude in the definition explanation, to exclude lawsuits brought directly by medical providers.

Mr. Arnold stated he did some research on the question raised regarding Pennsylvania and explained that a writ of summons allows someone to start a lawsuit without actually filing the complaint that would include the grounds on which the lawsuit is being filed, including specific allegations. He stated that the writ of summons just identifies the parties and that the details come later. He said he thinks waiting to include this as a lawsuit would be more appropriate when the actual complaint is filed and the details of the lawsuit are included.

Ms. LeDuc stated companies are already reporting lawsuits based on coverage type in the claims-related area and that there was a request to add all of the other types of non-claims related lawsuits. She stated companies would continue to report what they have been for lawsuits and then just add a single number for any non-claim related lawsuits, which would be the lawsuit total minus the claims related lawsuits. Ms. Brown stated companies would appreciate more time to get the programming in place to report this additional data element and that she will get more information from companies as to why more time is needed before this is collected. Ms. LeDuc and Ms. Huiskens stated they believe more time is needed before the proposal on lawsuit definitions and the placement of lawsuit data elements for the homeowners and PPA MCAS is considered. Ms. Weyhenmeyer agreed and stated the SME group will reconvene. Ms. Huiskens asked that information be shared regarding Michigan concerns, and Ms. Brown stated they would do that.
6. Received Guidance Regarding the New “Number of Lawsuits Closed with Consideration for the Consumer” Data Element for the Homeowner and PPA MCAS Lines of Business

Ms. Weyhenmeyer stated that the meeting materials include guidance for some of the questions that have been presented on the data element for “number of lawsuits closed with consideration for the consumer” data element for the homeowners and PPA MCAS lines of business. She stated this is being provided to let meeting attendees know that these will be added to the MCAS frequently asked questions (FAQ) document posted on the MCAS web page. No questions or concerns were presented.

7. Discussed Other Matters

Ms. Weyhenmeyer stated the next Working Group meeting is scheduled for April 21, 2022. She stated during that meeting, a draft for the AU proposal may be exposed, which would include a new definition and a draft for the other health MCAS reporting data call and definitions. She advised that if these items are exposed, the Working Group will consider them during its May meeting.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
## Homeowners (2023 - Digital Claims Single Element Explanation)

### Homeowners Interrogatories

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Response</th>
<th>Explanation</th>
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<tr>
<td>15</td>
<td>Does the company use Managing General Agents (MGAs)?</td>
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<tr>
<td>16</td>
<td>If yes, list the names of the MGAs.</td>
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<tr>
<td>17</td>
<td>Does the company use Third Party Administrators (TPAs)?</td>
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<tr>
<td>18</td>
<td>If yes, list the names of the TPAs.</td>
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<tr>
<td>19</td>
<td>Does the company use digital claim settlement?</td>
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<td>20</td>
<td>If yes, list the names of the the vendors providing third-party data and algorithms used in the digital claim settlement process.</td>
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</tr>
<tr>
<td>22</td>
<td>Additional state specific Underwriting comments (optional):</td>
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During the 6/30 WG meeting it was voted to include an interrogatory to capture third-party vendors. The SME group was tasked with review and determining the details of how it would be reported. Above is the wording proposed by the SME group. This proposal applies to both the Homeowner and Private Passenger Auto MCAS lines of business.

This proposal removes the requirement to identify vendor roles.
The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met March 10, 2022. The following Working Group members participated: Damion Hughes, Chair (CO); Erica Weyhenmeyer, Vice Chair, Susan Berry, and Patrick Tallman (IL); Jeff Cordell, Teri Ann Mecca, and Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Patrice Garnette (DC); Susan Jennette and Frank Pyle (DE); Paula Shamburger (GA); Daniel Mathis (IA); Ron Kreiter (KY); Mary Lou Moran (MA); Airic Boyce and Jill Huiskens (MI); Teresa Fischer (MN); Cynthia Amann, Jennifer Hopper, Teresa Kroll, Jo LeDuc, and Win Nickens (MO); Tracy Biehn (NC); Edwin Pugsley (NH); Ralph Boeckman and Erin Porter (NJ); Leatrice Geckler (NM); Hermoliva Abejar and Barbara D. Richardson (NV); Sylvia Lawson (NY); Rodney Beetch (OH); Landon Hubbard and Shelly Scott (OK); Brian Fordham, Ana K. Pace, and Tasha Sizemore (OR); David Buono and Paul Towsen (PA); Brett Bache, Segun Daramola, Matt Gendron, and Brian Werbeloff (RI); Kelly Christensen and Shelley Wiseman (UT); Andrea Baytop, Julie Fairbanks, Joy Morton, and Bryan Wachter (VA); Mary Block, Isabelle Turpin Keiser, and Karla Nuissl (VT); Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Darcy Paskey, Rebecca Rebholz, Mary Kay Rodriguez, and Jody Ullman (WI).

1. **Heard Opening Remarks**

Mr. Hughes welcomed returning Working Group members and a new member state, Utah, to the Working Group, represented by Ms. Northrup and Ms. Wiseman. He also welcomed new member representatives Ms. Mecca, Ms. Shamburger, Ms. LeDuc, and Mr. Towsen.

2. **Discussed its Potential 2022 Tasks**

Mr. Hughes said the charges of the Working Group, as adopted by the Market Regulation and Consumer Affairs (D) Committee, are to:

- Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
- Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
- Develop updated standardized data requests (SDRs), as necessary, for inclusion in the *Market Regulation Handbook*.
- Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
- Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
- Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
- Discuss the role of market conduct examiners in reviewing insurers’ corporate governance as outlined in the *Corporate Governance Annual Disclosure Model Act* (#305) and the *Corporate Governance Annual Disclosure Model Regulation* (#306).
The Working Group will not meet at NAIC national meetings; it will accomplish its assigned tasks via regularly scheduled conference calls, to occur approximately every four to six weeks.


Mr. Hughes said the Working Group began discussing the draft Chapter 21—Conducting the Property and Casualty Examination, initially circulated on Oct. 27, 2021, at its Nov. 4, 2021, meeting. He said Sharon Shipp (DC) reviewed the *Real Property Lender-Placed Insurance Model Act* (#631) and recommended revisions to various areas of the chapter for the Working Group’s consideration. Since the Nov. 4, 2021, meeting, which was the last meeting of the Working Group, comments were received on the draft from the industry trade associations (comments dated Nov. 11, 2021, sent to the NAIC on Nov. 23, 2021) and Examination Resources LLC (comments dated Dec. 17, 2021). These comments were circulated to the Working Group, interested state insurance regulators and interested parties on Dec. 2, 2021, and Dec. 20, 2021, respectively.

Chrys Lemon (McIntyre & Lemon PLLC) presented the trade associations’ comments, which he submitted on behalf of the Consumer Credit Industry Association (CCIA), the American Property Casualty Insurance Association (APCIA), the American Bankers Association (ABA), the National Association of Mutual Insurance Companies (NAMIC), and the Council of Insurance Agents & Brokers (CIAB). He proposed the following:

1) Marketing and Sales Standard 1 – Adding “such certificates will only be requested for lender-placed insurance policies” to the Documents to be Reviewed section to the item, “New business policy forms and certificate of insurance” so it would then read, “New business policy forms and certificate of insurance (such certificates will only be requested for lender-placed insurance policies).”

2) Underwriting and Rating Standard 4 – Adding “For lender placed insurance” before “Documentation showing regulated entity’s separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate owned property” to the Documents to be Reviewed section so it would then read, “For lender placed insurance, documentation showing regulated entity’s separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate owned property.”

3) Underwriting and Rating Standard 6:
   a) Adding “and lender placed insurance examinations, as applicable” to the Apply to section so the section would then read, “All workers’ compensation examinations and lender-placed insurance examinations, as applicable.”
   b) Adding “except with respect to lender-placed flood insurance” to the item in the Documents to be Reviewed section, “Applicable reports filed with the commissioner (e.g., required reporting for insurers with at least $100,000 in direct written premium for lender-placed insurance, required rate filing for insurers with an annual loss ratio of less than 35% in any lender-placed program for two consecutive years)” so it would then read, “Applicable reports filed with the commissioner (e.g., required reporting for insurers with at least $100,000 in direct written premium for lender-placed insurance, required rate filing for insurers with an annual loss ratio of less than 35% in any lender-placed program, except with respect to lender-placed flood insurance, for two consecutive years).”
   c) Adding “and, with respect to losses under lender-placed insurance policies” to the first paragraph of the Review Procedures and Criteria section so the paragraph would then read, “Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves, deductibles, and, with respect to losses under lender-placed insurance policies, any excess amounts paid to the mortgagor can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items.”
4) Underwriting and Rating Standard 13 – Adding “For lender placed insurers” to two items in the Documents to be Reviewed section so the items would then read, “For lender-placed insurers, books and records containing compensation, contingent commissions, profit sharing, and other payments dependent on profitability or loss ratios” and “For lender-placed insurers, third-party agreements for outsourced services.”

Ms. Garnette indicated that the proposed language of the trade associations to Marketing and Sales Standard 1 and Underwriting and Rating Standards 4, 6, and 13 would be acceptable changes to the draft chapter.

Craig Leonard (Examination Resources LLC) presented his comments of Dec. 17, 2021, in which he said: 1) the language proposed by Ms. Shipp modifying Marketing and Sales Standard 8 in Chapter 21, “before the effective date of the insurance” would cause confusion among examiners/regulated entities; and 2) the meaning of the phrase, “near the expiration of a claim” is unclear.

Ms. Garnette indicated that Marketing and Sales Standard 8 of the chapter could be rewritten as follows to address Mr. Leonard’s comments, “Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than before the effective date of the insurance, near the expiration of coverage, or following a claim.” Mr. Leonard said the meaning of Ms. Garnette’s suggested change remains unclear, and he would still have some of the same concerns, specifically regarding what the difference is between “developed at or near inception of the coverage” rather than “before the effective date of insurance.” Mr. Gendron asked whether the proposed change would be made to the Conducting the Property Casualty Examination chapter or if the chapter is specific to lender-placed insurance. Mr. Hughes said the change is being made to the Conducting the Property Casualty Examination chapter. Ms. Abejar said the phrase, “near inception” is redundant with the phrase, “before effective date,” and she asked for additional time to review the revisions before consideration of adoption. Birny Birnbaum (Center for Economic Justice—CEJ) agreed and suggested that more time is needed to review the Chapter 21 exposure draft. Ms. Garnette said a better way to address the comments arising during the meeting might be to revise the Review Procedures and Criteria section of Marketing and Sales Standard 8, instead of revising the language of Standard 8 itself. Mr. Hughes said the comment due date will be extended on the exposure draft.


Mr. Hughes said the draft Chapter 20—General Examination Standards, which was circulated on Oct. 27, 2021, had been provided by Mr. Kreiter for the Working Group’s consideration. Mr. Hughes said Mr. Kreiter reviewed the Insurance Holding Company System Regulatory Act (#440) in 2021 and recommended corresponding revisions to the chapter. Since the Nov. 4, 2021, meeting, which was the last meeting of the Working Group, comments were received on the draft from State Farm on Nov. 24, 2021, and the American Council of Life Insurers (ACLI) on Dec. 17, 2021. These comments were circulated to the Working Group, interested state insurance regulators, and interested parties on Dec. 2, 2021, and Dec. 20, 2021, respectively.

Chuck Feinen (State Farm) presented his comments dated Nov. 24, 2021, on the Chapter 20 exposure draft. He said market conduct examinations involve surveillance of market practices (e.g., marketing and sales, underwriting and rating, claims practices); therefore, the addition of review procedures and criteria relating to solvency—i.e., liquidity stress testing (LST) and group capital calculation (GCC)—in Chapter 20 should not be included within the scope of market conduct examinations. He said such procedures/financial solvency filings are made by regulated entities with domestic or lead state financial regulators, so these areas should not be a focus of market conduct examinations. He said the revisions in Chapter 20 regarding LST and GCC should be removed from the exposure draft, as it is his opinion that these do not need to be addressed in a market conduct exam,
and a market conduct examiner should instead give deference to the lead state or the domestic financial regulator in these matters, especially since the GCC has an evaluation tool for solvency, and the lead state or domestic financial regulator has the ability to exempt various entities from making that type of solvency filing.

Gabrielle Griffith (ACLI) presented the ACLI Dec. 17, 2021, comments on the Chapter 20 exposure draft. She indicated that the issue of state insurance regulators’ review of LST and GCC is adequately addressed by state insurance department financial regulators, and market conduct examiners, therefore, need not review a regulated entity for compliance with the solvency provisions of Model #440. She expressed concern with the inclusion of LST and GCC guidance in the Chapter 20 draft since these are to be filed with a state insurance commissioner in the context of an acquisition or a merger, and the lead state or domestic regulator retains the authority and responsibility of the review of regulated entity compliance with these tools, not market conduct examiners.

Mr. Kreiter said market conduct examiners are not limited to reviewing only market conduct compliance issues; he quoted from Chapter 1—Introduction of the Market Regulation Handbook, “… market conduct compliance issues can have a significant effect on legal and compliance issues, which in turn can create material solvency issues. Coordination with the financial function is an important area for market conduct examiners ….” He recommended removing the text that was added within the Review Procedures and Criteria sections of both Operations/Management Standard 1 and Marketing and Sales Standard 1, while retaining the references to Model #440 within the NAIC model references of both of the examination standards, which will allow each jurisdiction to use the provisions of Model #440 as they deem appropriate.

Mr. Feinen said while market conduct examiners may discover during the course of an examination that underwriting practices might be creating a solvency issue for a regulated entity, market conduct examiners may not have the expertise needed for a review of the solvency tools mentioned in Chapter 20, and while the removal of the Model #440 guidance from the Review Procedures and Criteria sections would address his concerns to some extent, the main issue that remains is that the reference to Model #440 within the NAIC model references of the examination standards broadens a market conduct exam to areas that are generally handled by a lead state or domestic regulator, which would lead to the duplication of efforts.

Ms. Abejar said when there are issues found by market conduct examiners relating to marketing strategy, etc., her jurisdiction contacts the domestic (domiciliary) state’s financial analysis staff to ascertain if the regulated entity has any problem with any liquidity issues or if that state has performed a recent LST or Own Risk and Solvency Assessment (ORSA) report on the regulated entity. She said her jurisdiction would not perform that review themselves; her jurisdiction would instead rely on the lead state’s (domiciliary state) financial analysis staff for that information, as well as their opinions on the financial reports that have been submitted by the regulated entity. She said regarding newly hired examiners, it is beneficial to have guidance in the Market Regulation Handbook that indicates that there are other information/reference sources available that they can review; therefore, she suggested retaining Mr. Kreiter’s revisions to the Review Procedures and Criteria sections relating to Model #440 in the exposure draft.

Ms. Amann said the language in the Review Procedures and Criteria sections of the two revised examination standards could be changed from “Determine …” to “Discuss with the domestic …” or “In consultation with the domestic regulatory ….” Incorporating this language would provide guidance to a newly hired examiner that there is additional information they can review. Ms. Amann indicated that the remainder of the language Mr. Kreiter developed should remain in the chapter, as it would prompt an examiner to initiate some kind of consultation with the domestic state.
Ms. Plitt said market conduct examiners in Washington, upon opening a new examination, begin inquiries with its own financial division to ascertain if there are any current or pending issues Washington financial analysts have seen with a particular entity that market conduct examiners should be aware of. She said Washington market conduct examiners would not perform LST themselves; they are instead seeking information from the domestic state, or Washington’s own financial analysis division, to obtain support/confirmation that there is (or is not) a problem related to the solvency of a specific regulated entity.

Ms. Weyhenmeyer agreed, saying that qualifying language should be inserted within the Review Procedures and Criteria sections of both examination standards, prompting the examiner to inquire with the domiciliary state regarding solvency issues. Mr. Gendron said if the intent of ORSA is that of a regulated entity identifying its own risk, then a regulated entity should be aware that market conduct examiners would consider that an appropriate topic of consideration. He said Rhode Island’s market conduct examiners do not perform stress tests themselves; however, they want to be able to discuss the results of stress tests with domestic financial examiners.

Ms. Berry, who is a financial solvency regulator, said when a regulated entity identifies a risk in its ORSA report, it does not mean it is a risk; it means it has the potential to be a risk, and how that risk is mitigated, as well as what controls are in place, are what is important when analyzing the probability that an identified risk might occur. If a financial regulator feels that an identified risk is not adequately mitigated or inadequate controls are not in place, the financial regulator should then notify the market conduct area in his/her jurisdiction that there may be a potential issue with the regulated entity that could be addressed in a market conduct examination.

Ms. Abejar said the references inserted within the exposure draft to Model #440 should remain so examiners know that certain information is available to them, and direction should be provided in the exposure draft to prompt the examiner to reach out to the domiciliary state to ascertain if financial analysis is being conducted already on that regulated entity or if there are any issues of financial concern that the domiciliary state financial analysis staff has identified; that information is valuable to assist a market examiner in performing a more thorough market conduct examination. She said the word “coordination” could be used instead of “determination” in the exposure draft to direct the examiner to the domiciliary state for further information on solvency issues.

Mr. Feinen said his main concern remains, with the exposure draft as currently written, that market conduct examiners would make LST and GCC determinations; however, he does not have any concerns with examiners looking to a lead state or domestic regulator for further information on solvency topics.

Jeff Martin (UnitedHealthcare) said he would provide the Working Group with language from the Financial Analysis Handbook that might better address the coordination of market conduct examiners and financial solvency analysts in the Chapter 20 exposure draft.

Lisa Brown (APCIA) agreed with Mr. Feinen’s and Mr. Martin’s comments, and Mr. Martin added that this issue ties into the Working Group’s charge to “Discuss the role of market conduct examiners in reviewing insurers’ corporate governance ...”

Mr. Hughes said the comment due date on Chapter 20 will be extended to allow for further comments and revisions to the exposure draft.

5. Discussed Other Matters

Mr. Hughes said he and Ms. Weyhenmeyer have been collaborating with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group; there is a draft chapter that has been developed by the MHPAEA (B)
Working Group that will be distributed to the Market Conduct Examination Guidelines (D) Working Group after the Spring National Meeting. He said the draft, which is designed to replace the current Chapter 24B—Conducting the MHPAEA-Related Examination in the Market Regulation Handbook, has been updated to align with federal guidance more closely on the issue of compliance analysis requirements for non-quantitative treatment limitations (NQTLs).

Mr. Hughes said Mr. Werbeloff, Mr. Swan, Mr. Pyle, and other state insurance regulators on their respective teams collaborated to create a revised Chapter 23—Conducting the Life and Annuity Examination, which they updated to correspond with revisions to the Suitability in Annuity Transaction Model Regulation (#275), which was adopted by the NAIC in February 2020. Mr. Hughes said that draft would be distributed to the Working Group prior to the next meeting.

Mr. Hughes said a regulator-only subject matter expert (SME) group worked in 2021 on creating new travel-insurance related SDRs to address in-force policies and claims. He said those draft SDRs are now ready for the Working Group’s review and consideration, and they will be circulated to the Working Group soon.

Mr. Hughes asked the Working Group members to participate in as many Working Group meetings as possible this year so the Working Group can accomplish the tasks that are planned in 2022. He said NAIC staff will provide advance email notice of the next Working Group meeting, which is anticipated to occur in April.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in Kansas City, MO, April 6, 2022. The following Working Group members participated: Katie Johnson, Chair (VA); Cynthia Amann, Co-Vice Chair (MO); Chris Aufenthie, Co-Vice Chair (ND); Sarah Bailey (AK); Damon Diederich (CA); George Bradner (CT); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Ron Kreiter (KY); Robert Wake (ME); T.J. Patton (MN); Martin Swanson (NE); Teresa Green (OK); Raven Collins (OR); Gary Jones and David Buono (PA); Frank Marnell (SD); Carole Cearley (TX); Todd Dixon (WA); and Rachel Cissne Carabell (WI). Also participating were Trinidad Navarro and Frank Pyle (DE); Kathleen A. Birrane and Alexander Borkowski (MD); Chlora Lindley-Myers and Carrie Couch (MO); Tracy Biehn (NC); Eric Dunning (NE); and Don Beatty (VA).

1. **Heard Opening Comments**

Ms. Johnson said as this Working Group has an aggressive work plan, it is still accepting Working Group members who are committed to volunteering to work on specific sections as noted in the work plan. She asked those interested to contact Lois E. Alexander (NAIC) to become a Working Group member or to join one of the distribution lists for interested state insurance regulators and interested parties.

2. **Adopted its 2021 Fall National Meeting Minutes**

Ms. Johnson said the Working Group met Dec. 11, 2021. She also said the Working Group met March 23, 2022, and March 9, 2022, in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to draft its work plan. Ms. Johnson said a group of subject matter experts (SMEs) also met to draft revisions to the Preamble and the first three sections of the *NAIC Insurance Information and Privacy Protection Model Act* (#670) for the Working Group’s consideration.

Ms. Amann made a motion, seconded by Mr. Patton, to adopt the Working Group’s Dec. 11, 2021, minutes (see *NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Nine*). The motion passed unanimously.

3. **Heard Updates on State Privacy Legislation and on Federal Privacy**

Jennifer McAdam (NAIC) said the Working Group outlined in its report to the Market Regulation and Consumer Affairs (D) Committee at 2021 Fall National Meeting the state privacy legislation at that time, including the California Consumer Privacy Act (CCPA) and the California Data Privacy Act (CDPA), which amended the CCPA; the Colorado Privacy Act (CPA); and the Virginia Consumer Data Protection Act (VCDPA). Since that time, she said just one other state has adopted a similar data privacy law, and that is the Utah Consumer Privacy Act (UCPA). She said other states have proposed privacy legislation, but none of the bills have been signed into law yet. However, she said many of those state legislatures are still in session or will have carryovers until next year. She said there are currently more than 20 bills pending across the country and that she will continue to monitor those. Ms. McAdam said the NAIC Legal team tracks the legislation and has created two different charts listing the bills. She said the charts will be posted to the Working Group’s web page soon. She said the charts list the business obligations posed to the consumer rights provided by the manner of enforcement by the attorney generals or by private right of action and any federal Gramm-Leach-Bliley Act (GLBA) or federal Health Insurance Portability and
Accountability Act of 1996 (HIPAA) exemptions that might be found in those laws or bills. She said it is important for the Working Group to follow these laws because of the consumer rights and obligations that are being established, as well as to be aware of the carve-outs that are applicable to the insurance industry.

Ms. McAdam said California was the first U.S. state to adopt an omnibus privacy law that would impose its broad obligations on businesses that would provide consumers with transparency and control of their personal data. She said California’s law does not go as far as the General Data Privacy Regulation (GDPR), but it is certainly the most comprehensive of the other three existing state data privacy laws. As a refresher, she said many of the consumer rights that are found in the CCPA and GDPR can be traced back to the rights found in the federal Fair Credit Reporting Act (FCRA), which looks remarkably like Model #670. She said two updated charts on state privacy legislation will be posted to the Working Group’s web page soon. She said the charts include GLBA carve-outs and HIPAA exemptions. Ms. McAdam said California had adopted the first omnibus bill, and while it did not go as far as the GDPR, it went further than any other bill proposed by states and could be traced back to the FCRA. She said of the state privacy laws, California’s law could be categorized as being the most stringent and Utah’s as probably the most opposite of that continuum, with Colorado and Virginia in the middle. She said that Colorado may be closer to California and that Virginia may be slightly closer to Utah.

Ms. McAdam said for those tracking the GLBA and HIPAA preemptions found in these laws:

- California has a data level exemption for the GLBA and an entity level exemption for HIPAA.
- Virginia has an entity level exemption for the GLBA and HIPAA.
- Colorado has a data level exemption for the GLBA and HIPAA.
- Utah has a data level exemption for HIPAA and an entity level exemption for the GLBA, which is the opposite of California.

She said that current laws run the gamut and that the NAIC Legal team will continue to follow state privacy legislation for the states that remain in session this year.

Brooke Stringer (NAIC) said there have been reports in the media that U.S. Rep. Frank Pallone (D-WI), chair of the U.S. House Committee on Energy and Commerce, is going to be convening a meeting with staff for Sen. Maria Cantwell (D-WA), chair of the U.S. Senate Committee on Commerce, Science and Transportation; and Sen. Roger Wicker (R-MS), ranking member of the U.S. Senate Committee on Commerce, Science and Transportation. Ms. Stringer said their respective staff are going to be meeting to form a bipartisan agreement on comprehensive privacy legislation. She said these two committees have the primary jurisdiction over data privacy, as well as some of the financial services committees. She said it will be an elusive goal at the federal level, so what remains to be seen is what is going to come of this. She mentioned that over the past few years, there have been some key points of contention that can come up in these congressional discussions: 1) whether it attempts to preempt state laws; and 2) whether there is a private right of action at the state level. So, she said these negotiations will certainly evolve around certain trade-offs regarding the extent of the preemption, the private right of action, and the stringency of the privacy standards.

Ms. Stringer said bills that have been introduced or reintroduced by this Congress all recognize consumer rights to control their information; they all require companies to take steps to protect those rights; and they create enforcement procedures for those requirements. She said Sen. Wicker’s Safe Data Act (SDA) has been reintroduced with lofty standards for data privacy and security that would preempt all state data privacy and security laws. She said it has a GLBA carve-out, which may protect some state consumer data privacy laws, but it also has some instructions for the Federal Trade Commissioner (FTC) to develop privacy standards. Ms. Stringer said it is particularly important to watch due to Sen. Wicker’s position on that committee. She said that last year,
Sen. Cantwell had introduced legislation that had strict standards, but it would have established a preemptive privacy floor and it would have provided for a private right of action. However, it would not have prevented laws with much greater levels of protection. She said that in November 2021, the House Committee on Energy and Commerce Republicans released a draft bill of the Control Our Data Act (CODA), which would have created a national preemptive privacy standard. Ms. Stringer said Sen. Jerry Moran (R-KS) had reintroduced the Commerce Data Privacy and Security Act, which would preempt state data privacy and security authority with certain exceptions so it would not supersede laws that address financial institutions held by organizations held by Title V of the GLBA.

On the House of Representatives side, Ms. Stringer said Rep. Suzan DelBene (D-WA) reintroduced the Information Transparency and Personal Data Control Act, which is another bill that would create a national database of privacy standards and preempt state control if there are conflicting state laws. Ms. Stringer said it would allow users to opt out before companies can use their most sensitive personal information. She said all of this is to say that there are many flavors and approaches to federal data privacy bills, and Congress has struggled to reach any sort of compromise on the issue. However, she said that could change at any time. She said when momentum is growing at the state level to enact data privacy laws, the pressure ramps up at the federal level to act. In addition to Congress, it is also worth noting that the FTC is expected to provide data privacy regulations. Ms. Stringer said the NAIC continues to engage with Congress to oppose preemptive federal legislative proposals and to inform Congress of the Working Group’s efforts to update its models. She said the NAIC makes the point to Congress that states have proven the ability to act quickly to address technological changes that affect data privacy and data security. She also said that the NAIC underscores the importance of not undermining the existing state regulatory framework or inhibiting ongoing efforts in the states to develop data privacy laws and regulations so that state insurance regulators can continue working in the best interests of insurance consumers.

Mr. Patton asked about the difference between data versus entity-level exemptions. Ms. McAdam said the various laws treat the GLBA and HIPAA differently. She said that entity-level exemptions use the phrase “this law does not apply to entities covered by or controlled under GLBA or HIPAA covered entities” and that data-level exemptions use the phrase “data or information collected pursuant to GLBA or HIPAA.” Ms. McAdam said it would be up to the Working Group to determine whether only certain data is carved out or if any data collected by the entire entity is carved out. Mr. Wake said the Working Group should not even consider an entity-level exemption under the GLBA because it would mean excluding the financial sector, which would be fine if it could be said that the GLBA covers the financial sector, and the Working Group wants to cover the Facebooks of the world that are not financial institutions. However, he said since the Working Group consists of state insurance regulators drafting a state insurance privacy law, it is using its delegated functional regulatory authority under the GLBA to regulate. So, the Working Group cannot carve GLBA out because that would carve out everything that the Working Group wants to do. Mr. Wake said California’s data-level exemption for the GLBA means the data collected is not being regulated, but insurers might be regulated in other ways. It leaves everything up to state insurance regulators except the private right of action, which applies only to the attaching of the data to the regulation.

Chris Petersen (Arbor Strategies), speaking on behalf of the Coalition of Health Insurers, said there should be a HIPAA safe harbor like Model #670, under which there is no exemption from the law unless insurance companies comply with the Privacy of Consumer Financial and Health Information Regulation (#672). He said if insurance companies comply with HIPAA, they do not need to comply with any other lessor standard. Mr. Petersen said Model #672 is an insurance-only model, so he said the Working Group’s work plan should start with Model #672, not Model #670 as part of it is obsolete. Mr. Wake said the Working Group already had these discussions in regulator-to-regulator meetings prior to coming to the decision noted in the work plan. Ms. Johnson said the Working Group has determined that it would be looking at Model #670 and Model #672 and drafting a white paper on consumer data ownership.
4. **Adopted its Work Plan**

Ms. Johnson said the exposure draft of the Working Group’s work plan was drafted in two regulator-to-regulator meetings on March 23 and March 9, and that the draft was exposed for comment on March 23 for a seven-day public comment period ending March 30. She said written comments had been received from the American Council of Life Insurers (ACLI) and the Coalition of Healthcare Providers. Ms. Johnson asked if there were any comments from Working Group members, interested state insurance regulators, or interested parties. Birny Birnbaum (Center for Economic Justice—CEJ) said the work plan, while ambitious, showed a depth of understanding of the issue, so he agreed with it as a sound plan. However, he said the Working Group may need to revise or tweak it as it proceeds through it.

Robert Ridgeway (Coalition of Healthcare Providers) said he agrees with what Mr. Petersen had written in his comments on behalf of the Coalition of Healthcare Providers and that he also wanted to highlight two of the points made in that letter. One was that the Working Group should focus on Model #672 by starting its work with it, and the other was that a gap analysis should be done prior to any revisions being suggested. Mr. Ridgeway said the difficult timeline given would require all stakeholders to work together on drafting of any revisions, especially on wordsmithing.

Kristin Abbott (ACLI) said the comment period was too short and that future comment periods should be at least 30 days to give trade associations like hers enough time to distribute the drafts to their members and then compile all comments received prior to responding to the Working Group. She said the Working Group should be mindful to avoid holidays. Ms. Abbott also asked the Working Group for more detail about the white paper, particularly about its design and purpose.

Wes Bissett (Independent Insurance Agents and Brokers of America—IIABA) asked how the white paper would fit into the Working Group’s work plan. He asked what type of issues the white paper would address and if it would include any recommendations from the Working Group. Mr. Bissett also asked if the white paper would be looking into any private contracts. Ms. Johnson said the issues noted in the comments submitted would be considered by the Working Group as it moved through its work plan in 2022.

Ms. Amann made a motion, seconded by Mr. Aufenthie, to adopt the Working Group’s work plan for 2022 (Attachment Six-A). The motion passed unanimously.

5. **Discussed Other Matters**

Ms. Johnson said Mr. Aufenthie had volunteered to lead the workstream team on drafting the white paper on data ownership and use rights. Mr. Aufenthie said the team’s goal was to identify where the gaps are in Model #670 and Model #672 about who owns consumer data; where it comes from; who has control over it; for how long; and under what circumstances. He said the team would solicit questions from Working Group members, interested state insurance regulators, and interested parties (including NAIC consumer representatives) for a survey that would be exposed to seek other questions that could first be tied back to the six consumer data rights identified by NAIC Members over the last two years.

Ms. Johnson reminded the Working Group that the survey questions are scheduled to be exposed for a brief comment by May 11, with the final survey scheduled to be distributed in July.

Having no further business, the Privacy Protections (D) Working Group adjourned.
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<tr>
<th>Ref #</th>
<th>Priority</th>
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<th>Task/Working Group (includes regulator only meetings and open meetings [back to back])</th>
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<th>Comments from Interested Parties</th>
<th>Info for White Paper</th>
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<tbody>
<tr>
<td>1</td>
<td>Before 2023 Fall National Meeting</td>
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<td>A. Review state insurance privacy protections regarding the collection, data ownership and use rights and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (6870) and the Privacy of Consumer Financial and Health Information Regulation (6872).</td>
<td>Regulator Only vs. Open Meeting: Regulators discuss regulator-prepared draft in closed meeting and agree to suggested revisions. A draft is exposed for public comment for 2 weeks prior to discussion and consideration of adoption during open meeting.</td>
<td>Draft document [White Paper] on data ownership and use rights</td>
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<td>2</td>
<td>Ongoing Task</td>
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<td>The Group will receive updates from NAIC staff and review state/federal/international applications as appropriate. Engage with federal and international supervisors and agencies on efforts to manage, evaluate, monitor and regulate consumer data privacy as technology changes continue to evolve.</td>
<td>Frequency of updates; Determining whether a response is needed to ongoing developments</td>
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1. **Expose workplan timeframe and deliverables for public comment 3/23/22**

Review, discuss, and finalize exposure draft of work plan and deliverables for public comment.

| Agenda for the Spring National Meeting: Introduction of WG members; State and Federal Privacy Legislation Updates; Discuss and Consider for Adoption PPWG Workplan, Timeframe and Deliverables. |

Regulator Only meetings 3/8/22 & 3/23/22

Request information from companies and consumer reps about consumer data ownership and usage for White Paper?

2. **Focus on 2 specific workstreams:**

- Revisions to NAIC Privacy Models: (Model 670 First; then 672)
- White Paper on data ownership and use rights: with instructions, history, explanation about why we did what we did, etc.

Talk to Commissioner Birrane to focus the work on the white paper.
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<td>3</td>
<td>Before the Spring National Meeting (March 2022)</td>
<td>Solicit assign regulator volunteers who will meet separately to draft suggested revisions to each section</td>
<td>Modal 670 (how data is collected); Preamble and 24 Sections.</td>
<td>Revisions needed; Yes or No. If Yes, add in regulator session; expose 2 weeks for public comment; discuss and adopt revisions during that open meeting.</td>
<td>MO670_041520_ExposureDraftTopics_with_042920_CommentsonSection1-5_rev032221.pdf posted on PPWG Webpage includes EXPOSURE DRAFT TOPICS – APRIL 15, 2020 (and definitions from Modal 668-IDSM WITH APRIL 29, 2020 COMMENTS ON SECTIONS 1-9 as of 6/22/21)</td>
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<td>4</td>
<td>NAIC Spring National Meeting 3/22-3/25</td>
<td>3/23/22: (1) Finalize our workplan; (2) Discuss the goals of the white paper; (3) Make assignments for Sections 1-3 (due 4/4); (4) subgroup to develop 4-6 questions to give to interested parties to elicit comments on data use and ownership rights (due 5/4);</td>
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<td>MO 670</td>
<td>Break the sections into smaller drafting groups</td>
<td>March 23: Expose the workplan and goals for comment; discuss the goals of the white paper as outlined by Com. Barrane</td>
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<td>4/13/22: (1) Review drafts for Sections 1-3 and make any necessary changes; (2) Make assignments for Sections 4-7 (due May 4)</td>
<td>Preamble</td>
<td>Section 1. Scope</td>
<td>Replace existing definitions with applicable IDSA Model 668 definitions?</td>
<td>April 13: Expose drafts for Sections 1-3 for comments (due May 4)</td>
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<td>Section 2. Definitions</td>
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<td>Section 3. Proceed with interviews</td>
<td>Do we still need this provision?</td>
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<td>Item</td>
<td>Description</td>
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<td>1.</td>
<td>Discuss comments on drafts of Sections 8.10 and 11.15 and finalize sections.</td>
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<td>4.</td>
<td>Discuss comments on drafts for Sections 8.10 and 11.15.</td>
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<td>5.</td>
<td>Discuss comments on drafts for Sections 11.16, 11.17, and 11.18.</td>
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<td>8.</td>
<td>Provide comments on the draft for Sections 11.16, 11.17, and 11.18.</td>
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<td>Review drafts of Sections 16, 17, &amp; 20 and make appropriate changes; (3) Make assignments for Sections 21 &amp; 22 (due September 7)</td>
<td>Section 17, Cease and Desist Orders and Reports</td>
<td>Sections 16, 17, &amp; 20 for comments (due September 7)</td>
<td>Draft of white paper on data use and ownership rights available for WG to review (due 8/16/22)</td>
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<td>12</td>
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<td>The WG should discuss whether those sections should be amended or removed</td>
<td>Section 18: Penalties</td>
<td>Should we delete these provisions? These topics are dependent on state law.</td>
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<td>11</td>
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<td>See 8/17/23 above</td>
<td>Section 19: Judicial Review of Orders and Reports</td>
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<td>September 14: (1) Discuss comments on drafts for Sections 16, 17, &amp; 20 and make appropriate changes; (2) Review drafts of Sections 21 &amp; 22 and make appropriate changes; (3) Discuss whether Sections 14, 15, 16, 19 should be reviewed and make appropriate assignments (due October 9).</td>
<td>Section 20: Individual Remedies</td>
<td>September 14: Expose drafts of Sections 21 &amp; 22 for comments (due October 9)</td>
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<td>October 12: (1) Discuss comments on drafts for Sections 21 &amp; 22 and make appropriate changes; (2) Discuss drafts for any of Sections 14, 15, 16, 19, if applicable and make appropriate changes.</td>
<td>Section 21: Immunity</td>
<td>Section 22: Obtaining Information Under False Pretense</td>
<td>Should we delete these provisions? These topics are most likely dependent on state law.</td>
<td>October 12: If changes were made to Sections 14, 15, 16, 19, expose those drafts for comments (due November 2). Regulator comments and suggested changes due October 7</td>
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<td>November 9: (1) If applicable, discuss comments to any changes made to Sections 14, 15, 16, or 19 and make appropriate changes; (2) Review the draft of the white paper and make necessary changes in preparation to expose it for comment.</td>
<td>Section 23: Severability</td>
<td>Section 24: Effective Date</td>
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<td>12/7/22: Expose draft white paper on data ownership and use rights for comments (due 3/1/2023)</td>
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<td>December 7: Discuss which sections of Model 672 we requiring further review and revision</td>
<td>Section 25: Effective Date</td>
<td>Section 26: Effective Date</td>
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<td>12/7: Expose draft white paper on data ownership and use rights for comments (due )</td>
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<td>Required: Project History. Report from the Privacy Protections (H) Working Group to the H Committee</td>
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<td>1/1/2023-10/30/23: WG will complete its review and revisions of Model 672</td>
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<td>Model 672 (How data is used after it’s collected)</td>
<td>MO672_redline022221.pdf - posted on PWG webpage - has 17 Sections in six Articles and 2 Appendices (52 pages - last 4 are federal notions)</td>
<td>1/1/2023 - 10/30/2023: WG reviews the comments to the draft white paper and makes any necessary amendments as the WG finishes its work on Model 672. Any changes will be exposed for comment.</td>
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<td>ARTICLE I. GENERAL PROVISIONS</td>
<td>Work on General Provisions together?</td>
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<td>3/15/2023: (1) Review the workplan for the year; (2) discuss the comments on the draft of the white paper; (3) make assignments for Article I (due 4/12)</td>
<td>Section 1. Authority</td>
<td></td>
<td>Replace existing definitions with IDSA Model 668 definitions?</td>
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<td>4/19/2023: Review and make appropriate changes to the draft of Article I; (2) make assignments for Article II (due 5/10/23)</td>
<td>ARTICLE II PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION</td>
<td>Section 5. Initial Privacy Notice to Consumers Required</td>
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<td>Section 6. Annual Privacy Notice to Customers Required</td>
<td>Section 7. Information to be Included in Privacy Notices</td>
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<td>Section 8. Form of Opt Out Notice to Consumers and Opt Out Methods</td>
<td>Section 9. Revised Privacy Notices</td>
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<td>Section 10. Privacy Notices to Group Policyholders</td>
<td>Section 11. Delivery</td>
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<td>ARTICLE III LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION</td>
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<td>Determining whether action is needed to support state adoption</td>
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<td>5/17/2023: Review comments on draft of Article I, and make appropriate changes; (2) discuss the draft of Article II, and make appropriate changes.</td>
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<td>Section 12, Limitation on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties</td>
<td>5/17/23: Exposure of Article II revisions for comments due</td>
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<td>(1) make assignments for Article III (due 6/7/23)</td>
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<td>6/14/23: Review the comments on the draft of Article II and make appropriate changes; (2) discuss the draft revisions to Article III and make appropriate changes; (3) make assignments for Article IV (due 7/5/23)</td>
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<td>Section 13. Limits on Redisclosure and Reuse of Nonpublic Personal Financial Information</td>
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<td>ARTICLE IV. EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION</td>
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<td>Incorporate FAST Act Changes from Bulletin?</td>
<td>6/14/23: Expose the draft of Article III for comments (due 7/5/23)</td>
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<td>Section 15. Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing</td>
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<td>Section 16. Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions</td>
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<td>Section 17. Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information</td>
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<td>ARTICLE V. RULES FOR HEALTH INFORMATION</td>
<td></td>
<td>State Regulators can add requirements to HIPAA as needed, but cannot remove requirements.</td>
<td>7/12/23: Expose the draft revisions to Article IV for comments (due 8/2/23)</td>
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<td>Section 18. When Authorization Required for Disclosure of Nonpublic Personal Health Information</td>
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<td>5/9/2022: Review the comments on the draft of Article IV and make appropriate changes; (2) review the draft revisions to Article V and make appropriate revisions; (3) make assignments for revisions to Article VI and any revisions to the white paper as a result of changes to Model #72 (due 9/6/23)</td>
<td>ARTICLE VI. ADDITIONAL PROVISIONS</td>
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<td>8/9/23: Expose the draft revisions to Article V for comments (due 9/6/23)</td>
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<td>Appendix A: Sample Clauses</td>
<td>Delete Sample Clauses? Delete Safe Harbor?</td>
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<td>Appendix B: Federal Model Privacy Form</td>
<td>Changes to Federal Model Privacy Form?</td>
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<td>9/13/2023: (1) Review comments on draft revisions to Article V and make appropriate changes; (2) review the draft revisions to Article VI and make appropriate revisions; (3) review revisions to the white paper on data use and ownership rights and make any necessary changes</td>
<td>Report from the Privacy Protections (H) Working Group to the H Committee</td>
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<td>10/2/2022: (1) Review comments on the draft revisions to Article VI and make appropriate changes; (2) review the revisions to the draft white paper and make appropriate changes.</td>
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<td>10/31/2023</td>
<td>All drafts completed and sent to Lois to prepare for the Fall National Meeting</td>
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ANTIFRAUD (D) TASK FORCE

Antifraud (D) Task Force March 28, 2022, Minutes................................................................................................... 8-47
The Antifraud (D) Task Force met March 28, 2022. The following Task Force members participated: Trinidad Navarro, Chair, and Frank Pyle (DE); John F. King, Vice Chair, represented by Matthew Padova (GA); Lori K. Wing-Heier represented by Alex Romero and Jeanne Murray (AK); Alan McClain represented by Crystal Phelps, Pat O’Kelly, and Paul Keller (AR); Evan G. Daniels represented by Maria Ailor and Paul Hill (AZ); Ricardo Lara represented by Eric Charlick and George Mueller (CA); Andrew N. Mais represented by Amy Stegall and Kurt Swan (CT); Karima M. Woods represented by Brian Bressman (DC); Doug Ommen represented by Benjamin Olejnik, Cynthia Banks Radke, and Sonya Sellmeyer (IA); Dean L. Cameron represented by Eduardo Castaneda, Hermoliva Abejar, Kathy McFill, Kyle Cammack, and Kristen Finau (ID); Vicki Schmidt represented by Chris Hollenbeck and Tate Flott (KS); Sharon P. Clark represented by Juan Garrett (KY); Kathleen A. Birrane represented by Alexander Borkowski (MD); Anita G. Fox represented Chad Arnold, Jill Huisken, Michele Riddering, and Randall Gregg (MI); Grace Arnold represented by Chris Ness, Martin Fleischhacker, Matthew Vatter, Rick Cruz, and T.J. Patton (MN); Chlora Lindley-Myers represented by Carrie Couch, Jeana Thomas, Jo LeDuc, and Sheri Sloan (MO); Mike Chaney represented by John Hornback (MS); Troy Downing and Troy Smith (MT); Mike Causey represented by Angela Hatchell, Della Shepherd, Ted Hamby, and Tracy Biehn (NC); Jon Godfread represented by Dale Pittman and Helene Herauf (ND); Eric Dunning, Kimberly Church, and Martin Swanson (NE); Chris Nicolopoulos represented by Heather Silverstein (NH); Marlene Caride represented by Richard Besser (NJ); Judith L. French represented by Michelle Brugh Rafael (OH); Glen Mulready represented by Landon Hubbell, Shelly Scott, and Rick Wagnon (OK); Andrew R. Stolfi represented by Dorothy Bean and Stephanie Noren (OR); Michael Humphreys represented by David Buono (PA); Raymond G. Farmer represented by Juan Rodriguez and Melissa Manning (SC); Larry D. Deiter and Jill Kruger (SD); Cassie Brown represented by Chris Davis, Brad Carpenter, and Leah Gillum (TX); Jon Pike and Armand Glick (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); Scott A. White represented by Mike Beavers (VA); and Allan L. McVey represented by Greg Elam (WV). Also participating were: Matthew Stewart (LA); and John Haworth (WA).

1. **Adopted its 2021 Fall National Meeting Minutes**

   Mr. Wagnon made a motion, seconded by Ms. Rafeld, to adopt the Task Force’s Nov. 12, 2021, minutes (see NAIC Proceedings – Fall 2021, Antifraud (D) Task Force). The motion passed unanimously.

2. **Discussed Racial Bias and Discrimination**

   Commissioner Navarro said the Task Force received a letter from the Consumer Federation of America (CFA) and the Center for Economic Justice (CEJ) addressing an article from The New York Times concerning allegations of potential racial bias and discrimination practices taking place.

   The Task Force discussed the article and received comments from Birny Baughman (CEJ). Commissioner Navarro said Delaware the Department of Insurance (DOI) will be investigating this issue and will present any findings to the Task Force.

3. **Adopted a Recommendation to Disband the Antifraud Education Enhancement (D) Working Group**

   Commissioner Navarro said that due to the continued creation of new committees, task forces, and working groups, NAIC leadership has asked all chairs to review their current working groups to determine if they should continue in their current capacity. Commissioner Navarro said after reviewing the Task Force’s current working
groups, the discussion with the working group chairs led to the decision that the Antifraud Education Enhancement (D) Working Group would be temporarily disbanded. The current charge under the Working Group would be moved directly under the Task Force, and Ms. Rafeld would remain as the designated subject matter expert (SME) for training and education.

Mr. Mueller made a motion, seconded by Mr. Beaver, to adopt the recommendation that the Antifraud Education Enhancement (D) Working Group would be disbanded, and the current charge would be moved under the Task Force’s (see NAIC Proceedings – Spring 2022, Market Regulation and Consumer Affairs (D) Committee, Attachment One). The motion passed unanimously.

4. Received an Update from the Antifraud Education Enhancement (D) Working Group

Ms. Rafeld said the Working Group is working to schedule the investigator safety webinar for state insurance regulators and the private sector. She said the webinar is consistently being updated, and she encouraged everyone to attend due to the new information being added. Ms. Rafeld said she is also working with NAIC staff to schedule a webinar concerning an open-source webinar series presented by Michele Stuart (JAG Investigations). She said that she will continue to work with NAIC staff for new training topics, and she encouraged state insurance regulators or industry representatives to send in topics to the NAIC.

5. Received and Update from the Antifraud Technology (D) Working Group

Mr. Glick said the Working Group has been finalizing the creation of an Antifraud Plan Repository. He said the Working Group created an SME group to develop an antifraud template and workflow. Mr. Glick said the SME group has completed its work on the template and is working to finalize the workflow document. He said the final draft will be presented to the Working Group for its consideration and then will refer it to the Task Force for review. He said the Working Group will continue to coordinate with NAIC staff as they finalize the redesign of the Online Fraud Reporting System (OFRS). Mr. Glick said the Working Group is currently going through beta testing on the industry side of the OFRS, and once the testing is completed, the updates will be applied to the consumer side as well. He said he will report to the Task Force as more develops.

6. Received an Update from the Improper Marketing of Health Insurance (D) Working Group

Mr. Swanson said the Working Group will be holding its second opening meeting during the Spring National Meeting on April 4. He said the Working Group has continued to meet monthly in regulator-to-regulator session, which has contributed to actions taking place against fraudulent entities across the nation. He said the Working Group has created a regulator-only collaboration document with a list of entities that are potentially committing improper marketing of health insurance. Mr. Swanson said the open and closed discussions, in addition to the collaboration document, will be an asset to the Working Group as it continues its fight against improper marketing of insurance.

7. Heard a Report from the Coalition

Matthew Smith (Coalition Against Insurance Fraud) said the Coalition currently has 47 of the 51 domestic insurance departments as members. He said that in addition to research studies, the Coalition has more than 50 videos and infographics about health care sharing ministries (HCSMs), as well as a fraud tracker to track arrests and convictions across the states. Mr. Smith said the Coalition encourages the use of its information available to assist with states fighting insurance fraud. He said the Coalition is looking to partner with fraud directors to bring back the Annual Fraud Directors Conference, which was paused due to the COVID-19 pandemic. He said there will be more details to follow.
Mr. Smith said the Coalition will be providing a presentation during the NAIC/American Indian and Alaskan Native Liaison Committee during the Spring National Meeting. He said the goal is to present how insurance fraud affects those communities and other communities and how the Coalition can assist with their fight against insurance fraud.

Mr. Smith said a new study was completed concerning the state of insurance technology, which is available on the Coalition website. He said in addition, there will be an upcoming study concerning insurance companies.

Mr. Smith said on the advocacy front, the Coalition’s “friend of the court” program has been successful assisting states with laws being introduced and encourages states to reach out to the Coalition for any assistance.

Mr. Smith said the Coalition’s mid-year meeting will take place June 6–7 in Orlando, FL, and he encouraged state insurance regulators to attend if possible.

8. **Heard an Update from the NHCAA**

Leia McKenna (National Health Care Anti-Fraud Association—NHCAA) said over the past two years, the NHCAA has held its annual conference virtually due to the COVID-19 pandemic. However, this year the NHCAA’s will be in person in November in Orlando, FL. Ms. Mckenna said she encourages state insurance regulators to reach out to the NHCAA if there is anything they can assist states within fighting insurance fraud.

9. **Discussed Other Matters**

Commissioner Navarro said there are a few dates that he would like the Task Force members, interested state insurance regulators, and interested parties to be aware of taking place in 2022.

Commissioner Navarro said that on April 4, the Task Force will meet in regulator-to-regulator session, and the Improper Marketing of Health Insurance (D) Working Group will hold its second open meeting. He said details can be found on the NAIC national meeting web page.

Commissioner Navarro said this will be the third year for the Antifraud (D) Task Force to fully participate in the NAIC Insurance Summit. The antifraud track has continued to grow, and this year is shaping up to have a full two days of sessions. He encouraged everyone to attend if possible.

Commissioner Navarro said the Task Force has committed to bringing more training and insurance fraud training awareness not only to the insurance departments, but also to industry and consumers. He said information will be distributed as this training develops.

Having no further business, the Antifraud (D) Task Force adjourned.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

Market Information Systems (D) Task Force March 25, 2022, Minutes................................................................. 8-51
Market Information Systems (D) Task Force Dec. 3, 2021, Minutes (Attachment One) ........................................... 8-54
2022 Revised Charges (Attachment One-A) ..................................................................................................................... 8-55
Market Information Systems (MIS) Data Analysis Report (Attachment Two) .......................................................... 8-56
The Market Information Systems (D) Task Force met March 25, 2022. The following Task Force members participated: Dana Popish Severinghaus, Vice Chair (IL); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Pam O’Connell (CA); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); Vicki Schmidt represented by Tate Flott (KS); Sharon P. Clark represented by Ron Kreiter (KY); Chlora Lindley-Myers represented by Brent Kabler (MO); Marlene Caride represented by Ralph Boeckman (NJ); Barbara D. Richardson represented by Hermoliva Abejar (NV); Judith L. French represented by Rodney Beech (OH); Cassie Brown represented by Rachel Cloyd (TX); Nathan Houdek represented by Rebecca Rebholz (WI); and Allan L. McVey represented by Jeannie Tincher (WV). Also participating was: Erica Weyhenmeyer (IL).

1. **Adopted its Dec. 3, 2021, and 2021 Fall National Meeting Minutes**

Director Severinghaus said the Task Force adopted a revision to its 2022 charges on Dec. 3, 2021, via e-vote. She said the Task Force added back the charge to make recommendations regarding incorporating artificial intelligence (AI) abilities in the NAIC Market Information Systems (MIS), with a completion date of the 2022 Summer National Meeting.

Ms. Cloyd said the minutes did not reflect that Texas abstained from the vote. She requested that Texas’ abstention be noted in the minutes.

Mr. Flott made a motion, seconded by Mr. Swan, to adopt the Task Force’s Dec. 3, 2021, minutes with the addition that Texas abstained from the e-vote (Attachment One). The motion passed unanimously.

Mr. Kreiter made a motion, seconded by Ms. O’Connell, to adopt the Task Force’s Nov. 23, 2021, minutes (see NAIC Proceedings – Fall 2021, Market Information Systems (D) Task Force). The motion passed unanimously.

2. **Considered the AI Recommendations**

Director Severinghaus said the Task Force had a lengthy discussion during the 2021 Fall National Meeting and was not able to vote on the Market Information Systems Research and Development (D) Working Group’s report. She said she would give everyone as much time as needed to discuss the report and the feasibility of incorporating artificial intelligence (AI) analysis abilities in the MIS; whether the NAIC should proceed in that direction at this time; and, if so, what the first steps would be to put it in motion. She said the Task Force has until the Summer National Meeting to complete its charge, and it can meet again prior to the Summer National Meeting if necessary.

Director Severinghaus said that during the 2021 Fall National Meeting, Texas expressed concerns on whether the charge properly belongs with the Task Force rather than with the Big Data and Artificial Intelligence (H) Working Group. She said Texas also said they were concerned about the cost and availability of NAIC resources to implement the recommendations in the report. Director Severinghaus said industry representatives generally agreed with the idea of analyzing the quality of the current MIS data and the potential of applying AI analysis techniques to the data but expressed concerns regarding the collection of transactional level data. She said that consumer representatives supported the report’s recommendations of assessing the quality of the current MIS data and increasing the amount of data collected to make the use of AI on the market information systems as effective as possible.
Andrew Pauley (National Association of Mutual Insurance Companies—NAMIC) said the report was comprehensive and laudable. He said, however, that adopting it in full was premature due to other workstreams the NAIC is working on. He also said it was not clear that AI models are superior to the current analysis being done. He noted the paper said AI analysis methods could lead to many false positives. He said that would consume the time and resources of state insurance regulators and companies. He cautioned about confidentiality and cybersecurity if transactional data is collected.

Mr. Kabler said the paper outlined a process that begins with reviewing and correcting the current data in the MIS, and then refining analysis methods. After those steps, it could then be decided if incorporating AI is necessary. He said it is possible to minimize false positives as long as are aware of the potential.

Ms. Cloyd suggested that only the first two recommendations be adopted rather than all five and then ask the NAIC for feedback on whether AI methods could take the place of current methodologies. She noted that the third recommendation is to incorporate AI in the MIS after the first two recommendations are completed. She said more feedback is needed before taking that step. Mr. Kabler suggested revising the third recommendation to consider incorporating AI methods rather than incorporating various promising AI modes of analysis. Ms. Cloyd said it was better to just adopt the first two requirements because it is clear the data currently collected is insufficient for AI and there is no proof of concept. Mr. Kabler said that there are different levels of AI techniques and that it would not be too much to incorporate less sophisticated AI technologies that would do the same thing as traditional statistical and quantitative techniques. Ms. Cloyd said Texas is not opposed to improving analysis techniques but is concerned about the time and resources necessary to pursue all five requirements in the report.

Director Severinghaus said that the efficient use of time and resources is at the top of mind for everyone. She said unless we have hard data to show what the cost would be to pursue all five requirements, everyone is just guessing at the cost in time and resources. She asked if the NAIC has looked at AI before.

Randy Helder (NAIC) said the NAIC did investigate AI techniques for financial regulation, but this is the first time it has been considered for market regulation. He said the financial regulators involved did provide input to the Market Information Systems Research and Development (D) Working Group as it prepared this report.

Mr. Kabler said it was not clear whether the financial investigation of AI techniques showed any improvement over the traditional methods. He said he did not know the cost of the financial regulator investigation, but it did involve hiring a consultant.

Ms. Weyhenmeyer suggested referring the report back to the Working Group to consider the costs. She also noted that since the chair and vice chair are new to the Task Force this year, it may be helpful to allow Commissioner Michael Conway (CO) an opportunity to also provide some input.

Director Severinghaus agreed and said the Task Force would not take a vote on the report during this meeting.


Mr. Kabler said the Working Group met on March 16 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings, and took the following action: 1) reviewed the current NAIC projects and Uniform System Enhancement Request (USER) forms submitted to the Working Group; 2) adopted a USER request to create a personalized information capture system (PICS) event to notify subscribers on a recurring basis of outstanding waiver and extension requests; 3) adopted a request to add a new Complaints Database System (CDS) coverage type code for telehealth; and 4) considered a request from the Market Analysis Procedures (D) Working Group to add the lender-placed insurance and disability insurance Market Conduct Annual Statement (MCAS) data
into the Market Analysis Review System (MARS). Finally, Mr. Kabler noted the Working Group completed its work on the 2020 MIS data analysis and recommendations.

Mr. Kreiter made a motion, seconded by Ms. Ailor, to adopt the report of the Market Information Systems Research and Development (D) Working Group. The motion passed unanimously.

4. Received an Update on MIS Projects and USER Forms

Chris Witt (NAIC) said the NAIC Information Technology (IT) team has completed the migration to the cloud. He said that the MCAS system has now opened and is receiving filings and that all the MCAS i-Site+ reports used by state insurance regulators will be available by the filing deadline. Mr. Witt said the Market Actions Tracking System (MATS) web service should be completed by the end of the first quarter. Mr. Witt said the next major project to be started is the separation of the MCAS system from the Financial Data Repository (FDR) system.

5. Adopted the MIS Data Analysis Metrics and Recommendations

Director Severinghaus said that during the 2021 Fall National Meeting, the Task Force was not ready to adopt the analysis and recommendations for improving the data in the MIS databases and that the Working Group only provided a preliminary report. She said the MIS data analysis metrics results are now ready to be reviewed along with the Working Group’s recommendations. She said that while the meeting materials only provide an aggregated look at the MIS data, each of NAIC member jurisdictions’ market analysis chiefs (MACs) will be sent the specific results for their jurisdictions.

Mr. Kabler said the MIS data analysis report evaluates the quality of the data in the MIS databases to identify issues with the data and alert states of those issues and ways to improve the quality. He said there are no recommendations based on the 2020 analysis. He noted that the report evaluates the timeliness, accuracy and completeness of the MIS data submitted by each jurisdiction through tests that are summarized in the report. He noted as an example that the accuracy of complaint data can be measured by comparing the disposition code with whether the complaint was coded as confirmed or unconfirmed.

Mr. Kabler said the detailed reports were sent to each jurisdiction’s MAC.

Ms. Rebholz made a motion, seconded by Ms. Abejar, to adopt the MIS data analysis report (Attachment Two). The motion passed unanimously.

Having no further business, the Market Information Systems (D) Task Force adjourned.
The Market Information Systems (D) Task Force conducted an e-vote that concluded Dec. 3, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice-Chair (MO); Lori K. Wing-Heier (AK); Peni Itula Sapini Teo (AS); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Trinidad Navarro (DE); Doug Ommen (IA); Dana Popish-Severinghaus (IL); Vicki Schmidt (KS); James J. Donelon (LA); Grace Arnold (MN); Troy Downing (MT); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Cassie Brown (TX); Michael S. Pieciak (VT); Mark Afable (WI); and Allan L. McVey (WV).

1. **Adopted a Revision to its 2022 Charges**

The Task Force considered adoption of a revision to its 2022 charges. The Task Force’s 2022 charges adopted on Oct. 29 removed the charge to make recommendations for the incorporation of artificial intelligence (AI) abilities in the NAIC market information systems. Because the charge was not completed during its Nov. 23 meeting, the Task Force considered adding the charge back to its 2022 charges with a completion date of the 2022 Summer National Meeting.

Twelve states voted to adopt the revised charges, three states voted against adopting the revised charges, and Texas abstained. A majority of the Task Force members voted in favor of adopting the revision to its 2022 charges.

Having no further business, the Market Information Systems (D) Task Force adjourned.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems (MIS) and the prioritization of regulatory requests for the development and enhancements of the MIS.

Ongoing Support of NAIC Programs, Products or Services

1. The Market Information Systems (D) Task Force will:
   A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
   B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2022 Summer National Meeting.
   C. Analyze the data in the MIS. If needed, recommend methods to ensure better data quality. Complete by the 2022 Fall National Meeting.
   D. Provide guidance on the appropriate use of the MIS and the data entered in them.
      2. Electronic Forums.
      4. Market Analysis Profile.
      5. Market Analysis Prioritization Tool (MAPT).
      9. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).

2. The Market Information Systems Research and Development (D) Working Group will:
   A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
   B. Assist the Task Force with tasks as assigned, such as:
      1. Analyze MIS data.
      2. Provide state users with query access to MIS data.
      3. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder
# Objective

It is essential that the systems on which insurance consumers and state insurance regulators depend use reliable data. These systems include, but are not limited to, the Consumer Insurance Search (CIS), Market Analysis Prioritization Tool (MAPT), Market Analysis Profile (MAP) and Market Analysis Review System (MARS). In addition to these National Association of Insurance Commissioners (NAIC) systems, many state systems and processes use NAIC Market Information System (MIS) data. Therefore, MIS data quality is critical.

The MIS data analysis metrics were developed at the direction of the Market Information Systems (D) Task Force to identify potential data quality issues in the NAIC MIS database. For each system, three aspects of data quality are considered: 1) completeness; 2) timeliness; and 3) accuracy.

# Results

Note: These symbols indicate the following changes between periods: (△) trending in positive direction; (–) no change or unable to determine trend; and () trending in negative direction.

## Complaint Database System (CDS)

### Completeness:

C1. Identify errors that prevented submitted complaints from successfully loading to the NAIC MIS database.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Complaints Submitted</th>
<th>Complaints Not Loaded First Time</th>
<th>Complaints Not Loaded</th>
<th>Complaints Loaded</th>
<th>Errors Created</th>
<th>% Errors to Total Complaints Submitted</th>
<th>% Complaints Not Loaded to Total Complaints Submitted</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020*</td>
<td>339,137</td>
<td>129,851</td>
<td>102,373</td>
<td>236,764</td>
<td>141,385</td>
<td>41.69%</td>
<td>30.19%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>367,880</td>
<td>93,518</td>
<td>22,926</td>
<td>344,954</td>
<td>112,725</td>
<td>30.64%</td>
<td>6.23%</td>
<td>–</td>
</tr>
</tbody>
</table>

* The 2020 results reflect issues one jurisdiction encountered after changing internal procedures. NAIC staff is working with them on a resolution and does not anticipate this will be an on-going issue once resolved.

C2. Identify jurisdictions with no complaints with an entry date for year.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Actions</th>
<th>% Jurisdictions That Did Not Submit Actions</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>3</td>
<td>5.36%</td>
<td>–</td>
</tr>
</tbody>
</table>

### Timeliness:

T1. Identify jurisdictions that did not submit closed complaints to the NAIC MIS database at least monthly.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
<th># Jurisdictions That Did Submit Closed Complaints At Least Monthly</th>
<th>% Jurisdictions That Did Not Submit Closed Complaints At Least Monthly</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>6</td>
<td>50</td>
<td>10.71%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>9</td>
<td>47</td>
<td>16.07%</td>
<td>△</td>
</tr>
<tr>
<td>2018*</td>
<td>6</td>
<td>50</td>
<td>10.71%</td>
<td>△</td>
</tr>
<tr>
<td>2017*</td>
<td>9</td>
<td>47</td>
<td>16.07%</td>
<td>–</td>
</tr>
</tbody>
</table>
With the introduction of a new load process, 2017 (Aug – Dec) and 2018 (May – Dec) results represent partial year data.

T2. Identify jurisdictions that did not submit a current complaint to the NAIC MIS database at least monthly.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit a Current Complaint At Least Monthly</th>
<th># Jurisdictions That Did Submit a Current Complaint At Least Monthly</th>
<th>% Jurisdictions That Did Not Submit a Current Complaint At Least Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>13</td>
<td>43</td>
<td>23.21%</td>
</tr>
<tr>
<td>2019</td>
<td>20</td>
<td>36</td>
<td>35.71%</td>
</tr>
</tbody>
</table>

Accuracy:

A1. Identify complaints submitted with a confirmed indicator and only a disposition of “Complaint Withdrawn,” “No Action Requested/Required,” “Question of Fact/Contract Provision/Legal Issue,” “Company Position Substantiated,” “No Jurisdiction” or “Insufficient Information.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Confirmed Complaints With Only the Specified Disposition Codes</th>
<th>Total Number of All Complaints</th>
<th>%</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,897</td>
<td>185,736</td>
<td>1.02%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>3,122</td>
<td>224,846</td>
<td>1.39%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>4,485</td>
<td>233,562</td>
<td>1.92%</td>
<td></td>
</tr>
</tbody>
</table>

A2. Identify complaints submitted for lines of business on companies that have no premium written for those lines of business on the financial annual statement.

<table>
<thead>
<tr>
<th>Year</th>
<th># Complaints with No State Level Premium</th>
<th># Complaints with No National Level Premium</th>
<th>Total Number of Complaints</th>
<th>% No State Level Premium Complaints to Total Complaints</th>
<th>% No National Level Premium Complaints to Total Complaints</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>16,097</td>
<td>12,953</td>
<td>185,736</td>
<td>8.67%</td>
<td>6.97%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>11,541</td>
<td>7,656</td>
<td>224,822</td>
<td>5.13%</td>
<td>3.41%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>10,484</td>
<td>6,240</td>
<td>233,562</td>
<td>4.49%</td>
<td>2.67%</td>
<td></td>
</tr>
</tbody>
</table>

Market Action Tracking System (MATS)

Completeness:

C1. Compare number of “Closed” exams and entities in exams with the reported completed exams and entities in the NAIC’s corresponding year’s Insurance Department Resources Report (IDRR).

<table>
<thead>
<tr>
<th>Year</th>
<th>Exams Closed in MATS</th>
<th>Exams Closed in IDR</th>
<th>Difference Between IDRR and MATS Exams</th>
<th>% Diff to Exams in IDRR</th>
<th>Entities in Exams Closed in MATS</th>
<th>Entities in Exams Closed in IDR</th>
<th>Difference Between IDRR and MATS Entities</th>
<th>% Diff to Entities in IDRR</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>405</td>
<td>396</td>
<td>-9</td>
<td>2.27%</td>
<td>504</td>
<td>442</td>
<td>62</td>
<td>14.03%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>382</td>
<td>511</td>
<td>-129</td>
<td>25.24%</td>
<td>461</td>
<td>548</td>
<td>-87</td>
<td>15.88%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>477</td>
<td>598</td>
<td>-121</td>
<td>20.23%</td>
<td>616</td>
<td>645</td>
<td>-29</td>
<td>4.50%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>525</td>
<td>544</td>
<td>-19</td>
<td>3.49%</td>
<td>604</td>
<td>920</td>
<td>-316</td>
<td>34.35%</td>
<td></td>
</tr>
</tbody>
</table>

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C2. Compare number of entities included in “Closed” actions with the reported entities included in market actions including Focused Inquiries and Non-Exam Regulatory Interventions in the IDRR.

<table>
<thead>
<tr>
<th>Year</th>
<th>Entities in Market Actions Closed in MATS</th>
<th>Entities in Market Actions Closed in IDRR</th>
<th>Difference</th>
<th>% Diff to Entities in IDRR</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>731</td>
<td>3,162</td>
<td>-2,431</td>
<td>76.88%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>617</td>
<td>3,885</td>
<td>-3,268</td>
<td>84.12%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>784</td>
<td>2,197</td>
<td>-1,413</td>
<td>64.31%</td>
<td>△</td>
</tr>
<tr>
<td>2017</td>
<td>834</td>
<td>2,705</td>
<td>-1,871</td>
<td>69.17%</td>
<td>–</td>
</tr>
</tbody>
</table>

C3. Identify records in the Regulatory Information Retrieval System (RIRS) with an origin code of “Market Conduct Exam” that do not have a corresponding record in MATS.

<table>
<thead>
<tr>
<th>Year</th>
<th>RIRS Actions with 'Market Conduct Exam' Origin</th>
<th>RIRS Actions with 'Market Conduct Exam' Origin with MATS</th>
<th>RIRS Actions with 'Market Conduct Exam' Origin without MATS</th>
<th>% RIRS Actions without MATS to RIRS Actions with 'Market Conduct Exam' Origin</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>170</td>
<td>1</td>
<td>169</td>
<td>99.41%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>243</td>
<td>8</td>
<td>235</td>
<td>96.71%</td>
<td>–</td>
</tr>
</tbody>
</table>

Timeliness:

T2. Identify actions with an estimated start date that has passed more than 30 days ago, and the status is “Called Not Begun.”

<table>
<thead>
<tr>
<th>Year</th>
<th># Actions in 'Called Not Begun' Status with Estimated Start Date Passed the Following # Days</th>
<th>Actions in 'Called Not Begun' Status w/Estimated Start Date &gt; 30 Days</th>
<th>% Actions in 'Called Not Begun' w/ Estimated Start &gt; 30 Days to Total 'Called Not Begun'</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>95, 44, 41, 66, 84, 330</td>
<td>235</td>
<td>71.21%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>84, 168, 186, 167, 733</td>
<td>649</td>
<td>88.54%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>195, 66, 69, 67, 453</td>
<td>258</td>
<td>56.95%</td>
<td>–</td>
</tr>
</tbody>
</table>

T3. Identify actions with a status of “In Settlement” for more than 180 days.

<table>
<thead>
<tr>
<th>Year</th>
<th># Actions in 'In Settlement' Status for the Following # Days</th>
<th>Actions in 'In Settlement' Status &gt; 180 Days</th>
<th>% Actions in 'In Settlement' &gt; 180 Days to Total 'In Settlement'</th>
<th>△</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>60, 17, 1, 8, 86</td>
<td>26</td>
<td>30.23%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>49, 13, 2, 11</td>
<td>26</td>
<td>34.67%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>44, 2, 1, 10</td>
<td>13</td>
<td>22.81%</td>
<td>–</td>
</tr>
</tbody>
</table>
### MATS T4 Trending Results As of 4/1/2021

<table>
<thead>
<tr>
<th>Year</th>
<th>0-18 Months</th>
<th>19-24 Months</th>
<th>25-48 Months</th>
<th>48+ Months</th>
<th>Total Actions in 'In Progress' Status</th>
<th>Actions in 'In Progress' Status &gt; 18 Months</th>
<th>% Actions in 'In Progress' &gt; 18 Months to Total 'In Progress'</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>712</td>
<td>110</td>
<td>183</td>
<td>79</td>
<td>1084</td>
<td>372</td>
<td>34.32%</td>
</tr>
<tr>
<td>2019</td>
<td>747</td>
<td>105</td>
<td>243</td>
<td>60</td>
<td>1155</td>
<td>408</td>
<td>35.32%</td>
</tr>
<tr>
<td>2018</td>
<td>871</td>
<td>92</td>
<td>101</td>
<td>43</td>
<td>1107</td>
<td>236</td>
<td>21.32%</td>
</tr>
</tbody>
</table>

### T5. Identify actions with a status of “Work Concluded” for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in 'Work Concluded' Status</th>
<th>Actions in 'Work Concluded' Status &gt; 120 Days</th>
<th>% Actions in 'Work Concluded' &gt; 120 Days to Total 'Work Concluded'</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>53</td>
<td>26</td>
<td>32</td>
<td>37</td>
<td>148</td>
<td>95</td>
<td>64.19%</td>
</tr>
<tr>
<td>2019</td>
<td>47</td>
<td>35</td>
<td>36</td>
<td>32</td>
<td>150</td>
<td>103</td>
<td>68.67%</td>
</tr>
<tr>
<td>2018</td>
<td>73</td>
<td>13</td>
<td>25</td>
<td>6</td>
<td>117</td>
<td>44</td>
<td>37.61%</td>
</tr>
</tbody>
</table>

### T6. Identify actions with a status of “Anticipated” for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in 'Anticipated' Status</th>
<th>Actions in 'Anticipated' Status &gt; 120 Days</th>
<th>% Actions in 'Anticipated' &gt; 120 Days to Total 'Anticipated'</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>7</td>
<td>18</td>
<td>2</td>
<td>21</td>
<td>48</td>
<td>41</td>
<td>85.42%</td>
</tr>
<tr>
<td>2019</td>
<td>32</td>
<td>15</td>
<td>23</td>
<td>33</td>
<td>103</td>
<td>71</td>
<td>68.93%</td>
</tr>
<tr>
<td>2018</td>
<td>16</td>
<td>15</td>
<td>23</td>
<td>28</td>
<td>82</td>
<td>66</td>
<td>80.49%</td>
</tr>
</tbody>
</table>

### T7. Identify actions with a status of “Suspended” for more than 120 days.

<table>
<thead>
<tr>
<th>Year</th>
<th>0-120 Days</th>
<th>121-365 Days</th>
<th>366-730 Days</th>
<th>730+ Days</th>
<th>Total Actions in 'Suspended' Status</th>
<th>Actions in 'Suspended' Status &gt; 120 Days</th>
<th>% Actions in 'Suspended' &gt; 120 Days to Total 'Suspended'</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>162</td>
<td>173</td>
<td>165</td>
<td>95.38%</td>
</tr>
<tr>
<td>2019</td>
<td>6</td>
<td>14</td>
<td>3</td>
<td>160</td>
<td>183</td>
<td>177</td>
<td>96.72%</td>
</tr>
<tr>
<td>2018</td>
<td>6</td>
<td>6</td>
<td>40</td>
<td>129</td>
<td>181</td>
<td>175</td>
<td>96.89%</td>
</tr>
</tbody>
</table>

**Accuracy:**

Note: No metrics have been defined to measure MATS data accuracy.
Market Analysis Review System (MARS)

Completeness:
C1. Identify jurisdictions that did complete the minimum threshold that year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum Threshold</th>
<th># Jurisdictions That Did Not Complete Minimum Threshold</th>
<th>% Jurisdictions That Did Not Complete Minimum Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>25 Reviews</td>
<td>34</td>
<td>60.71%</td>
</tr>
<tr>
<td>2019</td>
<td>20 Reviews</td>
<td>30</td>
<td>53.57%</td>
</tr>
<tr>
<td>2018</td>
<td>15 Reviews</td>
<td>26</td>
<td>46.43%</td>
</tr>
<tr>
<td>2017</td>
<td>10 Reviews</td>
<td>19</td>
<td>33.93%</td>
</tr>
</tbody>
</table>

Timeliness:
T2. Identify reviews that did not use the most current financial annual statement data year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Current Data Year</th>
<th>Not Current Data Year</th>
<th>Total Reviews</th>
<th>% Current Data Year to Total Reviews</th>
<th>% Not Current Data Year to Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,169</td>
<td>291</td>
<td>1,460</td>
<td>80.07%</td>
<td>19.93%</td>
</tr>
<tr>
<td>2019</td>
<td>1,551</td>
<td>296</td>
<td>1,847</td>
<td>83.97%</td>
<td>16.03%</td>
</tr>
<tr>
<td>2018</td>
<td>1,511</td>
<td>57</td>
<td>1,568</td>
<td>96.36%</td>
<td>3.64%</td>
</tr>
<tr>
<td>2017</td>
<td>1,533</td>
<td>99</td>
<td>1,632</td>
<td>93.93%</td>
<td>6.07%</td>
</tr>
</tbody>
</table>

T3. Identify reviews that did not use the most current Market Conduct Annual Statement data year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Current Data Year</th>
<th>Not Current Data Year</th>
<th>Total Reviews</th>
<th>% Current Data Year to Total Reviews</th>
<th>% Not Current Data Year to Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,196</td>
<td>15</td>
<td>1,211</td>
<td>98.76%</td>
<td>1.24%</td>
</tr>
</tbody>
</table>

Accuracy:
Note: No metrics have been defined to measure MARS data accuracy.

Market Conduct Annual Statement (MCAS)

Completeness:
C1. Identify non-participating jurisdictions.

<table>
<thead>
<tr>
<th>Year</th>
<th># of Non-participating Jurisdictions</th>
<th>% Non-participating Jurisdictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2019</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2018</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2017</td>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
<td>12.50%</td>
</tr>
</tbody>
</table>
C2. Identify missing company filings for current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Total Required to File</th>
<th>Missing Filings</th>
<th>% of Missing Filings to Total Required to File △</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>34,459</td>
<td>249</td>
<td>0.72% △</td>
</tr>
<tr>
<td>2019</td>
<td>34,594</td>
<td>262</td>
<td>0.76% △</td>
</tr>
<tr>
<td>2018</td>
<td>31,331</td>
<td>121</td>
<td>0.39% △</td>
</tr>
<tr>
<td>2017</td>
<td>31,599</td>
<td>130</td>
<td>0.41% △</td>
</tr>
<tr>
<td>2016</td>
<td>29,645</td>
<td>81</td>
<td>0.27% –</td>
</tr>
</tbody>
</table>

C3. Identify companies that were required to file, requested a waiver, and the jurisdiction did not respond.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Waivers Approved</th>
<th>Waivers Denied</th>
<th>Waivers Pending</th>
<th>Total Waivers Requested</th>
<th>% Approved to Total Requested</th>
<th>% Denied to Total Requested</th>
<th>% Pending to Total Requested △</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,613</td>
<td>14</td>
<td>150</td>
<td>1,777</td>
<td>90.77%</td>
<td>7.9%</td>
<td>8.44% △</td>
</tr>
<tr>
<td>2019</td>
<td>617</td>
<td>16</td>
<td>38</td>
<td>671</td>
<td>91.95%</td>
<td>2.38%</td>
<td>5.66% △</td>
</tr>
<tr>
<td>2018</td>
<td>550</td>
<td>20</td>
<td>39</td>
<td>609</td>
<td>90.31%</td>
<td>3.28%</td>
<td>6.40% △</td>
</tr>
<tr>
<td>2017</td>
<td>600</td>
<td>88</td>
<td>58</td>
<td>746</td>
<td>80.43%</td>
<td>11.80%</td>
<td>7.77% –</td>
</tr>
</tbody>
</table>

Timeliness:

T1. Identify filings submitted 45 days after deadline for the current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Total Required to File</th>
<th>Filed 45+ Days Late</th>
<th>% of 45+ Days Late Filings to Total Required △</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>36,219</td>
<td>32</td>
<td>0.09% △</td>
</tr>
<tr>
<td>2019</td>
<td>35,190</td>
<td>36</td>
<td>0.10% △</td>
</tr>
<tr>
<td>2018</td>
<td>31,948</td>
<td>46</td>
<td>0.14% △</td>
</tr>
<tr>
<td>2017</td>
<td>31,599</td>
<td>261</td>
<td>0.85% △</td>
</tr>
<tr>
<td>2016</td>
<td>29,645</td>
<td>7</td>
<td>0.02% –</td>
</tr>
</tbody>
</table>

T2. Identify companies that were required to file, requested an extension, and the jurisdiction did not respond.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Extensions Approved</th>
<th>Extensions Denied</th>
<th>Extensions Pending</th>
<th>Total Extensions</th>
<th>% Approved to Total Requested</th>
<th>% Denied to Total Requested</th>
<th>% Pending to Total Requested △</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,465</td>
<td>54</td>
<td>92</td>
<td>1,611</td>
<td>90.94%</td>
<td>3.35%</td>
<td>5.71% △</td>
</tr>
<tr>
<td>2019</td>
<td>1,272</td>
<td>173</td>
<td>98</td>
<td>1,543</td>
<td>82.44%</td>
<td>11.21%</td>
<td>6.35% △</td>
</tr>
<tr>
<td>2018</td>
<td>1,468</td>
<td>63</td>
<td>150</td>
<td>1,681</td>
<td>87.33%</td>
<td>3.75%</td>
<td>8.92% △</td>
</tr>
<tr>
<td>2017</td>
<td>1,740</td>
<td>44</td>
<td>189</td>
<td>1,973</td>
<td>88.19%</td>
<td>2.23%</td>
<td>9.58% –</td>
</tr>
</tbody>
</table>

Accuracy:

A1. Review validation exceptions for the current MCAS data year.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Validation Exceptions on Original Filings</th>
<th>Current Unresolved Exceptions</th>
<th>Total Validations Run</th>
<th>Original Filing Exceptions/ Total Validations Run △</th>
<th>Current Unresolved Exceptions/ Total Validations Run</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>38,177</td>
<td>377</td>
<td>3,854,319</td>
<td>1.10%</td>
<td>0.01%</td>
</tr>
</tbody>
</table>
MCAS A1
Trending Results
As of 11/10/2021

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Validation Exceptions on Original Filings</th>
<th>Current Unresolved Exceptions</th>
<th>Total Validations Run</th>
<th>Original Filing Exceptions/Total Validations Run</th>
<th>Current Unresolved Exceptions/Total Validations Run</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>39,793</td>
<td>64</td>
<td>4,061,530</td>
<td>.98%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2018</td>
<td>22,216</td>
<td>53</td>
<td>2,911,446</td>
<td>.76%</td>
<td>0.00%</td>
</tr>
<tr>
<td>2017</td>
<td>19,958</td>
<td>2,386</td>
<td>2,677,924</td>
<td>.75%</td>
<td>0.09%</td>
</tr>
<tr>
<td>2016</td>
<td>17,626</td>
<td>252</td>
<td>1,719,728</td>
<td>1.02%</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

A2. Identify refilings.

<table>
<thead>
<tr>
<th>Data Year</th>
<th>Amended Filings or Refilings</th>
<th>Total Filings</th>
<th>% Amended Filings or Refilings to Total Filings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>4,560</td>
<td>40,459</td>
<td>11.27%</td>
<td>△</td>
</tr>
<tr>
<td>2019</td>
<td>5,392</td>
<td>41,518</td>
<td>12.99%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>5,488</td>
<td>38,607</td>
<td>14.22%</td>
<td>△</td>
</tr>
<tr>
<td>2017</td>
<td>4,325</td>
<td>36,749</td>
<td>11.77%</td>
<td>△</td>
</tr>
<tr>
<td>2016</td>
<td>5,608</td>
<td>36,676</td>
<td>15.29%</td>
<td>–</td>
</tr>
</tbody>
</table>

Regulatory Information Retrieval System (RIRS)

Completeness:
C1. Identify jurisdictions that have not submitted actions in the past year.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions That Did Not Submit Actions</th>
<th>% Jurisdictions That Did Not Submit Actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>5</td>
<td>8.93%</td>
<td>–</td>
</tr>
<tr>
<td>2019</td>
<td>5</td>
<td>8.93%</td>
<td>△</td>
</tr>
<tr>
<td>2018</td>
<td>7</td>
<td>12.50%</td>
<td>–</td>
</tr>
<tr>
<td>2017</td>
<td>7</td>
<td>12.50%</td>
<td>–</td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
<td>12.50%</td>
<td>–</td>
</tr>
</tbody>
</table>

C2. Identify errors that prevented submitted regulatory actions from successfully loading to the NAIC MIS database.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Actions Submitted</th>
<th>Actions Not Loaded First Time</th>
<th>Actions Not Loaded</th>
<th>Actions Loaded</th>
<th>Errors Created</th>
<th>% Errors Created to Total Actions Submitted</th>
<th>% Actions Not Loaded to Total Actions Submitted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>11,870</td>
<td>425</td>
<td>172</td>
<td>11,698</td>
<td>753</td>
<td>6.34%</td>
<td>3.58%</td>
<td>△</td>
</tr>
<tr>
<td>2019*</td>
<td>14,726</td>
<td>3,220</td>
<td>2,614</td>
<td>12,112</td>
<td>4,757</td>
<td>32.30%</td>
<td>17.75%</td>
<td>–</td>
</tr>
</tbody>
</table>

* For 2019, "Number of Complaints Not Loaded" were included in the results. Therefore, trending information to prior years is unavailable.

Timeliness:
T1. Identify regulatory actions with a date of entry 90 days after the effective date.
### RIRS T1
Trending Results
As of 4/7/2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Actions Entered Within 90 Days of Effective Date</th>
<th>Actions Entered 91 Days or Later than Effective Date</th>
<th>Total Actions Effective and Entered</th>
<th>% Actions Entered Within 90 Days of Effective Date to Total Actions</th>
<th>% of Actions Entered 91 Days or Later than Effective Date to Total Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>5,118</td>
<td>600</td>
<td>5,718</td>
<td>89.51%</td>
<td>10.49%</td>
</tr>
<tr>
<td>2019</td>
<td>7,049</td>
<td>547</td>
<td>7,596</td>
<td>92.80%</td>
<td>7.20%</td>
</tr>
<tr>
<td>2018</td>
<td>7,380</td>
<td>406</td>
<td>7,786</td>
<td>94.79%</td>
<td>5.21%</td>
</tr>
<tr>
<td>2017*</td>
<td>7,222</td>
<td>893</td>
<td>8,115</td>
<td>89.00%</td>
<td>11.00%</td>
</tr>
<tr>
<td>2016*</td>
<td>7,592</td>
<td>2,616</td>
<td>10,208</td>
<td>74.37%</td>
<td>25.63%</td>
</tr>
</tbody>
</table>

* Prior to 2018, this metric evaluated regulatory actions with a date of entry 90 days greater than the date of action.

### Accuracy:
A1. Identify regulatory actions with an ‘Other’ code and a write-in description that is identical to one of the other existing codes.

<table>
<thead>
<tr>
<th>Year</th>
<th>Actions With ‘Other’ Code and Write-In Description Identical to Existing Code</th>
<th>Total Actions with ‘Other’ Code</th>
<th>% Actions With ‘Other’ Code and Write-In Description Identical to Existing Code to Total Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>9</td>
<td>1,952</td>
<td>.46%</td>
</tr>
</tbody>
</table>

A2. Identify jurisdictions that used ‘Other’ codes in more than 20% of their regulatory actions loaded to the NAIC database.

<table>
<thead>
<tr>
<th>Year</th>
<th># Jurisdictions with &gt; 20% Actions w/’Other’ Codes</th>
<th>% Jurisdictions with &gt; 20% Actions w/’Other’ Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>25</td>
<td>44.64%</td>
</tr>
</tbody>
</table>
PRODUCER LICENSING (D) TASK FORCE

The Producer Licensing (D) Task Force did not meet at the Spring National Meeting.
FINANCIAL CONDITION (E) COMMITTEE

Financial Condition (E) Committee April 5, 2022, Minutes ................................................................. 9-2
  Financial Condition (E) Committee and Risk-Based Capital (RBC) Investment Risk and Evaluation (E)
    Working Group Jan. 12, 2022, Minutes (Attachment One) ................................................................. 9-9
  Group Capital Calculation (E) Working Group Feb. 9, 2022, Minutes (Attachment Two) ................. 9-12
    Memorandum Regarding Staff Proposed Changes as a Result of Trial Implementation
      (Attachment Two-A) ......................................................................................................................... 9-16
  Comments Regarding Changes to the 2022 Group Capital Calculation (GCC) (Attachment Two-B) .... 9-21
  Restructuring Mechanisms (E) Working Group March 28, 2022, Minutes (Attachment Three) ........ 9-25
    Request for NAIC Model Law Development for the Property and Casualty Insurance Guaranty
      Association Model Act (#540) (Attachment Three-A) ...................................................................... 9-30
    Referral Regarding Potential Change to NAIC Model (Attachment Three-B) ................................. 9-33
    Discussion Topic and Additional Calls for Feedback (Attachment Three-C) ..................................... 9-37
  National Treatment and Coordination (E) Working Group March 9, 2022, Minutes (Attachment Four) .. 9-42
  Responses to the Chief Financial Regulator Forum’s Referral (Attachment Four-A) .......................... 9-44
  Model Law Extension Request from the Mortgage Guaranty Insurance (E) Working Group
    (Attachment Five) ............................................................................................................................ 9-46
The Financial Condition (E) Committee met in Kansas City, MO, April 5, 2022. The following Committee members participated: Scott A. White, Chair (VA); Elizabeth Kelleher Dwyer, Vice Chair, represented by Jack Broccoli (RI); Michael Conway (CO); David Altmaier (FL); Doug Ommen represented by Carrie Mears (IA); Maine represented by Vanessa Sullivan and Robert Wake (ME); Grace Arnold represented by Kathleen Orth and Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Adrienne A. Harris represented by My Chi To and Bob Kasinow (NY); Raymond G. Farmer (SC); Cassie Brown, Jamie Walker, and Mike Boerner (TX); Nathan Houdek and Amy Malm (WI); and Jeff Rude (WY). Also participating were: Phillip Barlow (DC); and Dale Bruggeman (OH).

1. **Adopted its Jan. 12, 2022, and 2021 Fall National Meeting Minutes**

The Committee met Jan. 12 to expose a request for comment suggesting a revised approach to risk-based capital (RBC) requirements for structured securities and other asset-backed securities (ABS) with comments due to the Risk-Based Capital Investment Risk and Evaluation (E) Working Group.

Commissioner Caride made a motion, seconded by Ms. Malm, to adopt the Committee’s Jan. 12, 2022 (Attachment One) and Dec. 13, 2021 (see NAIC Proceedings – Fall 2021, Financial Condition (E) Committee) minutes. The motion passed unanimously.

2. **Adopted the Reports of its Task Forces and Working Groups**

Commissioner White stated that the Committee usually takes one motion to adopt the Committee’s task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards; i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial. He reminded Committee members that subsequent to the Committee’s adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC members for review shortly after the conclusion of the Spring National Meeting as part of the Financial Condition (E) Committee Technical Changes report. Pursuant to the Technical Changes report process previously adopted by the NAIC Plenary, the members will have 10 days to comment. Otherwise, the technical changes will be considered adopted by the NAIC and effective immediately. With respect to the task force and working group reports, Commissioner White asked the Committee: 1) whether there were any items that should be discussed further before being considered for adoption and sent to the members for consideration as part of the Financial Condition (E) Committee Technical Changes report; and 2) whether there were other issues not up for adoption that are currently being considered by task forces or workings groups reporting to this Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for adoption, Commissioner White also noted that the Financial Analysis (E) Working Group met April 4, Feb. 23, and Jan. 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met March 23, Feb. 8, and Jan. 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.
Commissioner Caride made a motion, seconded by Director Lindley-Myers, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Reinsurance (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Two); Restructuring Mechanisms (E) Working Group (Attachment Three); and National Treatment and Coordination (E) Working Group (Attachment Four). The motion passed.

3. **Adopted a Model Law Extension Request from the Mortgage Guaranty Insurance (E) Working Group**

Commissioner White described how the Committee and the Executive (EX) Committee approved a project in years prior to update the *Mortgage Guaranty Insurance Model Act* (#630). He described how the Working Group still had develop a new capital model, as well as finalized the changes to #630. He noted the Working Group was requesting an extension on the development of changes to (#630) as outlined in the request, but that based upon where things stood today and things being in the home stretch, he was not sure why the Committee would not approve the request.

Director Farmer made a motion, seconded by Commissioner Conway, to adopt the extension request (Attachment Five). The motion passed.

4. **Received an Update on Committee-Supported Initiatives**

Commissioner White stated the next item was to receive an update on what is described as Committee-supported initiatives. He said what he means by that are updates from several chairs on work that he would describe as a priority. He stated the organizing principle underlying the priorities of the Committee this year is tied to the low interest rates and the impact that has had on asset risk in the industry. He noted that the industry has been in this low interest rate environment more or less since the Great Recession of 2007. That environment has put pressure on the life insurance industry in particular, given its dependence on long-term investments. That has led some insurers to adopt a riskier asset strategy. Commissioner White provided an example where state insurance regulators have seen a shift away from more conservative senior debt holdings towards higher yielding investments such as structured securities and other ABS. He noted state insurance regulators have also seen the growing trend of many insurers selling their annuity business to private equity investors. All of this has led to increased complexity and heightened scrutiny on the part of the Committee to determine whether additional safeguards to the solvency framework are needed. He said as state insurance regulators, it is important to make sure that this trend toward higher yields is balanced with the security necessary to ensure that companies can meet their obligations.

a. **Investment RBC**

Commissioner White noted that there are some concerns that the RBC framework may be contributing to this behavior of companies searching for higher yield. He noted that for those who were at the 2021 Fall National Meeting, at that time he led a discussion about the fact that structured credit is treated the same as corporate bonds for the purposes of RBC. That is true even though structured credit has a more extreme risk profile. He indicated that in order to address this, the Committee supported creating a new working group to examine whether increased RBC charges for these types of investments should be considered. He introduced Mr. Barlow to provide an update on the work.

Mr. Barlow discussed how the Risk-Based Capital Investment Risk and Evaluation (E) Working Group met March 22 to discuss four comment letters received from the Financial Condition (E) Committee exposure. He noted that during the meeting, the Working Group also adopted its working agenda. Finally, the Working Group discussed the path forward to address the charges and working agenda. He noted that among the conclusions from that meeting were: 1) a series of meetings following this meeting will provide an opportunity to address the charges
and working agenda; 2) assets will be addressed sequentially, starting with those having the biggest impact, which is likely the collateralized loan obligations (CLOs); 3) the Working Group is not ready to engage a consultant, but it may need consulting assistance as details emerge. Mr. Barlow noted that the Working Group also has a long list of investment-related issues that had been referred to Capital Adequacy (E) Task Force, but the goal is to address the priority items identified by the Committee first. As this is done, the Working Group will look at the process holistically from the financial statement reporting and assignment of designations through the RBC charges.

Mr. Barlow discussed his desire to have a process that relies on the annual statement reporting and rating designations to determine the RBC charge rather than “company records” or information in the notes, interrogatories, or otherwise determined by the filer. This should help with transparency and consistency. He stated he would also like a process that establishes a methodology for identifying and dealing with new assets or asset classes that can adjust in response to the volume in insurers portfolios. He noted that the Working Group has good representation from other impacted task forces and working groups, including the Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group, Property and Casualty Risk-Based Capital (E) Working Group, Capital Adequacy (E) Task Force, Valuation of Securities (E) Task Force, and Statutory Accounting Principles (E) Working Group. At this point, Mr. Barlow said there seems to be a general consensus on the path forward. Since all of the members bring different expertise to this, he said the Risk-Based Capital Investment Risk and Evaluation (E) Working Group is engaging in some educational sessions to increase its collective knowledge, gathering data to help prioritize projects, and making sure all information is equally shared so there is a collective understanding of the issues involved. Mr. Barlow closed by noting that while there are a lot of items on the Working Group’s agenda, it will address them as expeditiously as possible.

b. Statutory Accounting

Commissioner White discussed how the Statutory Accounting Principles (E) Working Group is currently focused on improving accounting for certain structured securities and cited an example where there has been an increase in debt instruments that have underlying collateral assets that are more equity-based. He said state insurance regulators want to make sure that equity risk is not masked and that the asset receives the proper RBC charge.

Mr. Bruggeman, Statutory Accounting Principles (E) Working Group chair, noted that the Working Group has been working on a long-term project to update the investment-related Statements of Statutory Accounting Principles (SSAPs), which are currently focused on the legal form or structure of investments rather than their substance. He noted how opportunity existed, and still exists, to report any item as a bond by acquiring it through a special purpose vehicle (SPV) in the form of a debt instrument, regardless of whether the insurer investor was in a different economic position; i.e., holding the underlying assets directly. For example, under the existing guidance, an SPV could hold equity items, the SPV could issue an instrument in the form of debt (various tranches, but not the residual tranche, which is now a Sch BA investment) with pass-through performance of the equity items, and the reporting entity would be permitted to report that debt issuance from the SPV as a bond, when in actuality they have equity risk. Mr. Bruggeman described that the Statutory Accounting Principles (E) Working Group knew it needed more principle-based bond accounting. Doing so would allow an increasingly innovative asset-backed bond market to be accounted for based upon its substance as opposed to its form.

Mr. Bruggeman said that in fall 2020, a small group of state insurance regulators and industry with detail investment knowledge produced principles and a flowchart of when an investment can be reported as a bond. The group also had initial discussion to increase transparency in reporting with improved classifications on the distinct types of bonds and ABS that qualify for reporting as a bond. In May 2021, the Statutory Accounting Principles (E) Working Group exposed and heard comments on the principles-based bond definition, which included many examples of what would meet the definition. It also expanded the small group of state insurance regulators with industry to get more perspectives for staff direction. After much discussion and clarifying examples, the Statutory Accounting Principles (E) Working Group exposed a revised principles-based bond
definition and an issue paper for a public comment period ending May 6, and it directed NAIC staff to begin amending language for state insurance regulators’ review. During the Spring National Meeting, the Statutory Accounting Principles (E) Working Group received comments and an update regarding potential reporting options to revise the bond schedule. After hearing comments, the state insurance regulators directed NAIC staff to develop a more robust illustration of the reporting proposal selected, with a choice for certain ABS bonds to be on a bond sub-schedule versus wedging in with sub-total lines, and with a goal to expose in May. The direction also noted that NAIC staff should continue to work with interested parties, especially category descriptions.

c. **Reliance on Rating Agencies**

Commissioner White noted that another area the Committee is looking at is the role of rating agencies. The key role that rating agencies play in the value of insurer investments again ties into this concern over how the industry is reacting to the low interest rate environment. He said the Committee has been asking if there is an overreliance on rating agencies, and if so, how can it address that.

Ms. Mears described how the Valuation of Securities (E) Task Force had initiated several steps to look at how the NAIC uses rating agency ratings in the assignment of NAIC designations. The first is a proposal from Securities Valuation Office (SVO) staff to add market-data analytical fields for bond investments to the annual statement instructions. She described how the proposed amendment, if adopted, would be a first step towards achieving a core recommendation from the former Rating Agency (E) Working Group to the Committee in 2010 to lessen the NAIC’s reliance on rating agency ratings by looking at other measures of risk. The proposed additional fields would include market yield, interest rate sensitivity measures like effective duration and convexity, and risk premium indications, among others. After this critical analytical information on bond risk is reported, the Task Force and the SVO will be able to review for inconsistencies that may appear between these risk measures and the reported rating and determine if additional changes are needed.

Ms. Mears noted that the Valuation of Securities (E) Task Force sent informational referrals on this proposal to the Life Actuarial (A) Task Force and the Capital Adequacy (E) Task Force as this information could be useful in the achievement of their objectives and charges. She said the Valuation of Securities (E) Task Force anticipates continued coordination with the Statutory Accounting Principles (E) Working Group and its updates to the bond reporting schedules.

Ms. Mears explained that another key effort is the establishment of an ad hoc discussion group that includes state insurance regulators, insurance company staff, and NAIC staff. The ad hoc group is talking through the issue of the NAIC’s reliance on rating agency ratings and the rating inconsistencies across rating organizations observed by the SVO and reported to the Task Force in their memorandum from November of 2021. Some key objectives of this ad hoc group include: 1) establishing a framework of qualitative and quantitative criteria for being a credit rating provider (CRP) to the NAIC; 2) eliminating or minimizing RBC arbitrage opportunities between CRP ratings and asset classes; 3) defining a repeatable quantitative process to evaluate rating performance for all rating agencies consistent with RBC factors; and 4) considering how the incorporation of market data noted earlier can be used to identify potential misalignments of risk. Finally, the SVO continues to make targeted recommendations to the Task Force to address specific issues with ratings. The most recent include proposed changes to the definition of principal protected securities to include synthetic variants of these securities not previously contemplated, and an updated definition of securities with non-payment risks other than traditional credit risk that will need to be reviewed by the SVO.

Ms. Mears explained that a key to many of these efforts is the SVO need for additional technology resources. This will become more of an issue as the group takes on some of these additional responsibilities that are more analytically intensive. Finally, the NAIC’s Structured Securities Group (SSG), which currently models residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) for designation and
capital purposes, is looking at the possibility of modeling additional asset classes to lessen the NAIC’s reliance on rating agency ratings for these complex investment structures.

d. **Asset Adequacy Testing for Complex Assets**

Commissioner White said that not all of the work in this area is being done in the Committee. He noted several ongoing projects in the Life Actuarial (A) Task Force, adding that the Committee and in particular Director Judith L. French (OH) are engaged with those. He asked Mr. Anderson to provide an update on a proposed actuarial guideline to address certain high risk or “high yield” assets in an insurer’s asset adequacy testing.

Mr. Andersen discussed the development of a new actuarial guideline related to asset holdings and their related risks. He noted that the work was part of the coordinated efforts of the NAIC, overseen by the Macroprudential (E) Working Group, to ensure appropriate regulation of the developments seen regarding an increase in private equity and complex assets in the life insurance industry. He explained that the Life Actuarial (A) Task Force is focused on aspects related to reserve adequacy and, as a result, working to help ensure life insurers involved in complex assets will be able to pay claims even if those assets do not perform as expected. Mr. Andersen noted during its most recent meeting, the Life Actuarial (A) Task Force met to discuss comments on a first draft of an actuarial guideline that would provide documentation and sensitivity testing requirements on life insurers engaged in such activity. Mr. Anderson noted that the guideline was expected to be adopted by the NAIC at the Summer National meeting in early August. He said, however, that partly due to the aggressive time frame, some of the more controversial aspects that were in the first draft, including application of guardrails that could directly affect the financials of some insurers, will be deferred to later discussions that are not part of the aggressive 2022 time frame. He said that the resulting documentation and sensitivity tests that will likely be included in the 2022 guideline adoption will provide information to state insurance regulators, including: analysis of the risks of the complex assets, details underlying the assumptions on how those assets will perform, expectations on the sophistication of the company models matching the complexity of the assets, identification of practices in determining fair values for assets that do not have deep markets, information on privately-originated assets and fees, and assurance that any counterparty risk related to reinsurance deals are considered and documented. He concluded by noting that over the next several weeks, there will be movement to turn the first draft into a final draft that is ready for adoption.

e. **ESG**

Commissioner White introduced Mr. Boerner, Life Actuarial (A) Task Force chair, who updated the Committee on a new economic scenario generator (ESG) that is intended to better capture the potential for lower interest rates for extended periods, which is lacking in the current ESG.

Mr. Boerner provided background on the work, noting that in 2017, the American Academy of Actuaries (Academy) notified the Life Actuarial (A) Task Force that it did not have the resources to maintain the prescribed ESGs, except in their current form until a suitable replacement could be found. In June 2019, the Financial Stability (E) Task Force noted a potential deficiency in the prescribed ESGs related to a limited reflection of extended periods of low and even negative interest rates and requested the Valuation Analysis (E) Working Group assess the macro prudential risk to insurance organizations in the U.S. with a focus on variable annuity writers. He noted that in July 2019, the Life Actuarial (A) Task Force and Life Risk-Based Capital (E) Working Group requested that NAIC staff consider issuing a request for proposal (RFP) for a vendor to build and maintain a new ESG to be used in the determination of statutory reserves and capital. After extensive work with state insurance regulators and ESG subject matter experts (SMEs) from the life insurance industry, the NAIC issued the RFP for a new ESG in March 2020.
Mr. Boerner stated that upon reviewing proposals from six companies, Conning was selected as the ESG vendor and approved by the Executive (EX) Committee in September 2020. After the contract was in place with Conning, an ESG Drafting Group comprised of state insurance regulators, Conning staff, and NAIC staff was formed to develop ESG recommendations to the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group. To incorporate more industry feedback into the process, industry SMEs were added to the ESG Drafting Group in June 2021, which met weekly until recently to focus more attention on planning a June field test. He noted that any ESG for field testing or a final ESG is composed of three sets of scenarios: 1) those from a Treasury model; 2) those from an Equity model; and 3) those from a Corporate Bond model. With such models in mind, a few collaborative examples over the course of the ESG Drafting Group discussions, where state insurance regulators incorporated feedback from the industry SMEs, included 1) using statistics and input from the SMEs to develop the acceptance criteria for the Treasury model; 2) directing Conning to produce scenarios according to alternative calibration suggested by SMEs and including the alternative calibration as one of the proposed Treasury models to field test; and 3) directing Conning to alter the international equity indices to align the fund’s expected returns on a risk/reward basis relative to the U.S. large cap fund for the Equity model.

Mr. Boerner said that it was also planned for Conning to work on development of an SME-proposed “simplified corporate bond model” after the field test begins. Conning’s corporate bond model is able to reproduce the key dynamics of bond returns. However, some of the information in this model is proprietary. The SMEs’ simplified corporate bond model is intended to be fully transparent and nonproprietary. The development of such a simplified corporate bond model involves a significant effort, which would not make it in time for a June field test. However, such a simplified corporate bond model would focus on having similar scenarios as the Conning corporate bond model so that use of the Conning corporate bond model will be relevant for the June field test.

Mr. Boerner noted that achieving the June field test is especially important to help determine the ESG’s impact on industry reserves and capital and to help state insurance regulators understand the materiality of technical issues brought up by the industry SMEs. In place of the ESG Drafting Group meetings, the state insurance regulators have transitioned to conducting weekly meetings with state insurance regulators, industry SMEs, Conning staff, and NAIC staff to plan for the June field test. This is in addition to weekly planning meetings, which also include American Council of Life Insurers (ACLI) and Academy representation to plan for future efforts and meetings of the ESG initiative. Mr. Boerner noted next steps that would take place prior to the ESG June field test include: 1) refining the recommended ESG models for field testing; 2) building out field test specifications, instructions for participants, and a results template; 3) determining the final set of field test participants and field test product coverage; and 4) preparing the necessary scenario sets for delivery to field test participants.

Mr. Boerner said the steps that would occur after the June field test include: 1) analyzing results of the field test; 2) adjusting ESG models as appropriate where model office programs may help inform appropriate adjustments; 3) planning for a follow-up field test early next year to test adjusted models; and 4) discussing results of that field test. He also noted that if the ESG models were ready for implementation, then work on implementation for 2024 would begin if timing permits. He explained that the steps will involve: 1) joint open meetings of the Task Force and the Life Risk-Based Capital (E) Working Group; 2) continued planning meetings, including early next year field test planning calls; and 3) ESG Drafting Group meetings as needed.

Commissioner White stated his appreciation for all of the chairs who provided updates on these important initiatives, as well as all the state insurance regulators involved in developing the work. He stated it should be clear to the Committee that a lot of great work is occurring, with a great deal of coordination also occurring on these projects—all intended to address the low yield environment. He said that it is not the intent of the Committee to overrule the details of work of these groups and noted that each of these projects are important and are supported by the Committee given their objectives. Ms. To agreed with Commissioner White and noted her support for all of the projects given each is intended to address the asset and spread risk faced by the industry.
She stressed that they were also important to level the playing field and described how she expects the industry to fully participate and collaborate in helping to develop these solutions to these issues.

Having no further business, the Financial Condition (E) Committee adjourned.
The Financial Condition (E) Committee met Jan. 12, 2022, in joint session with the RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force. The following Committee members participated: Scott A. White, Chair, represented by Doug Stolte (VA); Michael Conway, Vice Chair, represented by Rolf Kaumann (CO); Dana Popish Severinghaus represented by Vincent Tsang (IL); Amy L. Beard represented by Roy Eft (IN); Eric A. Cioppa represented by Vanessa Sullivan (ME); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Russell Toal and Leatrice Geckler (NM); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Tom Botsko and Dale Bruggeman (OH); Raymond G. Farmer (SC); Cassie Brown represented by Jamie Walker (TX); Nathan Houdek (WI); and Jeff Rude (WY). The following Working Group members participated: Philip Barlow, Chair (DC); Wanchin Chou (CT); Ray Spudeck (FL); Kevin Clark and Carrie Mears (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung and Debbie Doggett (MO); Lindsay Crawford (NE); Bob Kasinow and Bill Carmello (NY); Tom Botsko and Dale Bruggeman (OH); Mike Boerner and Rachel Hemphill (TX); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Discussed Phase II of a Bond Factor Proposal for Structured and Asset-Backed Securities

Mr. Stolte discussed his objectives for the conference call: 1) officially handoff the two projects Commissioner White spoke about at the 2021 Fall National Meeting related to asset-backed securities RBC changes and residual interest securities to the new Working Group; and 2) give some direction to the Working Group on the first of those issues. He provided a recap of some of the items Commissioner White spoke about at the 2021 Fall National Meeting to address the first part of the first objective.

Mr. Stolte stated that in 2021, the Life Risk-Based Capital (E) Working Group received a proposal from Moody’s Investors Service (Moody’s) and the American Council of Life Insurers (ACLI) that ultimately included the new bond factors adopted for the life RBC formula for year-end 2021. Most importantly, within that proposal, it was suggested that in the future, the NAIC should consider a second phase to such work to look at other asset classes of fixed income securities. Mr. Stolte noted that the life insurance industry has been challenged with the continued low interest rate issues, but the Committee and its task forces and working groups have also spent a great deal of time talking about the industry’s search of yield and a shift away from corporate debt holdings towards structured securities and other asset-backed securities, particularly collateralized loan obligations (CLOs). He noted that these types of securities tend to carry more tail risk than a typical corporate debt offering, and state insurance regulators need to start thinking about that tail risk more explicitly in the RBC formula for such types of assets. He stated that there were basically two ways the NAIC could take on this work: 1) use the model used for variable annuities and mortgage guaranty insurance a few years ago where the NAIC issues a request for proposal (RFP) on a project and then hires a consultant that the NAIC controls, but it gets reimbursement commitments from members of the industry before doing so; and 2) use the approach the ACLI used during the bond factor proposal last year where the state insurance regulators control the scope of work before the ACLI puts out a bid, and the ACLI funds the project. He noted that either approach could work, but one of the reasons he wanted to have this call in early January was in case there was a strong sentiment to have the NAIC contract this work since that would require the commissioner to take such a proposal to the Executive (EX) Committee, perhaps during the Commissioners’ Conference in early February. He discussed how Mr. Barlow and Dan Daveline (NAIC) have experience with both and can help to facilitate either approach.
Mr. Stolte suggested that before moving into this idea of hiring a consultant, Commissioner White wanted to suggest the release of a 45-day public comment period after the call. The purpose of such a request would be to solicit if members of the industry, and perhaps consultants that follow the NAIC work, have views on possible methodologies that could achieve the objective of capturing the tail risk on CLOs and other structured securities and asset-backed securities. Mr. Stolte noted that Commissioner White’s suggestion was that ultimately, it will be up to the RBC Investment Risk and Evaluation (E) Working Group to determine which of the recommended methodologies are chosen, as well as various other details. He described how Commissioner White envisioned how the NAIC data on CLO stress tests could be used to back into a factor, or how other methods, such as that used for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS), could be used. He added that for other asset classes, perhaps some form of ratings is used where the consultant can prove the effectiveness of some ratings, or perhaps some ratings with adjustments. He noted his hope that the Working Group and Securities Valuation Office (SVO) staff could possibly review the proposals in March and select a methodology(ies) before the Spring National Meeting to where a consultant could be hired after the Spring National Meeting and possibly come back to the Working Group with specific proposed factors by the Summer National Meeting; then, perhaps the Working Group could adopt something by the end of the year. He noted that Commissioner White knows that this is an aggressive timetable, but he believes an aggressive goal should be set.

Superintendent Toal stated that he believes Commissioner White’s proposal is logical, and he supports it and his proposed timeline. Mr. Barlow stated his appreciation for the background information and thinking, and he noted that he looks forward to chairing the Working Group. He stated his support for considering more granular investment factors on certain investments, at least for the life RBC formula, but there would need to be more discussion at the Working Group or the Capital Adequacy (E) Task Force on whether the same is needed for the property/casualty (P/C) formula and the health formula. He also stated that he strongly supports not having the NAIC contract a consultant but instead having the Working Group direct the engagement by the industry of such a consultant, noting that the latter worked well for the life RBC bond factors adopted in 2021. He stated that he has some concerns with the proposed timeline, and he stated that while a similar timeline worked for the 2021 bond factors, a lot of leg work was done by the American Academy of Actuaries (Academy) that does not exist for this proposal. He also discussed the need for the project to complete a proper risk analysis to determine the appropriate factors, noting the potential for a lack of data on newer types of securities. Mr. Stolte responded that he would be certain to communicate Mr. Barlow’s concerns to Commissioner White. Superintendent Toal indicated that he respectfully disagrees with Mr. Barlow’s comments about the reasonableness of the timeline, as well as how he believes it would be better if the NAIC controlled the consultant simply for objectivity. Mr. Stolte responded that he would be certain to communicate Superintendent’s Toal’s concerns to Commissioner White. Mr. Spudeck stated that he supports the comments made by Mr. Barlow related to the process to use, noting that under that process, the state insurance regulators would still be in control of the work. He also noted that he believes the proposed timeline is not just aggressive but aspirational. He noted that the work could begin, but depending upon the depth and granularity chosen, it could be very labor intensive. He also suggested avoiding applying it to health companies, at least initially. Mr. Botsko stated his support for Mr. Barlow’s comments, and he noted the importance of how this as well as future work is coordinated with the Task Force. Mr. Stolte responded that his comments would be noted.

2. Discussed SSAP No. 43 Residual Interests

Mr. Stolte noted that the next issues deal with residual interests where the underlying issue affects the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, and the various RBC formulas and RBC groups. He noted that Commissioner White was made aware that there had already been some informal coordination among the chairs of these groups. He asked if some of the key members of those groups—Mr. Barlow, Mr. Bruggeman, and Ms. Mears—could briefly discuss each of their views on plans to coordinate activities
Mr. Barlow noted his support for this work, bearing in mind the incentives for this type of change, and he noted his goal to make RBC not be the issue for investments in these types of structures. He looks forward to working with the other groups, but like the first issue, consideration will need to be given to whether such changes are needed for the health and P/C formulas. Mr. Bruggeman stated his agreement with Mr. Barlow from the sense that development of a factor will be a challenge. He discussed how these will be reported within Schedule BA, but currently, there is no detailed reporting to capture these. However, he hopes that with a new blanks proposal, the NAIC can at least capture the impact on the asset valuation reserve (AVR). He stated that he also agrees with Mr. Barlow with respect to whether this need for health and P/C remains to be seen. Ms. Mears stated her agreement with Mr. Barlow and Mr. Bruggeman, and she noted that materiality is something else she wants to look at. She also questions if there could be some overlap between this issue and the issue discussed within the first agenda item. She suggested that the request for comments be revised to solicit information on the availability of data on residual interests, and she wonders about how the availability of collateral may need to be considered as well.

Having no further business, the Financial Condition (E) Committee and RBC Investment Risk and Evaluation (E) Working Group adjourned.

[Attachment One-Joint Call January 12 E min.docx]
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met Feb. 9, 2022. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Ray Spudeck (FL); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); John Turchi (MA); Judy Weaver (MI); Kathleen Orth (MN); Justin Schrader (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Adopted its 2021 Fall National Meeting Minutes**

The Working Group met Nov. 22 and took the following action: 1) adopted its Nov. 8, 2021; Sept. 8, 2021; and Summer National Meeting minutes, which included the following action: a) exposed a staff memorandum that includes possible group capital calculation (GCC) modifications for a public comment period ending Dec. 23, 2021; b) exposed clarifying changes to the GCC instructions that were previously provided to the Working Group and the public as part of the GCC Trial Implementation for a public comment period ending Dec. 8, 2021; c) discussed comments on maintenance documents and proposed revisions; d) discussed comments on a draft referral to the Capital Adequacy (E) Task Force; and e) adopted recommended changes to the Financial Analysis Handbook that incorporate guidance on utilizing the GCC and subsequently distributed these changes to the Financial Analysis Solvency Tools (E) Working Group; and 2) discussed the results of the GCC Trial Implementation.

Ms. Belfi made a motion, seconded by Mr. Spudeck, to adopt the Working Group’s Nov. 22, 2021, minutes (see NAIC Proceedings – Fall 2021, Financial Condition (E) Committee, Attachment Two). The motion passed unanimously.

2. **Discussed Comments Received on Possible Changes to the 2022 GCC**

Mr. Rehagen announced his objectives for the conference call: 1) discuss each of the issues (Attachment Two-A) and the related comments (Attachment Two-B) from America’s Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI); and 2) ask the Working Group to make decisions on each of those issues. He noted that for those issues that the Working Group chooses to make a change to the GCC, he will ask NAIC staff to develop a revised template and instructions with such changes incorporated. The revised template and instructions will be exposed for a public comment period and be discussed on the Working Group’s next conference call. Mr. Rehagen stated that ultimately, he wants the Working Group to adopt a revised template and instructions that will be used for year-end 2022 so all parties can begin to prepare for the year-end filing. He stated that year-end 2022 will be the NAIC’s first year for the GCC filing with its published template and instructions, and it will be available for any state that is requiring it for their groups for year-end 2022. He also stated that NAIC staff expect to develop training for companies for the summer of 2022, while training for the state insurance regulators will be closer to the expected filing date. He emphasized that while the Working Group will be making some changes for 2022, that is not meant to suggest that changes will not occur in the future. In fact, he noted that once the GCC is adopted for year-end 2022, he wants the Working Group to adopt its form and procedures documents that will be used in the future for any party suggesting a change to the GCC.
a. **Eliminate Stress Scenario**

Mr. Rehagen reminded call participants of the fact that in 2021, the GCC Trial Implementation template and instructions included a stress scenario; but at that time, the Working Group concluded that it would not include a stress scenario in the GCC’s first implemented version. He noted, however, that the Working Group had already discussed that it may decide in future years to add different stresses to the GCC as a supplemental disclosure. He reiterated this point in response to a written comment from AHIP, but he noted that if the Working Group desires to include stresses in the future, just like any other proposal, the state insurance regulators will expose such a proposal, and the details of that proposal will be debated just like any other new proposal. He asked if any Working Group members are opposed to removing the GCC Trial Implementation stress scenario out of the 2022 GCC. No members objected to removing this item.

b. **Debt Allowance**

Mr. Rehagen discussed his belief that NAIC staff were under the impression from comments made by interested parties in 2021 that there was a desire to increase the debt allowance to account for procyclicality. NAIC staff had proposed a way to deal with that in the exposed memorandum, which he suggested was not well received from AHIP and the ACLI based upon their written comments. He provided his opinion that he believes the Working Group was already in favor of the levels of debt that were included in the GCC Trial Implementation, and he suggested moving forward without any change to the GCC Trial Implementation because he believes the Working Group has already recognized that most senior debt is already being recognized in the GCC. He noted that if members of the Working Group have strong feelings, they can consider the comments from AHIP and the ACLI, but he reiterated that he is inclined to keep the debt levels the same as they were during the GCC Trial Implementation. It was noted how the current debt allowance is at 75% in total, and the subcategory limits are 30% for senior debt and 15% for hybrid debt, but both subcategory limits are a percentage of available capital plus senior and hybrid debt. Mr. Rehagen stated that he believes the ACLI is proposing some changes to that construct that would likely just push up those limits a little.

Tom Finnell (AHIP) noted that AHIP does not have strong feelings on the NAIC staff proposal to increase the debt allowance, and it certainly would not stand in the way, but it would not carry the flag for it either. He noted that AHIP’s concerns regarding the NAIC staff proposal are more directed at including triggers based upon an external factor, which seems similar to relying on rating agency ratings, which showed triggers can have issues as witnessed during the financial crisis. Mr. Rehagen asked AHIP if that means it is supportive of leaving the current debt limits as is, as opposed to making the changes recommended by NAIC staff. Mr. Finnell responded affirmatively.

Kristin Abbott (ACLI) noted the ACLI comment it would consider a technical correction to the exposed NAIC staff proposal, and she asked Martin Mair (MetLife) to expand on the ACLI views on the issue. Mr. Mair stated that what the ACLI is proposing is that the subcategories be a percentage of the total category. He described that if one went back to the original debt framework and its cap of 50% and considers the total debt allowance has been increased to 75%, the senior debt limit and the hybrid debt limit should both be increased. With the ACLI proposal, if one takes those subcategories on a percentage basis, then the senior debt should now be 45% instead of 30%, and the hybrid would be 22.5% instead of 15%. Mr. Mair described how the NAIC staff memo suggests an adjustable debt limit, and the ACLI proposal is that as the total debt limit increases, the subcategories should automatically be increased, which the ACLI sees as a technical correction to the NAIC staff proposal.

Ned Tyrrell (NAIC) asked for clarification on the proposal, noting that it seems that the ACLI proposal is simpler but less nuanced. He noted that under the ACLI proposal, adjusting subcategories described by Mr. Mair would result in a higher amount of debt being added into the available capital. Mr. Mair responded that the ACLI proposal is intended to align the subcategory limits with the total limit. Mr. Tyrrell noted the importance of looking at the
fact that the current limits use a different denominator for the subcategories as the total limit. Specifically, he noted that the total limit of 75% is a percentage of available capital excluding debt, while the subcategories are a percentage of available capital plus total debt. He added that consequently, a group could have a situation where one limit is binding but the other is not. He stated that for most groups, in particular life groups, the debt is concentrated as senior debt, so the subcategory is the binding limit. Mr. Rehagen agreed with Mr. Tyrrell, and he noted that there is not really an existing issue with the current debt limits, and for most companies, all debt was allowed as in addition to available capital. He noted that in summary, he does not believe a change is necessary, but what Mr. Mair is describing is something that could be studied. He asked if any Working Group members believe this is something the Working Group should make a change to the debt limit today.

Mr. Bruggeman offered an example to demonstrate the impact of the proposed change from the ACLI. In his example, a group has available capital of $100 million, and in such a situation, 75% of the total capital would provide the group with an additional $75 million, for a total of $175 million used in the calculation. Then, applying the 30% and 15% to the $175 million, the total allowance is over $78 million from the two individual amounts. Changing the subcategory percentages as well as the rest of the proposal has the result of increasing the amount of debt that can be added into the available capital and count toward the GCC because of the different denominator, and Mr. Bruggeman believes that is the point Mr. Tyrrell was making. He added that they were not trying to match up the 30% and the 15% with the $75 million additional capitals allowed from debt; it is 30% of $175 million. Mr. Tyrrell confirmed that is what is currently embedded within the current GCC. Mr. Bruggeman confirmed that he does not believe a change needs to be made to the debt limit at this time for the proposal. Mr. Barlow asked whether a group would be more restricted if it has a lot of hybrid debt and not much senior debt. Mr. Bruggeman responded that this is correct, as the group would not be able to recognize all of that in the group capital numerator. Mr. Rehagen asked if any Working Group members are opposed to keeping the current debt limit template the same with no changes from this proposal or any suggested modifications from the ACLI. No members objected to keeping the GCC the same for the current debt limits.

Lou Felice (NAIC) suggested that the issue being discussed is one the NAIC may want to keep an eye on because not every group is going to get to 75% of the $175 million; some may only be at 60%, in which case the mathematics changes a bit. Consequently, there will likely be some cases where there is some haircut on the amount of debt that the group can carry simply because it does not have 75% of its otherwise available capital total. Mr. Rehagen agreed, noting that as state insurance regulators begin to receive their filings, to the extent that several such groups are being finalized, it is something the Working Group can look at again more closely. Mr. Bruggeman clarified that the current limit is not allowing groups to obtain debt; rather, it is simply limiting how much debt can be added into the existing available capital and counted within the GCC.

c. **Eliminate Sensitivity Test Related to “Other Debt”**

Mr. Rehagen noted that NAIC staff had proposed the elimination of the sensitivity test around the other debt; given that the industry was not opposed, the proposed change will be made unless Working Group members express disagreement. No members disagreed with the proposal elimination.

d. **Non-Risk Sensitive Foreign Jurisdiction**

Ms. Abbott stated that ACLI members have varying perspectives on this issue; some prefer 50% because 100% can be viewed as punitive, and it gives zero credit for all available capital that is above the required capital. Also, a 100% factor treats capital from those jurisdictions as not existing. Ms. Abbott noted that this is why the ACLI believes 50% seems like a reasonable middle ground for now, and perhaps the Working Group or others could undertake some study to determine if that is the appropriate level. Mr. Rehagen stated that he believes the ACLI proposal is reasonable, and while he does not know exactly what such a proposal that may come from the industry
may look like, he is supportive of reducing the factor to 50% for now, but a different approach could be considered in the future. He asked if any Working Group members are opposed to making the change proposed by NAIC staff. No members objected.

e. Schedule 1 Related Changes

Mr. Finnell described how AHIP’s comments are intended to be helpful. He noted that while AHIP is not too concerned where the information is captured, it has numbers who believe in constructing a template that has everything listed in one place. He noted that if it gets broken up in different spots, AHIP believes that would make the process a little more cumbersome. He stated that he also does not believe the state insurance regulators would want to take the items on the template. Ms. Abbott discussed how the ACLI supports efforts to streamline Schedule 1. She noted that the ACLI believes it is important for state insurance regulators to have the detail they need, and the ACLI supports the NAIC staff recommendation to include the information elsewhere in the template. Mr. Rehagen noted that it does not appear that there is agreement between the interested parties on the way to move forward. He stated that he does not have strong opinions, but the first time a company fills the GCC out, it is going to present them with some challenges and confusion. He noted, however, that he believes it will become easier after the first year; therefore, he stated that he is not inclined to make a change at this time. He noted that this is not to suggest that future changes cannot be considered, but he does not want to make a change at this time. Mr. Spudeck agreed stating that he prefers to make no changes at this time, and the GCC instructions is a living document that can always be changed in the future. Mr. Bruggeman noted that there are some oddities when going through the Schedule 1. He noted that if a group elects to exclude the state insurance regulators and then elects to include them, depending upon the situation, when the equity values are rolled up and then onto the schedules, it can create some confusion. He noted that if the group is going from statutory accounting to U.S. generally accepted accounting principles (GAAP) accounting, it gets a little odd if a company all of a sudden says exclude and the state insurance regulator says include. He stated that the dollars kind of flow funny, and he noted that he is testing a couple of groups to see what happens, including double counting, but those things can be part of the training or just need to be handled with care. Mr. Rehagen noted how Missouri would probably be a guinea pig this year because it will require several groups to complete it in 2022. Mr. Bruggeman confirmed that the template could be maintained as it is for now, and no changes are needed at this time. The Working Group did not disagree.

f. Asset Managers

Mr. Rehagen noted that the last item deals with asset managers, who are currently treated as financial entities. The question is whether the industry can bring back a proposal and basis for making a proposal that asset managers be considered financial entities subject to an existing capital requirement. Mr. Rehagen stated that the comments do not include such a proposal, so at this time, he is inclined to keep it as is, but he believes the Working Group would always be open to a proposal in the future. The Working Group did not disagree.

Mr. Rehagen asked the Working Group whether it agrees with asking NAIC staff to develop changes to the template and instructions for year-end 2022 based upon the decisions during the call by the Working Group. He indicated that he would review the template and instructions once the changes have been made, and he suggested that both could be exposed for 30 days once he completes his review. The Working Group did not disagree.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.
MEMORANDUM

TO: Group Capital Calculation (E) Working Group

FROM: Dan Daveline, Ned Tyrrell, and Jane Ren

DATE: Nov. 8, 2021

RE: Staff Proposed Changes as a Result of Trial Implementation

While the 2019 GCC Field Test was invaluable in finalizing major changes to the GCC Template and Instructions before implementation, the 2021 Trial Implementation allowed preparers and reviewers of the GCC to focus more on the nuances of the GCC. As expected, a number of changes to the instructions were suggested during the completion of the template based upon comments and feedback from preparers, which the Working Group has been made aware of with each new release of the same during the trial period. Such changes are included in today’s materials, and we request the Working Group to expose these updated instructions with these modifications. The purpose of this memorandum however is to highlight more material changes, or potentially material changes to the extent the Working Group agrees with the staff recommendation. The following summarizes such changes.

Due to the fact that in accordance with draft procedures for the Working Group, template changes need to be adopted earlier in the year before instructional changes, we have listed those that require template changes first so they can be prioritized in discussions.

Template Changes

1. **Eliminate Stress Scenario**: While some Working Group members may want to consider adding informational stresses to the GCC in the future, the current sentiment among the Working Group seems to suggest that should only be considered after the GCC is fully implemented. Based upon that, it seems appropriate to remove the current stress from the template and the instructions.

2. **Debt Allowance**: One of the reasons the industry proposed the idea of including stress testing in the GCC for the Trial Implementation was to understand the sensitivity of the debt allowance after an economic downturn, therefore addressing its procyclicality. While it’s true that a 30% decline in the capital of a group can impact the debt allowance of the GCC in certain situations, thereby reducing the GCC ratio, NAIC staff does not believe this is a sufficient cause for increasing the debt allowance. As a reminder, the debt allowance is a proxy for the amount of subordinated capital embedded within the GCC and we believe the current allowance approximates this proxy well. A number of volunteers participating in the Trial Implementation suggested the 30% decline was generally not a very reasonable stress given past performance of the industry during previous financial crisis (e.g., 2008/2009 great
recession). However, some of those volunteers pointed to monetary policy during a financial crisis which actually encourages entities of all industries to increase debt as a means to push back against the negative impact. They pointed to the industry’s issuance of debt immediately after COVID and suggested the GCC should not go against these policies. NAIC staff does not disagree in principle, and would suggest a better way to address these points is through a simple annual 10% cap that enables the debt allowance to increase 10% from the prior year, but only during a period where the Federal Reserve has taken a public position of reducing the cost of borrowing through reducing interest rates either by lowering the Federal Funds rates or by purchasing debt instruments (additional if applicable). However, the 10% increase must be reversed once the Federal Reserve has taken action to reverse its trend (e.g., increase rates or reduce purchasing debt instruments). Perhaps this could be formally implemented only upon issuance of “guidance” by the Working Group that is posted to the Website. The details of whether this is appropriate and how it should be considered for adoption should first be determined by the Working Group. NAIC Staff would welcome proposed changes to the GCC instructions and template that could achieve this type of approach or any other similar approach that reduces the perceived procyclicality of the GCC limitation in this area.

3. **Eliminate Sensitivity Test Related to “Other Debt”** — We recognize that some members of the industry continue to believe that the debt allowance should include “other debt” beyond “senior debt” and “hybrid debt”. However, NAIC staff continues to believe that the approach already adopted by the Working Group to have an individual limit for each of those items (30% and 15% respectively) and the overall cap of those two is appropriate for the previous points made regarding how the debt allowance is a proxy for subordinated capital already within the insurance companies. With the previous consideration about adding an additional 10% annual change meeting the criteria, we further support no change to allow other debt. This should be further deliberated by the Working Group before taking action on this issue and input from interested parties may assist the Working Group in such a deliberation.

4. **Non-Risk Sensitive Foreign Jurisdictions**— One recommendation that has already been made by NAIC staff and regulators during the Trial Implementation is a different approach related to non-risk sensitive foreign jurisdictions. In summary, these are jurisdictions whose capital requirements are not responsive to the magnitude and/or nature of an insurer’s risk profile. During the Trial Implementation, a conservative approach was used on this matter, and the template included a capital charge equivalent to 100% of the carrying value of the non-U.S. insurer, which is similar in the life RBC formula today. However, to be clear, since 2010, the life formula has required companies to use a zero value for foreign affiliates statutory carry value is excluded from both total adjusted capital (the numerator) and RBC (the denominator) of the RBC ratio. This was done to level the playing field between stock and mutual insurers on the basis that most stock insurers where such entities are owned by a sister non-insurance holding company rather than the U.S. life insurance company.
NAIC staff suggestion during the Trial implementation was that groups with such entities consider using a lower factor, such as 50% of the carrying value, and be given the option to calculate the insurers capital requirement using RBC (with reasonable simplifications/estimates) if that is preferred to the 50% carrying value. At this point we have included this option in the revised instructions pending approval with exposure of such a substitute.

5. **Schedule 1 Related Questions/Considerations** The last item actually includes a number of separate questions or considerations, but they are all related to Schedule 1 and its purpose. More specifically, from the onset, the regulators have always stated they would like a way to make sure that the GCC includes all of the entities included in Schedule Y. Said differently, as drafted today, the Schedule 1 requires all entities to be listed in the Schedule Y, thereby providing that starting point the regulators requested. However, the instructions do provide one exception, and that is for Schedule A and BA entities, since those entities are already reflected in the RBC, and they don’t result in double counting of capital. Instead, these entities are listed in the Q&A tab, thereby having the effect of keeping the Schedule 1 cleaner, but still allowing a way for the regulator to reconcile back to the Schedule Y if they chose to do so. The question is whether similar exceptions in Schedule 1 should be provided for other entities. This would be for simplicity and to allow the regulator to focus on the entities more easily in the group on that matter. NAIC staff welcomes input on these considerations. The following presents such types of entities to the Working Group in a way to see if they would like a different approach:

a. **Other entities included in the RBC** The GCC does not require non-insurance/non-financial entities to be destacked, but they are required to be included in Schedule 1 and certain limited information included in the Inventory. The question is whether a listing of these entities could be included in the Q&A similar to the Schedule A and BA entities. The idea being that would keep the Schedule 1 cleaner, but for anyone wanting to reconcile back to the Schedule 1, they could do so with the listings in the Q&A. The NAIC raises this issue in case the current approach results in confusion by the preparer, or even for the reviewer since the inventory does not include any calculated capital amounts for these entities.

b. **Consideration of Entities “Not material” or “Excluded” from the GCC ratio** The GCC currently requires the group to list out its entities on Schedule 1, then mark each as either “Included” or “Excluded” for the purpose of calculating the GCC ratio. Specifically, for those that do not meet the GCC definition of material, the entity can “Exclude” them, however they have to be marked as such. The regulator then reviews the same listing and determines for themselves if each entity should be “Included” or “Excluded”. It’s likely that in the majority of situations, once a regulator
determines an entity may be “Excluded” from the ratio, that they will likely be excluded in the future. This is based upon the fact that the general reason for exclusion tends to be driven by the nature of the entity and its risks, and not its size. However, to clarify, not all entities that are once approved to be excluded always will be, and for that reason there will be a continued need for the GCC to provide information that allows the regulator to decide whether they can be excluded. The question is whether such information could be different than what is provided in Schedule 1, and, if so, whether perhaps such information could be reported elsewhere (e.g., Q&A tab). This would reduce the number of entities on Schedule 1 and perhaps help the regulator to focus on material entities in that schedule. The NAIC raises this issue for two reasons; 1) whether a different approach would allow for a more efficient review of the GCC by the regulator; 2) whether the current approach results in confusion by the preparer.

i. **Sensitivity Analysis** There is currently a sensitivity analysis related to “Excluded” entities to help the regulator understand the impact of the excluded entities on the GCC. The question is whether this should be removed. To the extent these excluded entities were no longer included in the Schedule 1 and Inventory, this sensitivity analysis could not be calculated, again, suggesting the need for some type of information to still be captured elsewhere in the GCC.

### Instruction Only Changes

6. **Asset Managers** The GCC currently considers asset managers as financial entities, and therefore subject to a factor of either 2.5%, 5.0%, or 10% of 3-year average revenue (same as other financial entities) based upon the material risk principles defined in Section II of the instructions. Some members of the industry have suggested that asset managers should instead utilize the regulatory capital standards imposed by the Financial Industry Regulatory Authority (FINRA). NAIC staff have always believed that while the base GCC requirements should generally remain the same as the principles under which they have been developed by the Working Group, it’s only natural that it evolves over time to carve out new factors for specific industry’s where a different factor can be supported. As it relates to the current GCC, this would include either specific financial entities having a different factor than those noted above, or potentially even for non-insurance/non-financial industries, a different factor than is used for all other non-insurance/non-financial entities. Additionally, perhaps more specific to the point, one of the GCC principles is that it defers to the specific capital requirements of the regulator of the entity, which in this case may include FINRA to the extent they have specific capital requirements. NAIC staff attempted to gather information on such requirements through the review of FINRA 15c3-1, but it was unclear how such capital requirements practically work as they seem to be more principle-based. NAIC Staff would
recommend the Working Group consider such a request, but only upon deliverance of documentation, including examples, that enable the regulators to understand. This does not need to be a full presentation to the Working Group unless the members indicate such is needed but could instead be full documentation and time for the Working Group to ask questions.
December 22, 2021

Mr. John Rehagen, Chair
Missouri Department of Insurance
Division Director – Financial Institutions & Professional Registration
NAIC Group Capital Calculation Working Group
Via e-mail: ddaveline@naic.org

Re: Comments on NAIC Group Capital Calculation (E) Working Group exposed proposed changes to the Group Capital Calculation (GCC) following the 2021 Trial Implementation

Dear Mr. Rehagen:

The American Council of Life Insurers appreciates the opportunity to comment on the Proposed changes to the Group Capital Calculation (“GCC”) following the 2021 Trial Implementation. We appreciate the significant and thoughtful work that has gone into the GCC framework and the NAIC’s ongoing commitment to developing a GCC that is fit-for-purpose.

ACLI is generally supportive of the proposed changes, however, we do have some comments to provide in relation to the Debt Allowance, Schedule 1 Considerations, and Non-Risk Sensitive Jurisdictions.

Debt Allowance

In 2020, the NAIC agreed to increase the overall debt cap from 50% to 75% but left the subcategory caps unchanged: (1) Senior debt cap remains at 30%; (2) Hybrid debt cap remains at 15%. ACLI suggests that the subcategory caps should instead be set at a percentage of the overall cap: (1) Senior debt cap should be 60% of the overall cap (i.e., the original 30%/50%); and (2) Hybrid debt cap should be at 30% of the overall cap (15%/50%). Having the subcategories as a percentage of the overall cap allows the subcategories to adjust automatically as the overall cap adjusts up and down.

Schedule 1 Considerations

ACLI supports the streamlining of Schedule 1, however, we want to ensure that regulators have the detail they need for entities that are not already included in the GCC via the parent insurer’s RBC. Our recommendation would be to treat immaterial non-insurance/non-financial entities on Schedule Y of an RBC-filing US insurer like non-financial BA and A entities and create a place for them to be included in the GCC.
identified on Input 6. That way, while they are not listed on Schedule 1, they would continue to receive the same treatment as under the parent insurer’s RBC.

**Non-Risk Sensitive Jurisdictions**

ACLI members have varying perspectives on this issue. Some are comfortable with lowering the risk-charge for non-risk sensitive jurisdictions from 100% to 50%. Others believe that to uphold credibility in the GCC, non-risk sensitive jurisdictions should apply an RBC-type charge in the GCC or default to a 100% factor absent any other information. To move materially away from a 100% factor should require analysis and an explanation for why a different factor, in this case 50%, is more appropriate. They do agree with the proposed alteration to allow groups to calculate the insurer’s capital requirement using RBC, with simplifications, if that is preferable to the 100% risk charge approach.

There is potentially room for a compromise on this issue, where the 50% factor is maintained in the GCC Trial Implementation Instructions, but it is clearly labeled as an interim factor until more thorough analysis can be done on the appropriate factor(s) for non-risk-based jurisdictions. Some key items of the GCC are yet to be finalized and/or may change over time, such as scalars and calibration levels. The non-risk-based jurisdiction factors could be added to that list.

**Conclusion**

Thank you for the opportunity to comment. We look forward to continuing to support the efforts of the Working Group and staff as work continues on other GCC elements, like scalar methodology. As always, we would be happy to discuss our comments, or any other issue, with you or your staff at your convenience.

Many thanks,

Kristin Abbott
Group Capital Calculation (E) Working Group – Staff Memo of Proposed Changes to the GCC as a Result of Trial Implementation

Dear Mr. Daveline:

On behalf of AHIP’s member plans, we welcome the opportunity to comment on the Staff Memo of Proposed Changes to the GCC as a Result of Trial Implementation (Staff Memo). Our comments follow and are arranged by the topics captioned in the Staff Memo:

Template Changes

1. Eliminate Stress Scenario – AHIP agrees with Staff Memo’s proposal to eliminate the stress scenarios in the template. Should the working group consider adding those scenarios back to the template later (which is stated as a possibility in the Staff Memo), we would expect that to be subject to another exposure process at that time and that we would again have an opportunity to comment.

2. Debt Allowance – The Staff Memo proposes that the debt allowance currently provided in the GCC Instructions be allowed to increase 10% from the prior year, but only during a period where the Federal Reserve has taken a public position of reducing the cost of borrowing through reducing interest rates either by lowering the Federal Funds rates or by purchasing debt instruments; the 10% increase would then be reversed once the Federal Reserve has taken action to reverse its trend. AHIP is concerned that the proposed 10% decrement in capital when the Federal Reserve reverses its action could have the same systemic impacts of triggers based on rating agency downgrades as was experienced during the financial crisis. The Financial Analysis Handbook guidance that was recently adopted on the use of the GCC suggests that regulatory analysts focus on year-over-year GCC consistency to identify red flags that would trigger a deeper level of regulatory review of the GCC, both of capital resources and of calculated capital. The subject proposal could trigger unintended "red flags" and a deeper regulator review based solely on the toggling of the debt allowance, rather than an underlying economic cause impacting the group. As new debt is issued or debt retired, the true capital picture may thus be clouded by change to the debt allowance. Therefore, AHIP does not support the proposed changes to the debt allowance presented in the Staff Memo.
Schedule 1 Related Questions/Considerations – Relating to "non-insurance/non-financial entities" and "not material/excluded entities," AHIP prefers the current template structure, which has all Schedule Y entities listed in Schedule 1. Including all entities in Schedule 1 provides better controls to ensure completeness and accuracy. Members report that the control process becomes more complicated if they have multiple lists of entities in different places, and especially if entities move from one list to another.

* * * * *

We thank you again for the opportunity to comment and for your patience and consideration of our views. We look forward to discussing them with you further.

Sincerely,

Bob Ridgeway  
Bridgeway@ahip.org  
501-333-2621

Cc: Tom Finnell
Restructuring Mechanisms (E) Working Group
Virtual Meeting
March 28, 2022

The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met March 28, 2022. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair, Matt Gendron, and Jack Broccoli (RI); Andrew Schallhorn, Co-Chair (OK); Mel Anderson (AR); Rolf Kaumann (CO); Kathy Belfi and Jared Kosky (CT); Judy Mottar and Vincent Tsang (IL); Judy Weaver (MI); Fred Andersen (MN); John Rehagen (MO); Lindsay Crawford (NE); Bob Kasinow (NY); Jeffrey Smith (PA); Amy Garcia (TX); Doug Stolte and David Smith (VA); Steve Drutz (WA); and Amy Malm (WI). Also participating was: Bob Wake (ME).

1. Heard Introductory Comments

Superintendent Dwyer stated that it had been some time since the Working Group last met, noting that in December, the Working Group met and discussed a significant number of comments; i.e., over 300 pages of materials. She noted that since that time, NAIC staff reviewed those comments, making changes where they deemed appropriate; then, both co-chairs and their staff began reviewing and developing further changes to address the comments. She stated that Mr. Gendron is on her staff and has done excellent work in wading through all those pages and making suggestions as to changes to the white paper as a result. Both co-chair commissioners then reviewed it, and now the co-chairs are ready for the Working Group to discuss.

2. Adopted a Referral to the Receivership and Insolvency (E) Task Force

Superintendent Dwyer noted that during the Working Group’s discussions, one area that has drawn a lot of strong opinions was in the area of guaranty fund coverage and the need for a policyholder to retain such coverage. She summarized a draft referral letter to the Receivership and Insolvency (E) Task Force that draws upon a recommendation from the National Conference of Insurance Guaranty Funds (NCIGF) made during its most recent comments to the Working Group. She described how the referral envisions that the Task Force would expose a Request for NAIC Model Law Development form taken from the recommendation from the NCIGF, discuss and debate the comments, and hopefully submit a response to the Working Group before the Summer National Meeting on the referral and related Request for NAIC Model Law Development form (Attachment Three-A). Barbara F. Cox (NCIGF) stated that the NCIGF supports the referral and is most eager for the work on the model law amendment to begin that would protect policyholders in this situation. Mr. Wake asked if the intent was to get a rubber stamp on the language included in the Request for NAIC Model Law Development form or whether editing could occur. Superintendent Dwyer responded that there could be some wordsmithing, some likely gaps, or improvements, but the intent is not to tie the hands of the Task Force in any way. Ms. Malm made a motion, seconded by Mr. Drutz, to adopt the referral letter (Attachment Three-B) and distribute it to the Task Force along with the Request for NAIC Model Law Development form. The motion passed unanimously.

3. Discussed Feedback from White Paper Comments

Superintendent Dwyer referred participants on the call to a listing of topics prepared by Mr. Gendron, which is broken up into two lists, one that requires further Working Group discussion and another where there is a desire for the industry and others to provide more suggestions in terms of language to address previous comments (Attachment Three-C). The first list—i.e., items labeled starting with the letter A—represent areas where further Working Group discussion is needed. The second list—i.e., items labeled starting with the letter B—represent
comments where it is not clear how the comment should be addressed in the white paper. In short, the Working Group needs some extra help and is open to anybody who wants to send in a comment letter.

a. **Comment A1**

Mr. Wake noted that he could develop potential language for the Working Group to consider that addresses the previous comment from him. However, he requested clarification on whether the intent was actual best practices that are being recommended to the states or places that are just being provided with an overview. Ms. Weaver asked if some of this guidance will go into the *Financial Analysis Handbook* or if it is just part of developing an overview with more specifics developed later. Mr. Gendron responded that to a certain extent, an overview is being developed; although, the Restructuring Mechanisms (E) Subgroup that is chaired by Virginia is coming up with specific financial best practices. He added that whether those standards developed later become accreditation standards is also part of the charges given to the Working Group, but it would be premature to consider those until after the best practices are developed and finalized. Mr. Rehagen noted that his preference would highlight that there are a lot of unanswered questions and concerns that still exist.

b. **Comment A2**

Mr. Wake noted that he seemed to recall that the white paper suggested that a state insurance regulator does not need as high of a standard of review on a corporate division (CD) as an insurance business transfer (IBT), and he questioned that premise. He said he could develop potential language for the Working Group to consider that addresses the previous comment from him.

c. **Comment A3**

Mr. Gendron stated that the next comment pertains to the principles developed by the American Council of Life Insurers (ACLI), which the white paper catalogues. He stated that he believes the ACLI suggested that its best practices be adopted as recommendations, which he believes is a decision to be made by the Working Group. Wayne Mehlham (ACLI) agreed that the ACLI would like its principles adopted as recommendations. Mr. Kosky stated that Connecticut is opposed to the ACLI principle that requires an independent expert. He suggested that such use should be at the discretion of the commissioner for several reasons. Mr. David Smith asked if any decision on making the independence a requirement could be held until the Subgroup discusses and decides on the matter. He noted that the Subgroup’s proposed best practices and foundational principles document will be coming out shortly and asked if that decision could be deferred for the Subgroup.

d. **Comment A4**

Superintendent Dwyer discussed how this issue is likely one that would require a referral to another NAIC group to develop changes to the *Protected Cell Company Model Act* (#290).

e. **Comment A5**

Mr. David Smith noted that he is not sure if this is something that the Subgroup is looking at. He noted that there may be some crossover with statutory accounting where all companies are required to follow. He said to that point, it does not distinguish between an IBT and a CD, and he believes Virginia tries to look for other issues. Mr. Gendron noted that he believes if the Subgroup is focused on the rules of the road for both types, regardless of type, this comment should be addressed, as that is the point of the comment.
f. **Comment A6**

Mr. Gendron noted that he believes the next comment is likely another one that is consistent with what Ms. Weaver noted earlier. To the extent that the Subgroup develops best practices, it will likely have addressed this comment; then, the suggested accreditation requirements can be developed as a recommendation after the procedures to be used by all states are developed.

g. **Comment A7**

Andy Vetter (Northwestern Mutual) stated that as one of the companies signing the comment letter, Northwestern Mutual is looking for a pathway to uniformity on what should be just baseline requirements for jurisdictions that permit these transactions, including not allowing for long-term care (LTC) insurers. Superintendent Dwyer asked if there is a desire to make a statement that would be a standard that long-term cannot be included. Mr. Andersen responded that he would prefer if such a statement is not made, noting that he does not want to completely shut the door, especially with something that might otherwise just slip through a single state. However, he noted that he wants to keep things open for something at the national level if developed. Superintendent Dwyer asked about adding language such as, “The Restructuring Mechanisms (E) Working Group strongly discourages states from entertaining the use of IBT or CD transactions involving long-term care insurance, but if a state does consider, they should bring to a particular NAIC group or a national group for their consideration of some type of national solution, before doing so.” Mr. Rehagen agreed with this language and noted at least taking such action with all the states in which the policyholders for the LTC carrier reside. Mr. Tsang noted that there are two ways of looking at such a transaction, one in which the long-term care insurance (LTCI) business is transferred and another where all the non-LTCI business is transferred. Superintendent Dwyer asked NAIC staff to develop language for possible inclusion in the white paper after review by Rhode Island and Oklahoma. Mr. Rehagen also asked that the domestic state of the insurer consider all the states having to receive notice and approve, as well as all the policyholders, which perhaps could become some type of accreditation standard.

h. **Comment A8**

Mr. David Smith stated that while there may be some of the issues identified in this comment that are not covered by the work of the Subgroup, he believes most of them are. He suggested that the Working Group see what the Subgroup develops, then revisit the matter after that.

i. **Comment A9**

Mr. Gendron suggested that the Working Group add language similar to what was suggested by the National Workers Compensation Reinsurance Association (NWCRA), which suggests that states coordinate with the NWCRA after transactions are paid by the resulting insurer.

j. **Comment B1**

Mr. Gendron requested input from other attorneys and interested parties that may have access to a fuller source of some of these decisions in the public sector and the public domain. Comments can come from any party.

k. **Comment B2**

Superintendent Dwyer recommended that this section be modified as recommended by Mr. Wake by starting with the conclusive action by the court. Mr. Gendron stated that he found a companion case to this case in one
of the Channel Islands, and it is going through a similar time period, but he requested assistance from someone more familiar with the non-U.S. laws and legal research.

i. Comment B3

Superintendent Dwyer stated that the comment from Mr. Wake suggested that the introduction of IBTs in the white paper be followed by a description of CDs that are at a similar level, and then a comparison between IBTs and CDs. She noted that it is natural that the co-chairs have more knowledge on IBTs and that someone with a similar knowledge of CDs offers suggestions to address this point. Mr. Kosky indicated that he could assist in drafting language for this section, but he suggested that since they Working Group had not yet approved of such a transaction, it might also be helpful to have another state add more color into what it develops that has reviewed a transaction. Superintendent Dwyer stated that she hopes Illinois can assist with that additional color added.

m. Comment B4

Mr. Gendron noted that this item is similar to comment B3, and he expects that the need for additional language from a CD is the same.

n. Comment B5

Mr. Gendron stated that he is open to adding language to address this point, and he asked that if Virginia wants to offer some language, he could take it from there. Mr. Stolte noted that he believes the redline version does a good job of addressing the Virginia issue, but the one thing that is not clear is that the anti-novation statute is not just applicable to assumption reinsurance, but all transactions. He added that the Virginia State Corporation Commission (SCC) would most likely never subject itself to another state jurisdiction since Virginia is a court of record. He added that with respect to the Yosemite transaction, Virginia would hold the insurer accountable for non-compliance with the Virginia Statute, and Virginia does not have a specific suggestion developed yet. He stated that what is needed is an accreditation mandate, with a model law or regulation that has uniformity. He noted that what was at issue is about transferring the fundamental insurance promise from one legal entity to another legal entity. He noted Virginia is not opposed to IBT or CD laws, but it believes a model law or regulation is needed. He summarized that he believes the issue calls for a model law and model regulation that becomes an accreditation standard. Superintendent Dwyer asked if there is a better title for incorporating the Virginia points through a new section label. Mr. Stolte responded that he simply referred to the law as anti-novation. Mr. Wake suggested that consent requirements might be the better terminology. Mr. Stolte responded that that is what the statute requires. Mr. Rehagen noted that a section is still needed for other states with assumption reinsurance statutes. Mr. Wake suggested that it could read, “assumption reinsurance model and other acts that limit notations without the affirmative consent of the policyholder”. Superintendent Dwyer indicated that the Working Group would reword it with a similar thought in mind.

o. Comment B6

Superintendent Dwyer noted that this was an issue raised by Mr. Wake. Mr. Gendron noted that Mr. Wake provided a lot of good comments, and only a small number of them were not incorporated. Mr. Gendron requested language to address this particular one of only a few where language had not been developed to address this.
p. **Comment B7**

Mr. Gendron noted that Mr. Wake raised a good question about whether recourse is possible under the United Kingdom (UK) law, and a bankruptcy citation was included. He noted that since he is not an expert, he requires assistance.

q. **Comment B8**

Mr. Gendron noted that he tried to address this issue but questioned if it could be better clarified by those with more expertise in this area, and he requested assistance.

r. **Comment B9**

Mr. Gendron stated that several comments were received about adverse consequences to policyholders of long duration products, and while he tried to address this comment, he noted that he was not sure he did the topic justice; therefore, he requested assistance.

Superintendent Dwyer asked if exposing the comments for a 30-day public comment period would be a sufficient time period for individuals to review and develop revised language for the list just reviewed. Ms. Weaver agreed with the 30-day comment period. Mr. Gendron said that would likely allow the Working Group to synthesize something in about a month and a half and then have a call in about two weeks. Superintendent Dwyer stated that comments would be due April 29. NAIC staff were asked to: 1) post the listing of topics discussed on the call as a means to solicit feedback and language; and 2) post the original December 2021 call materials for which the page numbers are used as a reference point in the listing of items that require additional feedback.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☐ New Model Law       or      ☑ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:
   Restructuring Mechanisms (E) Working Group

2. NAIC staff support contact information:
   Dan Daveline
ddaveline@naic.org
   816-783-8134

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.
   • Property and Casualty Insurance Guaranty Association Model Act (#540)

   In 2019, the Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group who was charged with the following:

   1. Evaluate and prepare a white paper that:
      a. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
      b. Summarizes the existing state restructuring statutes.
      c. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
      d. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
      e. Identifies and addresses the legal issues associated with restructuring using a protected cell.

   Background for Proposed Change
   This proposed change is being precipitated by discussions within the NAICs Restructuring Mechanisms (E) Working Group initiative, which is focused on documenting in the form of a White Paper, the various issues related to insurance business transfers (IBT) and corporate division (CD) transactions. The number of states adopting laws that permit either of these transactions is still relatively low, however one of the most significant issues that has been discussed during the meetings of the Working Group is the need for policyholders of such transactions to retain guaranty fund coverage. Representatives of the National Conference of Insurance Guaranty Funds (NCIGF) have suggested that an amendment to a state’s guaranty fund act, or other related law is necessary to address this issue. They have specifically suggested that the NAIC update the Property and Casualty Insurance Guaranty Association Model Act to incorporate specific language they have developed to address this issue. This will better enable those states that have incorporated #540 into their laws to update their laws for this important issue. This change is needed to ensure policyholders in all states retain their coverage, which is necessary regardless of how few states adopt changes to their laws to allow IBT and CD transactions.

   Scope of the Proposed Revisions to Model 540

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The scope of the request is limited to addressing the issue of guaranty fund coverage and as a result would be limited to specific suggestion of additional language within the definition of “Covered Claim” within #540. The following is the additional language (underlined language) that is being proposed to be added to Section 5, Definitions, within #540.

H. “Covered claim” means the following:

   (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or

   (b) The claim is a first party claim for damage to property with a permanent location in this State.

   (c) Notwithstanding any other provision in this Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as “Division” or “Insurance Business Transfer” statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.

   (d) An insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection (a) shall not be considered to have been issued by a member insurer for the purposes of this Act.

4. Does the model law meet the Model Law Criteria? ☑ Yes or ☐ No (Check one)

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☑ Yes or ☐ No (Check one)

      If yes, please explain why:

      This proposed change is needed to ensure policyholders in all states retain their guaranty fund coverage, which is necessary regardless of how few states adopted changes to their laws to allow IBT and CD transactions.

      It should be noted that with respect to guaranty fund coverage for life and health insurance, the National Organization of Life and Health Insurance Guaranty Associations are suggesting a different approach in addressing the same issue which centers around the need for such transaction to require the assuming or resulting insurer to be licensed in all states where the issuing insurer was licensed or ever was licensed to retain the needed coverage for policyholders.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law? ☑ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   ☑ 1   ☐ 2   ☐ 3   ☐ 4   ☐ 5 (Check one)

   High Likelihood          Low Likelihood
Explanation, if necessary:

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5  

High Likelihood Low Likelihood

Explanation, if necessary: See previous discussion.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5  

High Likelihood Low Likelihood

Explanation, if necessary:
At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

Not referenced in Accreditation Standards.

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
MEMORANDUM

TO: Receivership and Insolvency (E) Task Force

FROM: Restructuring Mechanisms (E) Working Group

DATE: March 28, 2022

RE: Referral Regarding Potential Change to NAIC Model

The NAIC formed the Restructuring Mechanisms (E) Working Group because of recent changes to state laws in the areas of Insurance Business Transfer (IBT) and Corporate Divisions (CD). The Working Group is in the process of drafting a white paper that, among other things, documents the issues the statutes are designed to address and some of the legal issues. Specific to that point, during public discussions, the Working Group received input from both the National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on how policyholders can retain guaranty fund coverage after such a transaction. The following summarizes such input, which is further explained at the end of this memorandum.

NCIGF – The NCIGF’s position is that where there was guaranty fund coverage before the IBT or CD, state insurance regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate, or in any way affect guaranty fund coverage. A CD or IBT should not create, expand, or in any way affect coverage. The NCIGF suggested that possible technical gaps may exist in states that have adopted the Property and Casualty Insurance Guaranty Association Model Act (#540) and proposed specific changes to the model to address.

NOLHGA – Described the three conditions that are needed for guaranty fund coverage after an IBT or CD. In general, restructuring statutes (or state insurance regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

To that end, attached is a Request for NAIC Model Law Development form, which sets forth proposed changes to Model #540, as suggested by the NCIGF. The Working Group is not the technical expert in this area, but it does support the intent of retaining guaranty fund coverage; therefore, the Working Group asks the Receivership and Insolvency (E) Task Force to review the attached and determine where
such changes could generally be supported. We are not trying to determine if this is the exact change to make to the model at this time, but rather whether the Task Force supports the project and would be willing to complete an update to the language if approved by the Financial Condition (E) Committee and the Executive (EX) Committee. To the extent possible, perhaps the Task Force could expose the attached Request for NAIC Model Law Development form, debate it, and return it to the Working Group prior to the Summer National Meeting, where the request could be made to the Financial Condition (E) Committee.

Please let the Working Group know if you have any questions.

The following is a more comprehensive summary of the positions of the NGIGF and the NOLHGA:

The Working Group received input from the NOLHGA about the concerns for insurance consumers of personal lines life and health insurance business. The NOLHGA indicated that for there to be guaranty association coverage in the event of a life or health insurer insolvency, there are three conditions that must be present. Those conditions are:

1. The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of the guaranty association’s state at the time of the insurer’s liquidation.

2. The product must be a covered policy.

3. The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can also be provided for an “orphan” policyholder of the insurer by the guaranty association in the insolvent insurer’s domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer is not a member insurer due to not being licensed at the time required by the Life and Health Insurance Guaranty Association Model Act (#520). The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed—i.e., is a member of the guaranty association—but subsequently moves to a state where the issuing insurance company was never licensed; i.e., is not a member of the guaranty association. The provision in Model #520, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer’s domestic state is designed to plug the gap in these rare situations.

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer is or will be a member insurer in each state. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed.
for all policyholders. Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency. If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or be covered as orphans by the guaranty association in the insurer’s domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to the domestic state guaranty association could result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to IBT and CD transactions involving life or health insurance, restructuring statutes (or state insurance regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

One interpretation of Model #540 is that based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction,” an orphan policyholder could not be covered by the state guarantee association. Consequently, there is a concern that no guaranty association coverage would be provided if policies are transferred to a nonmember insurer. Many property/casualty (P/C) guaranty fund statutes require that the policy be issued by the now-insolvent insurer, and it must have been licensed either at the time of issue or when the insured event occurred. However, these limitations are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an assessable policy later transferred to an insurer that was not a member at the time the policy was issued. Moreover, the restrictions exist to prevent claims resulting from a company regulated as surplus lines, or a similar structure, to benefit from the protections afforded licensed business when a licensed company is liquidated.

The NCIGF’s position is that where there was guaranty fund coverage before the IBT or CD, state insurance regulators should ensure there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate, or in any way affect guaranty fund coverage. A CD or IBT should not create, expand, or in any way affect coverage. The NCIGF suggested that possible technical gaps may exist in states that have adopted Model #540. These gaps could include the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claims Transaction” found in Section 5 of the model.

Fulfilling this intent will likely require that P/C guaranty fund statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. The NCIGF indicated that it created a subcommittee to address this issue and oversee a coordinated national effort to enact the necessary changes in each state. It should be noted that the same membership
and timing issues that are raised by IBTs could also be raised in the case of any other policy novation, including the assumption reinsurance transactions.
### Topics for WG to discuss:

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<thead>
<tr>
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<tbody>
<tr>
<td>A1</td>
<td>“How does this differ from Best Practices? If the intent is a two-tier recommendation, that’s awkward. “A good system will do X, but any system had better do Y.” Furthermore, if there’s going to be a two-tier system, the “best” should be more robust and detailed that the minimum, and we have the opposite here.”</td>
<td>Bob Wake 127</td>
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<td></td>
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<tr>
<td>A2</td>
<td>“With respect to intraholding company transactions, do we really need any lesser standard of review. If anything, an IBT to a nonrelated party might need fewer guardrails because the assuming company has its own interests to consider—but we have all seen transactions where the self-interest isn’t enough to prevent the assuming company from going down in flames and taking policyholder for the ride. Note that all CDs, by their nature are intra-group transactions at the time they’re consummated. And we have seen that both CDs and intra-group IBTs can seriously harm people who are left in the bad company.”</td>
<td>Bob Wake 128</td>
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<td>A3</td>
<td>Suggested “incorporation of the ACLI principles and guidelines into the White Paper”</td>
<td>ACLI 229</td>
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<tr>
<td>A4</td>
<td>Swiss Re suggests “an assessment of the use of protected cells in connection with an insurance business transfer”</td>
<td>Swiss Re 223</td>
</tr>
</tbody>
</table>
### ATTACHMENT 3C-DISCUSSION TOPICS.DOCX & ADDITIONAL CALLS FOR FEEDBACK

**RI Thought:** The Working Group has heard these comments from two commenters throughout the process. However, before adding it, we thought the Working Group itself should likely be polled to see if they’re open to addressing the issue as we understand that the use of protected cells have generated a substantial number of regulatory questions.

<table>
<thead>
<tr>
<th>A5</th>
<th>Statutory minimums (best practices) should have degree of parity between IBTs and CDs to prevent regulatory arbitrage.</th>
<th>Swiss Re</th>
<th>234</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RI Thought: The Working Group has heard these comments, but it seems like an issue the Working Group should discuss before adding this to the White Paper.</td>
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</table>

<table>
<thead>
<tr>
<th>A6</th>
<th>White Paper should recommend incorporation of all of the UKs Part VII standards and processes</th>
<th>NYL/W&amp;S/NW ML/MM</th>
<th>236-237</th>
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<tbody>
<tr>
<td></td>
<td><strong>RI Thoughts:</strong> This comment seems to tee up several steps that we thought the Working Group should consider:</td>
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<td></td>
<td>- Accreditation requirements of robust UK Part VII regulatory and court review process</td>
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<td></td>
<td>o Would require that this WG identify some best practices first, then refer those to F committee to consider as accreditation requirements.</td>
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<td></td>
<td>o <em>As a first step, is there any appetite at the WG to consider such a process?</em></td>
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<td>- UK process identified as including:</td>
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<td>o Independent Expert Report</td>
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<td></td>
<td>▪ ACLI then explains that even if Departments have sufficient staff, as a standard this would help protect consumers</td>
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<td></td>
<td>o Notice to all impacted policyholders</td>
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<td>o Court approval should be required</td>
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<td>o <em>Does the WG want to consider adding these 3 specific recommendations to the white paper as best practices?</em></td>
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<tr>
<th>A7</th>
<th>LTCI should be Ineligible for Division or Transfer</th>
<th>NYL/W&amp;S/NW ML/MM</th>
<th>238</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>RI Thought:</strong> We think this language could be added directly to the White Paper, but it seems like an issue the Working Group should discuss before adding this to the White Paper.</td>
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</tbody>
</table>
## ATTACHMENT 3C-DISCUSSION TOPICS.DOCX & ADDITIONAL CALLS FOR FEEDBACK

<table>
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<tr>
<th>A8</th>
<th>Study and report upon the financial standards to apply to RMs</th>
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<tbody>
<tr>
<td></td>
<td>a) Intragroup vs. third party transactions</td>
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<td></td>
<td>b) Comparison to procedures in law (Form A, dividends,</td>
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<td></td>
<td>reinsurance, affiliates, investment restrictions,</td>
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<tr>
<td></td>
<td>governance)</td>
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<td></td>
<td>c) Required longer-term projections, capital surcharges</td>
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<td></td>
<td>d) Definition and license of run-off insurers</td>
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<td></td>
<td>e) Reformulation of RBC or possible suspension of RBC for</td>
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<td></td>
<td>RMs through allowing chief insurance regulator latitude</td>
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<td></td>
<td>f) Study and develop a paper comparing differences between</td>
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<tr>
<td></td>
<td>Solvency II and U.S. solvency standards</td>
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<td></td>
<td>g) Regulatory principles currently being developed by</td>
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<td></td>
<td>subgroup</td>
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<td></td>
<td>h) Study and develop a paper on distinctions by line of</td>
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<td></td>
<td>business</td>
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<td></td>
<td>i) Guaranty association coverage</td>
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<td></td>
<td>j) Assumption reinsurance laws</td>
</tr>
<tr>
<td></td>
<td>k) Legal recognition of RMs</td>
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</table>

**RI Thought:** We think this language could be added directly to the White Paper, but it seems like an issue the Working Group should discuss before adding this to the White Paper. Alternatively, it could be addressed by the Subgroup through their efforts.

<table>
<thead>
<tr>
<th>A9</th>
<th>Add language to the White Paper that discusses the National Workers Compensation Reinsurance Association (NWCRA) NFP and the need for states to coordinate with it to ensure obligations after the transaction are paid by the resulting insurer</th>
</tr>
</thead>
</table>

**RI Thought:** We think this language could be added directly to the White Paper, but it seems like an issue the Working Group should discuss before adding this to the White Paper.

## II. Topics to solicit additional outside feedback:

<table>
<thead>
<tr>
<th>B1</th>
<th>Suggests “adding how many Part VII transfers failures” as a comparison to the 300 successfully cited transfers</th>
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</table>

**RI Thought:** We should solicit additional feedback from commenters to address this note.

<table>
<thead>
<tr>
<th>B2</th>
<th>Suggests rewriting “the Prudential/Rothesay section to address the issues, but make the outcome clear from the beginning. But what IS the outcome. The court of appeals didn’t actually approve the transfer, but remanded the case to the High Court to be heard by a different judge.”</th>
</tr>
</thead>
</table>

**RI Thought:** We should solicit additional feedback from commenters to address this note.
### ATTACHMENT 3C-DISCUSSION TOPICS.DOCX & ADDITIONAL CALLS FOR FEEDBACK

<table>
<thead>
<tr>
<th>RI Thought: We should solicit additional feedback from commenters to address this note.</th>
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<tr>
<td>Specifically, UK High Court eventually approved the transaction in November 2021, but we can’t identify an official UK decision.</td>
</tr>
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</table>

| B3 | “This doesn’t really fit here. The introduction to IBTs ought to be followed by a description of CDs that operates at a similar level, and then the comparison between IBTs and CDs, which is probably where the NCOIL Model goes—it can be included in the comparison with existing state law.” | Bob Wake | 118 |

| RI Thought: We added introductory language about Corporate Division states here, but should solicit additional feedback from commenters to address this note. |

| B4 | “Some of the material below needs to go above-there should be an introduction to the CD concept at about the same level of detail as the introduction to the IBT concept” | Bob Wake | 118 |

| RI Thought: We added language to address this comment, but don’t think we’ve done enough. Please offer specific language to assist the Working Group here. |

| B5 | “The question is whether a foreign state could prevent its own policyholders from being transferred without consent. This wouldn’t necessarily be limited to implicit conflicts with preexisting assumption laws—if a state explicitly sought to block or impose conditions on foreign IBTs affecting domestic business, which state prevails?” | Bob Wake | 123 |

| RI Thought: This is a critical question, but we’re not sure how to address it. Perhaps a commenter could propose language and conclusions for the Working Group to consider. |

| B6 | “As noted below, the doctrine of comity is separate from these two constitutional provisions...The whole section needs some editorial work.” | Bob Wake | 124 |

<p>| RI Thought: We added language to address this comment, but don’t think we’ve done enough. Please offer specific language to assist the Working Group here. |</p>
<table>
<thead>
<tr>
<th>ATTACHMENT 3C-DISCUSION TOPICS.DOCX &amp; ADDITIONAL CALLS FOR FEEDBACK</th>
</tr>
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<tr>
<td><strong>B7</strong></td>
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<tr>
<td>RI Thought: We should solicit additional feedback from commenters to address this note.</td>
</tr>
<tr>
<td><strong>B8</strong></td>
</tr>
<tr>
<td>RI Thought: We added language to address this comment in Section 4B, but don’t think we’ve done enough. Please offer specific language to assist the Working Group here.</td>
</tr>
<tr>
<td><strong>B9</strong></td>
</tr>
<tr>
<td>RI Thought: We added language to address this comment, but don’t think we’ve done enough. Please offer specific language to assist the Working Group here.</td>
</tr>
</tbody>
</table>
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met March 9, 2022. The following Working Group members participated: Jay Buschmann Co-Chair (MO); Cameron Piatt, Co-Chair (OH); Cindy Hathaway (CO); William Mitchell (CT); Alisa Pritchard (DE); Carolyn Morgan and Alison Sterett (FL); Stewart Guerin and Mike Boutwell (LA); Kari Leonard (MT); Karen Feather (PA); Amy Garcia (TX); Jay Sueoka (UT); Ron Pastuch (WA); Amy Malm (WI); and Linda Johnson (WY).

1. **Heard Opening Remarks**

Mr. Piatt provided a summary of his involvement with the Working group and announced his position as co-chair. He added that Debbie Doggett (MO) could not attend today’s meeting due to scheduling conflicts.

2. **Tabled Proposal 2021-07 (Instructions Regarding Company Responses)**

Mr. Piatt said the proposal for company response to state inquiries has been tabled. During discussions on a regulator-only call, it was determined that states have processes or procedures in place on the timing of company responses. Hearing no objections, the Working Group tabled further discussion of proposal 2021-07.

3. **Heard an Update on the Domestic Surplus Lines Insurers Drafting Group**

Crystal Brown (NAIC) said the Working Group established the Domestic Surplus Lines Insurers Drafting Group to address a memo from the Chief Financial Regulator Forum for domestic surplus lines insurers (DSLI). The Drafting Group reviewed and provided responses to each question from the original memo in the response memo of Attachment 4 in the materials. The Drafting Group addressed these questions through discussion, surveys, and a review of each DSLI state’s statute/regulation.

Through the Drafting Group’s work, it developed the DSLI chart that provides insurers with the information needed to become a DSLI. Only states that allow for DSLI carriers are included on the chart. Most states utilize the Uniform Certificate of Authority Application (UCAA) primary application for the authorization of a DSLI. The chart provides the following information: 1) statute/regulation reference; 2) additional requirements; 3) board of director requirements; 4) minimum capital and surplus requirements; 5) requirements for existing admitted business fees; and 6) state website and contact information.

Ms. Garcia made a motion, seconded by Mr. Sueoka, to approve the responses to the Chief Financial Regulator Forum’s referral (Attachment Four-A). The motion passed unanimously.

4. **Heard an Update on the Biographical Affidavit Database Project**

Jane Barr (NAIC) said the bio database project will move forward effective April 1. During the development phase, industry and state insurance regulator user input is imperative to the development of the electronic application functionality. Ms. Barr mentioned that volunteers are needed for development and testing. Any interested users should email Ms. Barr directly. Ms. Barr added that the ad hoc group will resume its semi-monthly calls to complete the domestic corporate amendment application and instructions. Once the domestic corporate amendment application is completed, the ad hoc group will move on to the Form A application and Form E
notifications for development in 2023 with an implementation date sometime at the beginning of 2024. Next, the current expansion and foreign corporate amendment applications will be enhanced with new technology and developed on the new format by year-end 2024. During 2024, the ad hoc group will begin discussions on the biographical affidavit database. Input from affiants, industry, third-party vendors, and state users will be imperative to the success of this database. Ms. Barr stressed that volunteers are needed during the information gathering process and development of the electronic tool, and all interested parties should contact Ms. Barr.

5. Discussed Other Matters

Ms. Brown explained that an issue was brought to the attention of NAIC staff regarding individual affiants that held multiple board positions within a group; i.e., 50+. Attached in the materials are several templates that NAIC staff created that could be used in lieu of the blank addendum pages currently provided on the website. Jeff Martin (UnitedHealth Group—UHG) said the UHG has multiple affiants that hold numerous positions in their holding group that the UHG has used when submitting bios that he believes would work for other companies in a similar structure. The attached proposal removes the addendum pages and creates a separate attachment with options that would fit the scenario of the affiant. Ms. Barr added that this is just a temporary work around until the bio database is developed. Ms. Brown said one example allows for multiple positions listed for one company so multiple entries did not need to be created on the blank addendum page.

Gina Hudson (Liberty Mutual) said Liberty Mutual lists an attachment along with the cover letter because she believes the cover letter would include this information. Ms. Brown said the cover letter does not request all the pertinent information currently listed on the bio. Mr. Martin asked if the Working Group will consider creating a template for licenses and memberships. Ms. Barr suggested that any other examples should be emailed to NAIC staff by March 18, and those templates will be included in the current exposure with comments due by April 20.

Ms. Barr explained that the biographical database project timeline will move forward in 2022 with the following:

- Roll out of the primary and redomestication applications.
- The development and testing phase will take most of the second and third quarter with an anticipated release date by October or November. The Working Group may decide to release the application on Jan. 1, 2023, instead of late 2022.
- Next will be the domestic corporate amendment application in 2023 followed by the Form A and Form E.
- The Form A application will tie into the existing regulatory only Form A database, so testing may take longer; the anticipated release date may be year-end 2023.
- Then, the conversion of the current expansion and foreign state corporate amendment applications will be enhanced and follow the new format with a release date in early to mid-2024.
- Last will be the development of the biographical affidavit database; testing and development will include industry, third-party vendors, and state users.

Ms. Barr said the ad hoc group will work continuously throughout the year, and volunteers should specify which project they want to participate in. She added that it is anticipated that all states will move forward with the electronic application. Any questions should be directed to Ms. Barr.

The next Working Group meeting is tentatively set for mid-May.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
MEMORANDUM

TO: Judy Weaver (MI), facilitator of the Chief Financial Regulator Forum

FROM: National Treatment and Coordination (E) Working Group

DATE: March 21, 2022

RE: Authorization of Domestic Surplus Lines Insurers

On its August 26, 2020 call, the National Treatment and Coordination (E) Working Group received a referral from the Chief Financial Regulator Forum on how to best handle Domestic Surplus Lines Insurers (DSLIs). The Working Group established a drafting group made up of both National Treatment and Coordination (E) Working Group and Surplus Lines (C) Working Group members to address the referral through discussion and surveys to the DSLI states. The drafting group addressed the following questions and developed guidance as requested in the referral:

- How to handle active or runoff admitted market premium written within the state of domicile post-DSLI authorization;
  - Of the states that responded to the initial survey a majority indicated that active or runoff admitted market premium was not allowed after conversion to a DSLI. Companies must either:
    - allow for the admitted business to lapse or expire;
    - be removed from the company through novation, cancellation, non-renewal or some other mechanism approved by the Director or Commissioner;
    - be assumed by a direct writer; or
    - cease writing admitted business on a specific date and allow the admitted block to go into runoff.

- How to address a DSLI that requests authorization to write both admitted and nonadmitted premiums in the state of domicile (unless prohibited in the legislation);
  - Based on the drafting group’s review of each state’s statute and the survey, state’s do not allow a DSLI to carry admitted policies on their books.

- The best approach for an analyst or examiner to review and test a sample of admitted polices that were subsequently converted to the nonadmitted market for a newly authorized DSLI;
  - The drafting group did not find that any state’s allowed for admitted business to be converted to non-admitted business.

- An understanding as to whether a DSLI with admitted premiums would continue to be eligible for guaranty fund protection;
Based on the drafting group’s review of each state’s statute and the surveys, no states allow for DSLI carrier to carry admitted business on their books and non-admitted business is not eligible for guaranty fund coverage.

- The best way for the state department of insurance to disclose authorized DSLIs; and
  - Based on the survey results, many states report DSLI carriers on their state website. Carriers also report DSLI status on Schedule T.
- The best method to be assured that the insurer is accurately reporting DSLI status, on its Schedule T, for its state of domicile.
  - The Annual Statement Instructions provide a DSLI status for those entities that are a DSLI.

The drafting group utilized the information obtained through their review of the state statutes and survey responses to develop a chart regarding the requirements for becoming a new DSLI carrier or converting from an admitted carrier to a DSLI. The chart was referred to the Working Group for review and posting to the UCAA webpage.

If you have any questions regarding the information outlined or guidance proposed, please contact NAIC staff: Jane Barr or Crystal Brown.

Cc: Debbie Doggett, Cameron Piatt NTC(E)WG co-chairs; NAIC staff support: Jane Barr, Crystal Brown and Andy Daleo
To:        Commissioner Scott White (VA), Chair, Financial Condition (E) Committee

From:     Richard Kohan (NC), Chair, Mortgage Guaranty Insurance (E) Working Group

Date:     March 7, 2022

Re:       Updated Request for Extension

The Mortgage Guaranty Insurance (E) Working Group is in the process of fulfilling its charge to update the Mortgage Guaranty Insurance Model Act (Model #630). The Working Group anticipated completion of its Charge by the 2022 Spring National Meeting. As Chair, I would like to update that request to the Financial Condition (E) Committee in accordance with NAIC procedures.

As background, the NAIC engaged Milliman to assist the Working Group in developing a Mortgage Guaranty Insurance Capital Model that will become part of the new capital standard for mortgage insurers. Subsequent to discussion at the 2019 Fall National Meeting, the Working Group exposed the Draft Mortgage Guaranty Insurance Capital Model, Mortgage Guaranty Insurance Model Act (#630), Mortgage Guaranty Insurance Standards Manual, and a proposed Mortgage Guaranty Insurance Exhibit. In 2021, the Working Group finalized the Mortgage Guaranty Insurance Exhibit that was integrated into the 2021 financial statement. The data for year-end 2021 will be provided by April 1, 2022 and will require a thorough analysis. After the data is analyzed, I anticipate reconvening the Working Group to continue our work Model #630.

At this time, we believe we can complete this work by the 2023 Spring National Meeting. The request for additional time is to allow the necessary time to address comments regarding the above referenced documents and ensure that a comprehensive regulatory framework is in place to effectively regulate these complex insurance entities. We are aware that we have been unable to complete our work within the one-year time period expected under the NAIC model law process and request an extension until the 2023 Spring National Meeting in order to finalize a product that can be adopted by the domestic states of the mortgage insurers, as well as any other state also wishing to adopt the same.
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The Accounting Practices and Procedures (E) Task Force met in Kansas City, MO, April 5, 2022. The following Task Force members participated: Cassie Brown, Chair, represented by Jamie Walker (TX); Mike Causey, Vice Chair, represented by Jackie Obusek (NC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sheila Travis and Blasé Abreo (AL); Alan McClain represented by Leo Liu (AR); Ricardo Lara represented by Kim Hudson and Susan Bernard (CA); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by N. Kevin Brown (DC); Trinidad Navarro, represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen represented by Carrie Mears and Daniel Mathis (IA); Dean L. Cameron represented by Amber Re (ID); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by John Turchi (MA); Pending represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicoloopoulos represented by Pat Gosselin (NH); Marlene Caride represented by David Wolf (NJ); Russell Toal represented by Beatrice Geckler (NM); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Dale Braggman (OH); Michael Humphreys represented by Melissa Greiner and Matt Milford (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Carter Lawrence represented by Trey Hancock (TN); Jon Pike represented by Jake Garn (UT); Scott A. White represented by David Smith, Doug Stolte and Greg Chew (VA); Michael S. Pieciak represented by Dan Petterson and Karen Ducharme (VT); Mike Kreidler represented by Steve Drutz (WA); Nathan Houdek represented by Amy Malm (WI); Allan L. McVey represented by Jamie Taylor (WV); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted its 2021 Fall National Meeting Minutes**


Mr. Braggman provided the report of the Statutory Accounting Principles (E) Working Group, which met April 4 to adopt its March 2, 2022; Jan. 27, 2022; and 2021 Fall National Meeting minutes. During its March 2, 2022, meeting, the Working Group exposed agenda item 2019-21: Proposed Bond Definition, a revised principle-based bond definition, and a draft issue paper for a public comment period ending May 6. In addition, the motion directed NAIC staff to continue discussions with industry on the bond definition and develop proposed reporting changes and potential statutory accounting revisions for subsequent exposure. Mr. Braggman stated that during its Jan. 27, 2022, meeting, the Working Group adopted two clarifications to statutory accounting principles (SAP), which were effective for year-end 2021 reporting. Agenda item 2021-31 reflects clarifications to life and health reinsurance disclosures and placement in the auditor report. Agenda item 2021-18 revisions remove reference to the “standard scenario” in Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees to ensure consistency with VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

Mr. Braggman stated that the Working Group adopted the following clarifications to statutory accounting guidance:
A. **SSAP No. 22R—Leases:** Revisions reject *Accounting Standards Update (ASU) 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments* for statutory accounting. (Ref #2021-29)

B. **SSAP No. 43R—Loan-Backed and Structured Securities:** Revisions reflect updated NAIC designation and designation category guidance adopted by the Valuation of Securities (E) Task Force to the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). (Ref #2021-23)

C. **SSAP No. 68—Business Combinations and Goodwill:** Revisions reject *ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events* for statutory accounting. (Ref #2021-28)

D. **SSAP No. 72—Surplus and Quasi-Reorganizations:** Revisions reject *ASU 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity's Own Equity (Subtopic 815-40)—Issuer's Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options* for statutory accounting while incorporating guidance on how to account for changes in fair values for written call options. (Ref #2021-27)

E. Adopted editorial revisions to update various terminology references of “substantive” and “nonsubstantive” to reflect “new SAP concept” and “SAP clarification.” Mr. Bruggeman noted that this completes the referral from the Financial Condition (E) Committee. (Ref #2021-26EP)

F. **Appendix D—Nonapplicable GAAP Pronouncements:** Revisions reject *ASU 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants* as not applicable for statutory accounting. (Ref #2021-30)

G. **Agenda items resulting in blanks proposals without statutory revisions:**

   i. **Adopted an agenda item supporting supplemental reporting of subsidiary, controlled, and affiliated (SCA) entities investments reported in Schedule D, Part 6, Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Companies.** The supplemental data is consistent with *SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities* disclosure requirements and did not result in statutory revisions. The adoption reflects support for blanks proposal 2022-02 BWG sponsored by the Working Group. (Ref #2021-22)

   ii. **Adopted an agenda item proposing to add a new general interrogatory to require disclosure pertaining to cryptocurrencies directly held or permitted for the remittance of premiums.** This agenda item did not result in statutory revisions. However, adoption reflects support for the blanks proposal 2022-01BWG sponsored by the Working Group. (Ref #2021-24)

Mr. Bruggeman stated that the Working Group exposed the following SAP clarifications to statutory accounting guidance:

Presentation, which identifies factors to consider when deciding how items should be displayed on the financial statements; and 2) Concepts Statement No. 8, Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements, which updates the definitions of an asset and a liability. The Working Group exposed two issue papers for historical documentation of these SAP clarifications. (Ref #2022-01)

B. SSAP No. 22R: Revisions reject ASU 2021-09, Leases (Topic 842), Discount Rate for Lessees That Are Not Public Business Entities for statutory accounting. (Ref #2022-05)

C. SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items: Revisions incorporate certain disclosures from ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance of terms and provisions of assistance received. (Ref #2022-04)

D. SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 43R: Revisions clarify the identification and reporting requirements for affiliated transactions and incorporate new reporting codes in the investment schedules to identify investments held that involve related parties. The new reporting requirements will identify investments acquired through, or in, related parties, regardless of if they meet the definition of an affiliate. (Ref #2021-21)

E. SSAP No. 47—Uninsured Plans and SSAP No. 68: Revisions reject ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers for statutory accounting. Revisions in SSAP No. 68 also note that the intent is not to modify any U.S. generally accepted accounting principles (GAAP) requirement for the determination of U.S. GAAP book value. (Ref #2022-07)

F. SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies: Revisions propose to either eliminate the audited U.S. tax basis equity valuation exception or clarify that the U.S. tax basis equity audit shall occur at the investee level. (Ref #2022-02)

G. SSAP No. 86—Derivatives: Revisions propose: 1) a new Exhibit A, which will replace both Exhibit A and Exhibit B of SSAP No. 86 that adopts with modification U.S. GAAP guidance in determining hedge effectiveness; and 2) revised measurement methods for excluded components in hedging instruments. The Working Group directed NAIC staff to continue to work with industry representatives on other elements within ASU 2017-12: Derivatives and Hedging: Targeted Improvements to Accounting for Hedging Activities. (Ref #2021-20)

H. SSAP No. 104R—Share-Based Payments: Revisions incorporate the practical expedient from ASU 2021-07, Compensation – Stock Compensation (Topic 718), Determining the Current Price of an Underlying Share for Equity-Classified Share-Based Awards for the current price input, a required component for option-pricing models used in determining fair value for share-based payments. (Ref #2022-06)

I. Interpretation (INT) 22-01: Freddie Mac When-Issued K-Deal (WI Trust) Certificates: A tentative interpretation to clarify that investments in the Freddie Mac “When Issued K-Deal” (WI) Program are in scope of SSAP No. 43R. (Ref #2022-08)

J. Blanks Proposal: Exposed an agenda item that expressed support for a blanks proposal with instructional changes to Schedule T, the State Page, and Accident and Health Policy Experience Exhibit (AHPEE) to clarify guidance for premium adjustments. The instructions clarify that all premium adjustments, including but not limited to federal Affordable Care Act (ACA) premium adjustments related to the risk adjustment program, shall be allocated as premium in the respective jurisdiction. This agenda item does not result in statutory revisions. (Ref #2022-03)
Mr. Bruggeman said the comment period for items exposed during the April 4 meeting—agenda items 2021-21, 2022-03, and 2022-08—is May 6 to allow for consideration of adoption during a meeting anticipated for May. He stated that the comment deadline for all other exposure items is June 3.

Mr. Bruggeman stated that the Working Group reviewed comments and directed NAIC staff on the Bond Proposal Project regarding potential reporting options to revise Schedule D, Part 1: Long-Term Bonds. The update included preliminary responses to certain aspects of those comments. He noted that the Working Group directed NAIC staff to proceed with developing a more robust illustration of proposed reporting revisions for subsequent exposure. (Ref #2019-21)

Mr. Bruggeman stated that the Working Group reviewed comments and directed NAIC staff on SSAP No. 22R on prior exposed revisions intending to clarify that in any scenario in which a lease terminates early, all remaining leasehold improvements shall be immediately expensed. He stated the Working Group directed NAIC staff to continue to work with interested parties to refine the guidance for subsequent consideration. (Ref #2021-25)

Mr. Bruggeman stated that the Working Group received updates on the following items:

A. Heard an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.

B. Received an update on the Working Group referral of agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in companies applying the retroactive reinsurance exception, which allows certain contracts to be reported prospectively. The Casualty Actuarial and Statistical (C) Task Force discussed this item on March 8. The Task Force directed and formed a small group to further work on this, including drafting instructional revisions to Schedule P – Analysis of Losses and Loss Expenses.

C. Received an update that the Working Group and the Valuation of Securities (E) Task Force both received a comment letter from the American Council of Life Insurers (ACLI) regarding a proposed amendment to the P&P Manual to permit unguaranteed and unrated subsidiary obligors in working capital finance investment (WCFI) transactions. As the Working Group does not have an exposure on this topic, the Working Group noted receipt but does not plan to address comments at this time; the comment letter will be included in the Valuation of Securities (E) Task Force minutes.

Mr. Bruggeman made a motion, seconded by Ms. Weaver to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.


Ms. Gosselin provided the report of the Blanks (E) Working Group, which met March 29, 2022, and took the following action:

Ms. Gosselin stated that the Working Group adopted its Nov. 16, 2021, minutes, (see NAIC Proceedings – Fall 2021, Accounting Practices and Procedures (E) Task Force, Attachment Two) which included the following action:

A. Adopted proposal 2021-14BWG – Expand the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. Modify the instructions so they will be uniform between life/fraternal and property.

B. Adopted its editorial listing.

C. Approved the State Filing Checklists content.
D. Rejected proposal 2021-11BWG requesting to add a new annual statement supplement to the Property/Casualty (P/C) statement to capture exposure data for Annual Statement Lines 4, 19.1, 19.2, and 21.2 of the Exhibit of Premiums and Losses.

E. Deferred proposal 2021-13BWG which adds a new supplement to capture premium and loss data for Annual Statement Lines 17.1, 17.2, and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business for a public comment period ending March 4.

F. Exposed seven new proposals for a public comment period ending March 4.

Ms. Gosselin stated that the Working Group adopted its editorial listing and the following proposals:

A. 2021-15BWG – Add a footnote to Exhibit 7 in the Life/Fraternal statement and the Health statement (Life Supplement) to capture the amount of Federal Home Loan Bank (FHLB) funding agreements reported in Columns 1 through 6 of the exhibit (2021-16 SAPWG).

B. 2021-16BWG Modified – For Note 9 – Income Taxes, remove the 9C illustration instructions for the deferred tax asset (DTA) and deferred tax liability (DTL) components, which state, “reporting entities should disclose those items included as ‘Other’ (Lines 2a13, 2e4, 3a5, and 3b3) as additional lines for those items greater than 5% in the printed/PDF filing document,” as the illustration is not set up to accommodate variable lines. Add formulas for calculation of total and subtotal on the illustration for 9C. For Note 15 – Leases, modify the illustrations to add a “Thereafter” line and add a formula for the “Total” line.

C. 2021-17BWG Modified – Modify the Analysis of Operations by Lines of Business in the Health Blank to include all of health lines of business included in the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health. Add instructions for the new columns and adjust the column references. Add the Health Blank Analysis of Operations by Lines of Business as a supplement to the Life/Fraternal blank with the appropriate instructions and crosschecks. Add crosscheck to the Health Blank Analysis of Operations by Lines of Business to the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health instructions.

D. 2021-19BWG Modified – Add columns and lines to U&I (Parts 1, 2, 2A, 2B, and 2D) and the Exhibit of Premiums, Enrollment and Utilization in the annual statement to bring the lines of business reporting in line with Life/Fraternal and Property. Add columns and lines to the Exhibit of Premiums, Enrollment and Utilization and U&I Analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made.

E. 2021-20BWG Modified – Starting at Line 72 of the Life/Fraternal Five-Year Historical, add or delete lines that do not capture the specific lines of business reported on the Life/Fraternal Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and accident and health (A&H) for Line 33 of those pages.

F. 2021-21BWG Modified – Add instruction to the Investment Schedules General Instructions to exclude non-rated residual tranches or interests from being reported as bonds on Schedule D, Part 1, and add lines to Schedule BA for the reporting of those investments (2021-15 SAPWG).

G. 2021-23BWG Modified – Add a line category for Residual Tranches or Interests in the Asset Valuation Reserve Equity and Other Invested Asset Component blank, and renumber lines below the addition. Modify instructions as appropriate for the added lines.
Ms. Gosselin stated that the Working Group re-exposed proposal 2021-22BWG Modified – Add a new reporting requirement in the investment schedules for investment transactions with related parties. In addition to capturing direct loans in related parties, it will also capture information involving securitizations (or other similar investments) where the related party is a sponsor/originator along with whether the underlying investment is in a related party.

Ms. Gosselin stated that the Working Group deferred proposal 2021-18BWG – Modify the Life Insurance (State Page) to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Two new Schedule T style pages (Exhibit of Claims Settled During the Current Year and Policy Exhibit) are created to include detail captured by state on the existing Life Insurance (State Page) that could not be included due to limited space. Add definitions for life and annuity products to the lines of business definitions in the health appendix.

Ms. Gosselin stated that the Working Group exposed 11 new proposals for a public comment period ending April 25.

Ms. Gosselin stated that the Working Group received the year-end disclosure memorandum from the Statutory Accounting Principles (E) Working Group.

Ms. Gosselin made a motion, seconded by Ms. Orth, to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/Financial Condition (E) Committee/Accounting Practices and Procedures (E) TF/minutes/APPTF 4-5-22 minutes.docx
1. **Adopted its March 2, 2022; Jan. 27, 2022; and 2021 Fall National Meeting Minutes**

   The Working Group met March 2, 2022; Jan. 27, 2022; and Dec. 11, 2021. During these meetings, the Working Group took the following action: 1) exposed a revised principles-based bond definition and related issue paper; and 2) received comments on items previously exposed for a public comment period ending Jan. 14, 2022.

   The Working Group also met March 31, 2022, and Feb. 28, 2022, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to: 1) discuss its Spring National Meeting agenda; and 2) receive information on the bond project development.

   Ms. Walker made a motion, seconded by Ms. Bernard, to adopt the Working Group’s March 2, 2022 (Attachment One-A), Jan. 27, 2022 (Attachment One-B), and Dec. 11, 2021 (see NAIC Proceedings – Fall 2021, Accounting Practices and Procedures (E) Task Force, Attachment One) minutes. The motion passed unanimously.

2. **Adopted Non-Contested Positions**

   The Working Group held a public hearing to review comments (Attachment One-C) on previously exposed items.

   Ms. Malm made a motion, seconded by Mr. Hudson, to adopt the statutory accounting principle (SAP) clarifications, detailed below as non-contested statutory accounting revisions. The motion passed unanimously.

   a. **Agenda Item 2021-24**

      Mr. Bruggeman directed the Working Group to agenda item 2021-24: Cryptocurrency General Interrogatory (Attachment One-D). Jake Stultz (NAIC) stated that this agenda item proposed a new general interrogatory within the annual reporting blanks specific to the use or acceptance of cryptocurrencies. The general interrogatory will capture whether cryptocurrencies are held, identification of which schedules cryptocurrencies held are reported, and whether cryptocurrencies are accepted for the payment of premiums. Mr. Stultz stated that while the agenda item did not propose statutory revisions, adoption will express support for the corresponding Blanks (E) Working Group’s proposal (2022-01BWG), which adds the new general interrogatory to the annual statement for year-end 2022 reporting.
b. **Agenda Item 2021-28**

Mr. Bruggeman directed the Working Group to agenda item 2021-28: ASU 2021-03, Intangibles – Goodwill and Other (Attachment One-E). Jim Pinegar (NAIC) stated that this agenda item reviews Accounting Standards Update (ASU) 2021-03, Intangibles – Goodwill and Other – Accounting Alternative for Evaluating Triggering Events. He stated that ASU 2021-03 provides private companies and not-for-profit entities with an optional accounting alternative for the performance of a goodwill impairment triggering evaluation. The amendments allow for the assessment of goodwill impairment at the end of a reporting period. Mr. Pinegar stated that the statutory accounting authoritative guidance regarding impairment is in Interpretation (INT) 06-07: Definition of Phrase “Other Than Temporary,” and this guidance does not permit the delay of an impairment assessment until a reporting period. He stated that since ASU 2021-03 provided guidance contrary to INT 06-07, this agenda item proposes SAP clarifications in Statement of Statutory Accounting Principles (SSAP) No. 68—Business Combinations and Goodwill to reject ASU 2021-03 for statutory accounting.

c. **Agenda Item 2021-29**

Mr. Bruggeman directed the Working Group to agenda item 2021-29: ASU 2021-05, Variable Lease Payments (Attachment One-F). Mr. Stultz stated that this agenda item reviews ASU 2021-05, Leases (Topic 842): Lessors—Certain Leases with Variable Lease Payments and applies to lessors with lease contracts that have variable lease payments that do not depend on a reference index or rate and/or would have resulted in the lessor being required to recognize a day one selling loss at lease commencement if those leases were classified as sales-type or direct financing lease. He stated that as SSAP No. 22R—Leases requires nearly all leases to be treated as operating leases, adoption of this guidance would be redundant and unnecessary. Accordingly, this agenda item proposes SAP clarifications in SSAP No. 22R to reject ASU 2021-05 for statutory accounting.

d. **Agenda Item 2021-30**

Mr. Bruggeman directed the Working Group to agenda item 2021-30: ASU 2021-06, Amendments to SEC Paragraphs (Attachment One-G). Mr. Stultz stated that this agenda item reviews ASU 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants. He stated that ASU 2021-06 provides formatting and paragraph references applicable to U.S. Securities and Exchange Commission (SEC) registrants. This agenda item proposes SAP clarifications to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2021-06 as not applicable to statutory accounting.

3. **Reviewed Comments on Exposed Items – Minimal Discussion**

a. **Agenda Item 2021-23**

Mr. Bruggeman directed the Working Group to agenda item 2021-23: SSAP No. 43R – Financial Modeling – Updated Guidance. Mr. Pinegar stated that this agenda item reflects SAP clarifications to be consistent with the revised NAIC designation financial modeling guidance adopted on Oct. 20, 2021, by the Valuation of Securities (E) Task Force to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). He stated that while the P&P Manual provides the financial modeling process, when this guidance was first adopted, a summarized narrative was reflected in the Accounting Practices and Procedures Manual (AP&P Manual). With
revisions to the financial modeling guidance, and as designations are determined by the Valuation of Securities (E) Task Force, the Working Group exposed two alternatives for consideration, noting that both options refer to the P&P Manual for detailed financial modeling guidance. He stated that the first option retained summarized financial modeling guidance in SSAP No. 43R—Loan-Backed and Structured Securities, updated to reflect the revisions to the P&P Manual by the Task Force. The second option removed financial modeling guidance from SSAP No. 43R and referred users to the guidance in the P&P Manual. He stated that in response to feedback from interested parties, which recommended a minor edit and supported option one, NAIC staff recommended retaining the summarized financial modeling guidance in SSAP No. 43R updated for the recent Task Force revisions.

Mr. Bruggeman stated that this agenda item updates the summarized financial modeling guidance in SSAP No. 43R and that it is important to note that the P&P Manual provides the detailed financial modelling and the designation process, which is the responsibility of the Valuation of Securities (E) Task Force. He stated that the AP&P Manual takes precedence over the P&P Manual in the statutory hierarchy. However, he noted that the AP&P Manual defers to the detailed guidance in the P&P Manual for the financial modeling process and the resulting NAIC designation.

Ms. Weaver made a motion, seconded by Ms. Bernard, to adopt the exposed option one SAP clarification revisions, updating the financial modeling guidance summarized in SSAP No. 43R and incorporating a grammatical edit as proposed by interested parties. Along with the updated financial modeling summary, this guidance continues to refer users to the detailed financial modeling guidance in the P&P Manual (Attachment One-H). The motion passed unanimously.

b. Agenda Item 2021-26EP

Mr. Bruggeman directed the Working Group to agenda item 2021-26EP: Editorial Updates (Substantive vs. Nonsubstantive). Mr. Pinegar stated that this agenda item is in response to the Working Group’s adoption of agenda item 2021-14: Policy Statement Terminology Change – Substantive and Nonsubstantive, which modified the use of the terminology of “substantive” and “nonsubstantive” in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (Policy Statement). He stated that this agenda item proposed editorial revisions to the preamble, table of contents, summary of changes, and the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process. He stated that interested parties’ comments requested further clarification during the development process, specifically requesting effective dates for every adopted revision, regardless of if the revision was deemed to be an SAP clarification or a new SAP concept. He stated that this comment, similar to what was expressed during the 2021 Fall National Meeting, goes beyond the Financial Condition (E) Committee request to simply change the terminology references. This current agenda item only enacts editorial updates to reflect the previously adopted terminology changes, and if the editorial revisions were not adopted, there would be a disconnect between the Policy Statement and the terminology reflected in other sections of the AP&P Manual.

Ms. Walker made a motion, seconded by Mr. Kasinow to adopt the exposed SAP clarification editorial revisions to the preamble, table of contents, summary of changes, and the NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process (Attachment One-I). The motion passed unanimously.

c. Agenda Item 2021-27

Mr. Bruggeman directed the Working Group to agenda item 2021-27: ASU 2021-04, Issuer’s Accounting for Certain Modifications. Mr. Stultz stated that this agenda item reviews ASU 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and
Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40): Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options. He stated that ASU 2021-04 directs that when a freestanding equity-classified written call option is modified or exchanged and the instrument remains classified as equity after the modification/exchange, the differences in fair value before and after the modification are accounted for as an adjustment to equity. However, conversely, ASU 2021-04 directs that if the modification/exchange is related to a debt instrument or line-of-credit, the differences in fair value before and after the modification may be capitalized in accordance with U.S. generally accepted accounting principles (GAAP) debt issuance guidance, a concept disallowed under SSAP No. 15—Debt and Holding Company Obligations.

Mr. Stultz stated that while this agenda item proposes to reject ASU 2021-04 for statutory accounting, it also proposes SAP clarifications to SSAP No. 72—Surplus and Quasi-Reorganizations, incorporating minor updates related to the accounting for changes in fair value involving the exchange of free-standing equity-classified written call options. He stated that in response to interested parties’ comments, NAIC staff recommended additional clarifications in SSAP No. 72 to precisely identify what guidance from ASU 2021-04 was adopted or rejected.

Mr. Bruggeman stated that while the additional clarifications proposed by NAIC staff do reflect the request by interested parties, they do make the sentence regarding applicable rejections quite lengthy. However, the applicable guidance should be sufficiently clear. Rosemarie Albrizio (Equitable), representing interested parties, agreed with the additional clarifications as proposed by NAIC staff. She noted this is consistent with other such clarifications in the AP&P Manual.

Ms. Malm made a motion, seconded by Ms. Weaver, to adopt the exposed SAP clarifications to SSAP No. 72, while incorporating additional clarification edits to precisely identify what guidance from ASU 2021-04 was adopted or rejected. (Attachment One-J). The motion passed unanimously.

4. Reviewed Comments on Exposed Items
   a. Agenda Item 2019-21

Mr. Bruggeman directed the Working Group to agenda item 2019-21: SSAP No. 43R – Proposed Bond Definition (Reporting Options). Julie Gann (NAIC) stated that this agenda item is a continuation of the bond definition project. She stated that during the 2021 Fall National Meeting, the Working Group exposed two additional elements regarding the bond project for public comment. The first item was a revised draft bond definition with limited edits focusing on changing the terminology of a “sufficient credit enhancement” to a “substantive credit enhancement” and a discussion document on potential reporting changes for initial comment. She stated that the comments on the bond definition were previously considered, and an updated bond definition and issue paper were exposed March 2 for a public comment period ending May 6. She stated that the exposed reporting changes discussion document is the focus for this meeting, with the intent to consider industry comments and receive Working Group direction. She stated that it is anticipated that the bond project will result in significant reporting changes to improve transparency and granularity of investments and that all reporting entities should be aware that these reporting changes are being discussed.

Ms. Gann stated that while there is not an exposure planned for this meeting, it was requested that the Working Group direct NAIC staff to work with state insurance regulators and industry in developing proposed reporting changes and SSAP edits for subsequent exposure. She stated that after considering interested parties’ comment letters, NAIC staff are planning not to proceed with edits on the following industry requests. However, state insurance regulator feedback is requested if consideration of these changes should occur:

- Interested parties recommended moving items in scope of SSAP No. 41—Surplus Notes from Schedule BA: Other Long-Term Invested Assets to Schedule D-1: Long-Term Bonds. Ms. Gann stated that as these
instruments have special characteristics and are not required to be reported with an NAIC designation, she does not believe state insurance regulators will support moving these items to Schedule D-1 and does not anticipate the proposed revisions to Schedule D-1 will include proposed reporting of surplus notes.

- Interested parties requested clarification on the use of a sub-schedule for Schedule D-1. She stated that the intent for a sub-schedule was to identify asset-backed securities (ABS) that qualify for bond reporting, but are financial asset-backed, but not self-liquidating (e.g., equity backed items), or that are not financial-asset backed and that do not meet the practical expedient for determining meaningful generation of cash flows. State insurance regulators wish to have the ability to identify these investments quickly and stated that a sub-schedule may be the preferred method for clear identification. Ms. Gann stated that when proposed reporting changes are drafted, that will likely assist in the understanding and use of the proposed sub-schedule.

- Interested parties requested that affiliate reporting be accomplished using an electronic column, rather than the current process of using an affiliate reporting line. Ms. Gann stated that NAIC staff believe regulators wish to continue the current process of utilizing separate reporting lines.

Ms. Gann stated that depending on the feedback from the Working Group, it is anticipated that a discussion document for possible reporting changes will be exposed by the Summer National Meeting. Mr. Bruggeman stated that NAIC staff will also draft revisions for SSAP No. 26R—Bonds and SSAP No. 43R to incorporate the principle-based bond definition into authoritative statutory guidance.

Tip Tipton (Thrivent), representing interested parties, stated that they appreciate the Working Group’s ongoing collaboration as they deem this will likely be one of the most significant reporting changes in recent years. He stated that interested parties look forward to continuing discussions so that they can get clarity on what is a sub-schedule, and what reporting columns and lines are required to meet the needs of state insurance regulators. Mr. Bruggeman stated that he believes the sub-schedule is required as the additional reporting elements (columns) do not fit within the existing reporting framework. He stated that the sub-schedule’s totals will still be reported as bonds, and state insurance regulators will be cognizant of reporting limitations of insurers. However, the use of the sub-schedule will be beneficial to the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group as its review these items for additional risk-based capital granularity.

Mr. Bruggeman, on behalf of the Working Group, directed NAIC staff to continue working with state insurance regulators and interested parties in developing potential reporting changes for bond investments. This discussion will include the development of illustrations and reporting instructions.

b. Agenda Item 2021-20

Mr. Bruggeman directed the Working Group to agenda item 2021-20: Effective Derivatives – ASU 2017-12. Ms. Gann stated that this agenda item was drafted to consider revising SSAP No. 86—Derivatives to mirror effective hedging determinations permitted in ASU 2017-12, Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities. While ASU 2017-12 was previously reviewed, the review was limited in scope and only adopted updates for hedging documentation, noting that a broader review would occur at a later date. Ms. Gann stated that both state insurance regulators and industry representatives requested further consideration of ASU 2017-12, particularly with regards to derivative arrangements that U.S. GAAP allow to qualify as an effective hedge. She stated that in general, NAIC staff believe that if a hedging relationship is considered to be effective under U.S. GAAP, it should also be considered effective for statutory accounting. However, differences in the valuation between U.S. GAAP and statutory accounting need to be reviewed before
those new effective hedging relationships are permitted to ensure the financial statement reporting and derivative impact is defined and understood. Ms. Gann stated since this item’s original exposure, NAIC staff have continued discussion with industry representatives. She stated that although industry has proposed revisions to SSAP No. 86 as part of their comment letter, NAIC staff are recommending exposure of two documents, which are more detailed than the industry proposed edits. She summarized the proposed revisions as follows:

- A new SSAP No. 86, Exhibit A, which is proposed to replace both of the existing SSAP No. 86, Exhibits A and B. This updated exhibit proposes adoption with modification of the overall U.S. GAAP guidance for determining hedge effectiveness even though not all paragraphs are proposed to be captured within the exhibit. The proposed modification would exclude U.S. GAAP guidance for the measurement of the hedging instruments, including excluded components of those instruments. This exclusion is required as statutory accounting has specific accounting and reporting guidance that differs from U.S. GAAP.

- Proposed SSAP revisions to incorporate new measurement guidance for different types of excluded components. As identified by industry, there are current inconsistencies in SSAP No. 86 for excluded components. While the proposed measurement methods vary by excluded component, the proposed accounting and reporting is consistent with the overall recommendations from industry. The proposed edits are more robust than what industry proposed to ensure that the measurement methods are clearly defined and with more detailed disclosures to allow state insurance regulators the ability to identify and assess the impact of any excluded component in the financial statements.

Mr. Bruggeman stated that review of this ASU is welcome as insurers have historically had differences in the assessment of hedge effectiveness for U.S. GAAP versus statutory accounting. He stated he was aware of instances where insurers would purchase supplemental derivative instruments to eliminate statutory surplus volatility of their original hedging instruments. This practice causes an insurer to incur excess costs that is likely not necessary.

Ms. Albrizio, representing interested parties, stated that they appreciate the collaborative efforts on this topic and support exposure of the proposed documents.

Ms. Walker made a motion, seconded by Ms. Bernard, to expose revisions to SSAP No. 86, which include: 1) a revised Exhibit A, which will replace Exhibit A and Exhibit B; and 2) proposed measurement guidance for excluded components. The motion passed unanimously.

c. Agenda Item 2021-21

Mr. Bruggeman directed the Working Group to agenda item 2021-21: Related Party Reporting. Mr. Stultz stated that this agenda item was drafted in response to recent discussions on the reporting and disclosure requirements for investments that involve related parties. He stated that the agenda item revised SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 43R to clarify related party and affiliate guidance, as well as to require new reporting information for investments that are acquired from a related party, regardless of whether the investment is captured on the affiliate reporting line. He stated that interested parties’ comments recommended additional clarifying language on the presumption of control, as well as modifications to the proposed annual statement instructions, and NAIC staff have incorporated limited changes in the proposal for exposure consideration.

Mr. Stultz stated that in response to interested parties’ comments, this agenda item does not intend to make any changes to items currently reported as affiliated transactions. He stated that the clarification is intended to be consistent with the definition of an affiliate pursuant to the Insurance Holding Company System Regulatory Act
(#440), SSAP No. 25, and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities. He stated that although the definition is consistently referenced, there is inconsistency in practice regarding the interpretation of what is required to be reflected on the affiliate reporting line. Pursuant to comments from interested parties, actual credit exposure should be present to report an investment on the affiliate reporting line. However, this interpretation is contrary to the preferences of some state insurance regulators who are expecting investment transactions with affiliates to be reported as affiliated transactions. Although there are no revisions proposed to change existing guidance for how affiliated investments are reported, it was noted that the expansion of the use of affiliates in structuring and procuring investment products has resulted with an increase in affiliated investment transactions in which there is no credit exposure to the actual affiliated entity, and state insurance regulators want to ensure that affiliated transactions are properly being disclosed to the domiciliary state. Mr. Stultz stated that interested parties also requested an effective date for 2023 year-end reporting. However, NAIC staff recommend a 2022 year-end effective date, as the reporting changes are in line with other state insurance regulators’ initiatives, including the Macroprudential (E) Working Group. In response to other interested parties’ comments, NAIC staff are recommending to also include additional clarifications that investments in exchange traded funds (ETFs) or mutual funds (as defined by the SEC) do not reflect ownership in an underlying entity, regardless of the ownership percentage the reporting entity holds, unless the mutual fund or ETF has the power to direct or cause direction of management of the underlying company. This additional revision is consistent with existing guidance in SSAP No. 97.

Angelica Tamayo-Sanchez (New York Life), representing interested parties, stated that it is important for the investment schedules to differentiate between investments that have true affiliated credit risk exposure from those that are simply managed/serviced by affiliates where the underlying assets of the investment structure do not have any credit risk exposure to affiliates and related parties. She stated that the investment codes being proposed would be beneficial to state insurance regulators for this identification and are supported by interested parties. Citing investments on Schedule D as an example, she stated that interested parties determine affiliated reporting based on the cash flows to service the underlying debt. In the case of debt service cash flow from an affiliate, those items would be reported as an affiliated transaction as the reporting entity is exposed to affiliated credit risk. However, this circumstance is very different from cases where an investment is managed by an affiliate, regardless of if the investment was originated by the affiliate. In these cases, interested parties do not believe these would be reported on the affiliated line as the cash flows do not originate from an affiliate, nor do they represent credit risk to an affiliated entity. She stated concern remains regarding state insurance regulator comments that affiliated transactions are reported as affiliated, regardless of any underlying credit exposure to an affiliate. However, the additional clarifications regarding the look through of ETFs and mutual funds are supported by interested parties. In terms of the look-through requirements, she stated that the requirement should be limited to private equity funds reported on Schedule BA. Additionally, while interested parties understand that there is a presumption of indirect control if an affiliated fund owns more than 10% of the voting shares of a corporation, they believe it would be rare for an investor that owns less than 50% of the voting stock of a corporation to have the ability to exercise control over the management and operations of such investee. Ms. Tamayo-Sanchez stated that while they understand that there is no desire by state insurance regulators to defer this requirement into 2023, the operational burden to insurers for year-end 2022 reporting will be significant.

Ms. Mears noted that she agrees that it was important to continue the discussions with industry on this topic to ensure that the reporting requirements were clear. Ms. Mears stated that she wants more industry feedback regarding cases with highly structured assets held primarily within a holding company group, especially when the underlying investments are not publicly available and there is no market validation of investment quality. She requested more input on the industry position on why such investments should not qualify for affiliate reporting, especially when these transactions either have previously been reported or should be reported to the domiciliary state pursuant to Model #440. She stated there is a differentiation between an affiliated transaction versus an
affiliated investment and that continued conversation should occur. She stated support for the additional reporting codes in the proposal, which will help identify related party involvement. Mr. Bruggeman stated he believes state insurance regulators still desire a 2022 reporting date and support efforts to achieve this objective.

Mr. Kasinow made a motion, seconded by Ms. Mears, to expose agenda item 2021-21, incorporating edits as proposed by NAIC staff for a 32-day public comment period ending May 6. The motion passed unanimously.

d. Agenda Item 2021-22

Mr. Bruggeman directed the Working Group to agenda item 2021-22: Schedule D-6-1, Supplemental Reporting. Mr. Pinegar stated that this agenda item proposed four additional data capture elements for Schedule D-6-1: Valuation of Shares of Subsidiary, Controlled or Affiliated Entities. He stated that the additional electronic-only columns will assist state insurance regulators in their review of subsidiary, controlled, and affiliated (SCA) filings, with a primary goal of helping identify filers who have repeated, identical adjustments year-after-year. He stated that in response to interested parties’ comments, the agenda details the current valuation communication process with the states and the respective filers, which includes details on the standard reporting templates and ongoing communication with the states of domicile. He noted that while this agenda item did not result in statutory revisions, adoption would express support for the corresponding Blanks (E) Working Group exposure (2022-02BWG). Mr. Bruggeman stated he believes this agenda item will further increase the efficiency of the SCA review process.

Ms. Walker made a motion, seconded by Ms. Gosselin, to adopt agenda item 2021-22, noting the agenda item did not result in statutory revisions (Attachment One-K). The motion passed unanimously.

e. Agenda Item 2021-25

Mr. Bruggeman directed the Working Group to agenda item 2021-25: Leasehold Improvements After Lease Termination. Mr. Stultz stated that this agenda item clarifies that when a lease terminates early, all remaining leasehold improvements shall be expensed, even if the leased asset is purchased. He stated that in response to interested parties’ comments, NAIC staff believe that if leasehold improvements are not expensed, items currently nonadmitted under SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements or SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities could ultimately be admitted under SSAP No. 40R—Real Estate Investments. Additionally, not all lease agreements include provisions for a purchase option at the time that the lease is signed, and in these situations, leasehold improvement assets should be expensed at the time the leased asset is purchased as almost all professional real estate companies would factor those leasehold improvements into the purchase price of the building. However, for lease agreements that include purchase options that discuss leasehold improvements, NAIC staff agree that these must be considered as part of the purchase of an asset that was part of a prior lease. He stated that NAIC staff recommended that the Working Group direct NAIC staff to work further with the interested parties in refining guidance for consideration. Ms. Albrizio stated that interested parties stand ready to assist with revised guidance for future consideration. Mr. Bruggeman agreed with the staff recommendation and directed NAIC staff to proceed accordingly.

5. Considered Maintenance Agenda – Pending Listing – Exposures

Ms. Mears made a motion, seconded by Ms. Travis, to move agenda items 2022-01 through 2022-08 to the active listing and expose all items for a public comment period. The motion passed unanimously.

Mr. Bruggeman stated that the public comment period for agenda items 2021-21, 2022-03 and 2022-08, is May 6. The comment deadline for all other exposure items is June 3.
a. **Agenda Item 2022-01**

Mr. Bruggeman directed the Working Group to agenda item 2022-01: Conceptual Framework – Updates. Mr. Pinegar stated that this agenda item reviews Financial Accounting Standards Board (FASB) Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 4, Elements of Financial Statements* (Chapter 4) and Concepts Statement No. 8, *Conceptual Framework for Financial Reporting—Chapter 7, Presentation* (Chapter 7) for their impact on statutory accounting. He stated Chapter 4 introduce revised definitions for the terms “asset” and “liability,” simplifying their definitional descriptions and redefining their essential characteristics. He stated that the historical definitions no longer include the term “probable” or the phrase “as the result of past transactions or events” citing rationale for their removal. He stated that as statutory accounting references these definitions, this agenda item proposed SAP clarifications to SSAP No. 4—Assets and Nonadmitted Assets and SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets to reflect the FASB’s updated definitions. He stated that in addition, NAIC staff recommended exposing two issue papers, each articulating the changes for SSAP No. 4 and SSAP No. 5R, FASB’s rationale for the changes, and discussion as to why the updates are proposed to be SAP clarifications in nature.

Mr. Pinegar stated the final topic reviewed Chapter 7 and proposed a minor SAP clarification to the Preamble, updating a paragraph reference to *Statement of Financial Accounting Concept 5*, which was superseded by Chapter 7. He stated that Chapter 7 describes what information should be included in the financial statements and how appropriate presentation can contribute to the objective of financial reporting. However, Chapter 7 concepts were not expected to modify current guidance, other than to update references to superseded accounting concepts.

b. **Agenda Item 2022-02**

Mr. Bruggeman directed the Working Group to agenda item 2022-02: SSAP No. 48 – Alternative Valuation of Minority Ownership Interests. Mr. Pinegar stated this agenda item reviews the audited U.S. tax equity financial statements U.S. GAAP audit exception provided in SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. He stated that this agenda item arose trying to address questions regarding at which level the audited U.S. tax basis should apply as there was ambiguity regarding if the insurer’s audit would suffice, or if the audit should reside at the investee level. He stated that informal comments from a member of the NAIC/American Institute of Certified Public Accountants’ (AICPA) (E) Working Group indicated they were not aware of anyone using the audited U.S. tax basis method, which is permitted as an exception if audited U.S. GAAP basis financial statements were not available. They further indicated that they were not aware of anyone issuing U.S. tax basis equity audits. This agenda item proposes two options for consideration. The first option seeks input as to whether the audited U.S. tax basis exception is being used and if not, whether it should be removed as a permissible exception to audited U.S. GAAP basis in SSAP No. 48. The second option proposes an SAP clarification that if the audited U.S. tax basis exception is retained, the audit is required at the investee (investment) level.

c. **Agenda Item 2022-03**

Mr. Bruggeman directed the Working Group to agenda item 2022-03: Premium Adjustment Allocated to Jurisdictions. Robin Marcotte (NAIC) stated that while this agenda item does not propose statutory revisions, it does propose blanks instructional changes to Schedule T, the State Page and Accident and Health Policy Experience Exhibit (AHPEE) to clarify guidance for premium adjustments. She stated that NAIC staff received inquiries regarding a minor number of entities that primarily wrote health business related to the federal Affordable Care Act (ACA), which are believed to have not properly allocated premium adjustments by jurisdiction on the statutory financial statement. The proposed instruction changes clarify that all premium adjustments (both increases and decreases), including but not limited to ACA premium adjustments related to the risk adjustment
program, shall be allocated as premium in the respective jurisdiction. This agenda item has a shortened comment period ending May 6.

d. Agenda Item 2022-04

Mr. Bruggeman directed the Working Group to agenda item 2022-04: ASU 2021-10, Government Assistance. Mr. Pinegar stated that this agenda item reviews ASU 2021-10, Government Assistance, Disclosures by Business Entities about Government Assistance, which increases transparency regarding certain types of government assistance by increasing the disclosure of such information in the financial statements. He stated that while ASU 2021-10 broadly defines government assistance, the disclosures are significantly reduced in scope as they would not apply to government transactions that are accounted for in accordance with other codification topics (e.g., accounted for as debt). He stated that due to the relative rarity of such disclosure, this agenda item proposed SAP clarifications to SSAP No. 24—Discontinued Operations and Unusual or Infrequent Items, incorporating certain disclosures from ASU 2021-10. The proposed additions will supplement existing disclosures to require that if the unusual or infrequent item is as the result of government assistance, the transaction will require identification, as well as a description of the terms and provisions of the assistance received.

e. Agenda Item 2022-05

Mr. Bruggeman directed the Working Group to agenda item 2022-05: ASU 2021-09, Leases, Discount Rate for Lessees. Mr. Stultz stated that this agenda item reviews ASU 2021-09, Leases (Topic 842), Discount Rate for Lessees That Are Not Public Business Entities, which states that when the rate implicit in the lease is readily determinable for any individual lease, that the lessee should use that rate (rather than a risk-free rate or an incremental borrowing rate), regardless of whether it has made the risk-free rate election. However, as statutory accounting generally requires all leases be classified as operating leases, this agenda item proposes SAP clarifications to reject ASU 2021-05 in SSAP No. 22R for statutory accounting.

f. Agenda Item 2022-06

Mr. Bruggeman directed the Working Group to agenda item 2022-06: ASU 2021-07, Compensation – Stock Compensation. Mr. Pinegar stated that this agenda item reviews ASU 2021-07, Compensation – Stock Compensation (Topic 718), Determining the Current Price of an Underlying Share for Equity-Classified Share-Based Awards which offers nonpublic companies a practical expedient to one of the several inputs necessary for option-priced modeling. He stated that when equity share options or similar instruments are granted in a share-based payment transaction, the fair value (which is used to determine expense recognition at inception and during any subsequent award modification) is estimated using an option-pricing model valuation technique. ASU 2021-07 provides a third practical expedient for nonpublic companies and is the third such practical expedient permitted, of which the two other practical expedients have previously been adopted and are currently permissible for use in SSAP No. 104R—Share-Based Payments. He stated that this agenda item proposes SAP clarifications to SSAP No. 104R to incorporate the new practical expedient for the current price input.

g. Agenda Item 2022-07

Mr. Bruggeman directed the Working Group to agenda item 2022-07: ASU 2021-08, Business Combinations. Mr. Pinegar stated that this agenda item reviews ASU 2021-08, Business Combinations, Accounting for Contract Assets and Contract Liabilities from Contracts with Customers, which requires acquiring entities to apply the revenue from contracts with customer standard (Topic 606), when valuing and recognizing contract related assets and liabilities in a business combination. Prior to the issuance of ASU 2021-08, acquirers would generally only recognize such items based on their fair values on the date of acquisition. He stated that in keeping with historical
precedent, this agenda item proposes SAP clarifications to reject ASU 2021-08 in SSAP No. 47—Uninsured Plans. However, as ASU 2021-08 is related to business combinations, the agenda item also proposes SAP clarifications to SSAP No. 68 to reject ASU 2021-08 for statutory accounting, while noting that rejection does not impact the determination of U.S. GAAP book value in an acquired entity.

h. Agenda Item 2022-08

Mr. Bruggeman directed the Working Group to agenda item 2022-08: INT 22-01T: Freddie Mac When-Issued K-Deal (WI Trust) Certificates. Ms. Gann stated that State Farm Mutual Automobile Insurance Company has sponsored this agenda item in collaboration with Freddie Mac requesting accounting and reporting clarification for Freddie Mac “When-Issued K-Deal (WI Trust) Certificates.” She stated that these certificates are akin to to-be-accounted (TBA) investments, in which certificate holders ultimately receive Freddie Mac guaranteed mortgage-backed securities. She stated that this program, in essence, creates an additional trust where the investor buys certificates in the “WI” trust, where then the WI trust uses the cash to purchase the mortgage securities from the real-estate mortgage investment conduit trust, who in turn purchases the mortgage securities directly from Freddie Mac. Upon conversion, the investor can take possession of the underlying mortgage securities or hold the trust certificates and receive the underlying mortgage security cashflows in a pass-through manner. In either event, the performance of the investment is guaranteed by Freddie Mac. The tentative statutory accounting interpretation clarifies that investments in the Freddie Mac WI Program shall be captured in scope of SSAP No. 43R from initial acquisition. This agenda item has a shortened comment period ending May 6.

6. Discussed Other Matters

a. Review of U.S. GAAP Exposure

Jason Farr (NAIC) stated that although there was one FASB exposure at the time the materials were published, its comment deadline of March 31 has passed. The proposed ASU would increase the disclosure regarding supplier finance programs. These programs allow a third-party financer to enter into the traditional buyer/supplier relationship, which effectively creates a structured payable agreement. NAIC staff recommend reviewing the final ASU under the SAP Maintenance Process as detailed in Appendix F—Policy Statements.

b. Referral to the Casualty Actuarial and Statistical (C) Task Force – Update

Ms. Marcotte stated that the Casualty Actuarial and Statistical (C) Task Force met March 8 to discuss a recommendation regarding the Working Group referral on agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in reporting for retroactive intercompany reinsurance contracts that meet the exception and allow for prospective reporting. She stated that the primary issue to address is whether to allocate premium back to prior years on annual statement Schedule P when multiple years of premium are ceded to a reinsurer. She stated that the Task Force plans to continue to work on this topic using a small group to draft proposed revisions to Schedule P instructions and other related guidance in SSAP No. 62R—Property and Casualty Reinsurance, specifically guidance in paragraph 36 and paragraph 37. NAIC staff were directed to continue working with the small group.

c. Comment Letter Received from the ACLI

Ms. Marcotte stated that the Working Group and the Valuation of Securities (E) Task Force received a comment letter from the American Council of Life Insurers (ACLI) regarding a proposed Task Force amendment to the P&P Manual to permit unguaranteed and unrated subsidiary obligors in working capital finance investment (WCFI) transactions. As the Working Group does not have an exposure on this topic, it noted receipt of the comments,
including the mention of the FASB exposure of proposed disclosures regarding supply chain finance programs. The Working Group does not plan to address the ACLI comments at this time (see NAIC Proceedings – Spring 2022, Valuation of Securities (E) Task Force, Attachment One and Attachment Two).

d.  **ASU 2016-13**

Ms. Gann stated that NAIC staff have received an inquiry regarding anticipated work related to **ASU 2016-13, Financial Instruments – Credit Losses (CECL)**. She stated that since its private company implementation is scheduled for enactment on Jan. 1, 2023, NAIC staff request input from industry representative on how CECL has affected their U.S. GAAP financial statements. Information on the U.S. GAAP impact may provide insight on how to approach the CECL standard for statutory accounting.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/2022 naic meetings/spring national meeting/committee meetings/financial condition (e) committee/accounting practices and procedures (e) tf/sapwg/sapwg minutes 4.4.22.docx
1. **Considered Maintenance Agenda – Active Listing**

   a. **Agenda Item 2019-21**

   Mr. Bruggeman directed the Working Group to agenda item 2019-21: Proposed Bond Definition. Julie Gann (NAIC) provided an overview of the project, stating that in May 2021, the Working Group exposed an original principles-based bond definition and affirmed the direction of the bond proposal after considering the comments in August 2021. Since that time, a small study group, representing state insurance regulators and interested parties have continued discussion and refinement of the principles-based bond definition. Ms. Gann stated that the purpose of holding today’s meeting is to consider exposure of a revised principles-based bond definition and draft issue paper. She stated that although limited edits are proposed to the proposed definition, the issue paper is detailed and intends to document the discussions that have occurred within the study group and the rationale supporting the various components of the bond definition. She stated that neither the proposed bond definition nor the issue paper would be considered authoritative. She stated that statement of statutory accounting principles (SSAP) revisions is not currently proposed as part of this exposure. She stated that with the specific deliberative process for this project, it is anticipated that comments on the issue paper and the revised definition would be considered prior to exposing proposed SSAP revisions.

   Ms. Gann then identified the various revisions to the principles-based bond definition:

   - Proposed revisions include explicit reference to U.S. Treasury Inflation-Protected Securities (TIPS) as an issuer credit obligation, which is in line with current guidance in SSAP No. 26R—Bonds. Ms. Gann stated that the inclusion of these securities was in response to another proposed edit, which clarifies the limitation for investments that have equity-driven results through a derivative or have an equity-based performance reference. With that clarification, U.S. TIPS, which are adjusted for inflation, could inadvertently be precluded from bond treatment.

   - Proposed revisions broaden the approach to identify investments that are in scope when repayment is fully supported by an underlying contractual obligation of a single operating entity that meets the bond definition. Rather than identify specific investments, the concept is included with examples of known investments. Ms. Gann stated that the guidance for “fully supported” was defined to require cash flows for repayment to cover 100% of interest and at least 95% of the principal, which is in line with the NAIC Securities Valuation Office (SVO) guidance related to credit tenant loans (CTLs).
• Proposed revisions delete the hybrid security reference as an explicit issuer credit obligation. This deletion does not intend to indicate that hybrid securities are prohibited from reporting on Schedule D-1—Long-Term Bonds; it only intends to clarify that such items shall be reviewed in accordance with the bond definition and only reported on Schedule D-1 if they qualify. Historically, a hybrid security was defined as a security with both debt and equity components, and a broad exception for such securities under the principles-based bond definition is not viable.

• Proposed revision includes specific identification of exchange-traded funds (ETFs) as issuer credit obligations if they qualify for bond treatment as identified in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Office). Ms. Gann stated that inclusion of these funds is not a change to the principle concepts, rather it has been added for clarification purposes.

• Proposed revision to clarify that an investment with the potential for “additional returns” must be assessed as if the “additional returns” are a component of the investment’s interest. This revision is to clarify that it is not permissible to have a “stated interest” and then the potential for “additional returns” and conclude that the investment does not have a variable interest based on underlying equity interests.

• Proposed revision to delete the stapling example from Appendix 1, which details situations where securities, despite their legal form, do not in substance represent a creditor relationship. This example originally precluded bond reporting for a qualifying debt tranche if the reporting entity was required to hold equity tranches from the securitization. However, after considering comments from the first exposure period, as well as discussions that occurred within the study group, this example has been eliminated. With this revision, tranches that separately qualify as bonds are permitted to be reported as bonds, and the other tranches would be reported as equity; however, holding both types of securities should not preclude bond reporting for any eligible components. Ms. Mears stated that the origination of this example was to recognize the fact that in some cases, if an insurance company owned both equity and debt components or were required to hold both components as “stapled investments,” they may not necessarily be in a different economic position than had they held the entire investment as an equity investment on Schedule BA—Other Long-Term Assets. However, she stated that the accounting for such an investment should entail the substance of the holding, not necessarily the underlying risk of an investment, which is captured within the purview of the Capital Adequacy (E) Task Force, not statutory accounting. In addition, if a company sold one of their investment components, with the current example, the remaining component could move investment schedules, which is also not a practical solution. Ms. Mears stated that this issue will be considered by the recently formed Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group, which will jointly review the substance and recommend RBC charges for these types of investments.

• Proposed revisions to the example for when a reporting entity invests in a debt instrument issued from a special purpose vehicle that owns underlying equity interests. Ms. Gann stated that the original example was designed to focus on characteristics of an investment that did not qualify as a bond; instead, the example has been revised to provide information to assist users in determining whether a structure could qualify for bond reporting. She stated that the example includes expanded factors to consider in determining whether the rebuttable presumption—i.e., the assumption that a debt instrument collateralized by equity interests does not qualify as a bond—has been overcome.

Ms. Gann stated that staff’s recommendation is to expose both the proposed revisions to the bond definition and the issue paper for public comment. After comments are received, the next steps would be to introduce possible statutory accounting revisions, likely using SSAP No. 26R as the standard for issuer credit obligations and SSAP No.
43R—**Loan-Backed and Structured Securities** as the standard for asset-backed securities (ABS). Ms. Gann stated that revisions are also anticipated for SSAP No. 2R—*Cash, Cash Equivalents, Drafts and Short-Term Investments* to clarify that ABS, due to their underlying nature of having a certain level of equity-backed cash flows, should not qualify for securities in the scope of SSAP No. 2R and SSAP No. 103R—*Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, as that standard currently refers all beneficial interests to SSAP No. 43R.

Ms. Gann stated that comments received from industry on potential reporting options is expected for the Spring National Meeting. However, as part of this exposure, input is requested regarding the reporting of investments that will not qualify as bonds. In addition to the reporting schedule, consideration will need to occur regarding measurement methods (e.g., amortized cost versus lower of cost or fair value). Accordingly, input regarding which approach is supported and what characteristics can be used to identify and support any preferred measurement method is requested during the exposure period.

Ms. Mears made a motion, seconded by Ms. Weaver, to expose the revised principles-based bond definition and draft issue paper for a public comment period ending May 6. In addition, the motion included a recommendation for NAIC staff to continue discussions on the bond definition and develop proposed reporting changes and potential statutory accounting revisions for a subsequent exposure. The motion passed unanimously.

2. **Discussed Other Matters**

Ms. Gann stated that the agenda for the Spring National Meeting has been posted on the NAIC website. The Working Group’s in-person public meeting is scheduled for Monday, April 4 from 9:45 a.m. to 12:00 p.m. CT. Ms. Gann stated that the meeting will have an audio-only option for those registered and not attending in person. Mr. Bruggeman stated that with the current schedule, regulator-only sessions are planned for immediately before and after the Working Group’s meeting, so the agendas will need to be efficiently discussed to allow attendees to move between meetings.

Mr. Bruggeman stated that in terms of the March 1 statutory filing deadline, the NAIC systems have been a bit delayed, so initial data runs may indicate a company has not filed when they have. It is anticipated that filings will be caught up in the next day, and state insurance regulators should be aware if they are looking for their domestic company filing results.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met Jan. 27, 2022. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Tom Hudson, Nicole Brittingham, and Rylynn Brown (DE); Cindy Andersen and Eric Moser (IL); Steward Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Reviewed Comments on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-B1) on previously exposed items.

a. Agenda Item 2021-18

Mr. Bruggeman directed the Working Group to agenda item 2021-18: SSAP No. 108 – VM-21 Scenario Consistency Update. Robin Marcotte (NAIC) stated that the Working Group previously received comments on the prior exposure and exposed additional statutory accounting principle (SAP) clarifications to Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees. The revisions exposed in December 2021 incorporated edits proposed by Life Actuarial (A) Task Force representatives and interested parties. The intent is to ensure consistency with revisions to VM-21, Requirements for Principle-Based Reserves for Variable Annuities. Ms. Marcotte stated that interested parties do not object to the exposed revisions. The Working Group also received additional informal comments from the Task Force that reorganized text within the document. The informal revisions proposed by a member of the Task Force were shared with interested parties prior to them submitting their comment letter, and the interested parties informally indicated that they do not object to the proposed edits. Ms. Marcotte stated that NAIC staff recommend that the Working Group adopt the exposed revisions classified as an SAP clarification incorporating the edits proposed. These revisions will have a Dec. 31, 2021, effective date so the Valuation Manual and Accounting Practices and Procedures Manual (AP&P Manual) will be synchronized.

Mike Monahan (American Council of Life Insurers—ACLI), representing interested parties, stated that they appreciate NAIC staff working to include the edits; they do not object to the changes and support moving forward with this agenda item.

Kim Hudson made a motion, seconded by Ms. Weaver, to adopt the exposed revisions to SSAP No. 108 with the edits presented by NAIC staff (Attachment One-B2), with an effective date of Dec. 31, 2021. The motion passed unanimously.

b. Agenda Item 2021-31

Mr. Bruggeman directed the Working Group to agenda item 2021-31: Life Reinsurance Disclosure Clarifications. Ms. Marcotte stated that this agenda item was exposed in December 2021 to address questions received from members of the American Institute of Certified Public Accountants’ (AICPA) NAIC Task Force regarding the life reinsurance disclosures and the related audited notes that were first effective in December 2020. The disclosures were adopted in SSAP No. 61R—Life, Deposit-Type and Health Reinsurance in agenda item 2017-28: Reinsurance
Risk Transfer for Short Duration Contracts. Preparers and auditors highlighted unclear elements in the disclosures that could use additional clarification. Comments were received from both interested parties and members of the AICPA NAIC Task Force. NAIC staff recommend that the Working Group adopt the exposed SAP clarifications with additional revisions that reflect the following: 1) revisions from the interested parties and the members of the AICPA NAIC Task Force as detailed in the comment letters; and 2) additional NAIC staff proposed edits to paragraph 78 that were developed in discussions with representatives from the AICPA NAIC Task Force. The edits were recommended to be added with a Dec. 31, 2021, effective date to assist preparers and auditors.

Ms. Marcotte summarized the revisions by paragraph. The main revisions in paragraph 78 addressed two issues. The first was the audit report location of the disclosures. The exposed revisions clarified that the information could be in the audited notes or the supplementary schedules. After discussions with members of the AICPA NAIC Task Force, it requested edits to clarify that the information resides in the supplementary schedules to the audited report, unless there are no such contracts subject to the disclosures identified, in which case the information that no such contracts were identified could be located in either the audited note or the supplementary schedule. Ms. Marcotte stated that the reason for this requested clarification was that the notes to the financial statement are subject to more review than the supplemental schedules. Clarification was requested as to whether the audited note in the supplemental schedules was required to be comparative. Comments noted that most supplemental schedules, including the one for similar reinsurance disclosures required by SSAP No. 62R—Property and Casualty Reinsurance, are not comparative and are only for contracts in effect during the current period covered by the statement. NAIC staff verified that the related property and casualty disclosures in the general interrogatories are focused on contracts in effect for the period covered by the statement. Therefore, NAIC staff drafted proposed revisions to further clarify that the audited note did not have to be comparative, meaning the inclusion of contracts in the prior years; i.e., it only needs to address current period contracts covered by the statement. Ms. Marcotte also discussed grammatical edits proposed by interested parties and the removal of a reference to assumed reinsurance contracts from paragraph 81. NAIC staff noted that the revision to paragraph 81 will make the life and health disclosure similar in scope to the related property and casualty disclosure, which addresses ceded contracts.

Mr. Bruggeman noted agreement with the revision to paragraph 81, as it made the text in the beginning of the paragraph consistent with the text of sub paragraphs a. and b. He also stated support for the clarifications, noting that the supplemental schedule is not required to be comparative.

Jean Connolly (PricewaterhouseCoopers LLP), chair of the AICPA NAIC Task Force, stated appreciation for NAIC staff and the Working Group’s assistance in working through the clarifications. She stated that the revisions were what was requested.

Steven Clayburn (ACLI) stated that interested parties were very appreciative of narrowing the scope of the disclosures, and they support the revisions discussed.

Ms. Malm made a motion, seconded by Mr. Smith, to adopt the exposed revisions to SSAP No. 61R on life reinsurance disclosures (Attachment One-B3), with the effective date of Dec. 31, 2021. The motion passed unanimously.

Ms. Marcotte stated that since the agenda items were adopted after year-end, which is the normal cutoff for edits to the AP&P Manual, the adopted revisions will be included in the updates section at the back of the 2021 and 2022 publication. Additionally, a guidance memo will be sent to the Blanks (E) Working Group for posting regarding the disclosures. Given the timing, NAIC staff will post the two adoptions on the Statutory Accounting Principles (E) Working Group’s web page on the documents tab. NAIC staff will also update the SSAP to annual statement disclosure checklists.

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Mr. Bruggeman inquired, and Julie Gann (NAIC) confirmed that a printed hard cover copy of the AP&P Manual is not an option for interested parties now. The NAIC is still working on having a printed copy as a potential option for state insurance regulators through a local printing vendor. Ms. Gann stated that industry representatives would need to acquire an electronic version of the AP&P Manual, which is accessed through Bookshelf.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

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January 14, 2022

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Comments on the Items Exposed for Comment during the Statutory Accounting Principles Working Group (the “Working Group”) Meeting on December 11, 2021 with Comments Due January 14, 2022

Dear Mr. Bruggeman:

Interested parties would like to thank the Statutory Accounting Principles Working Group (the “Working Group”) for the opportunity to comment on the items exposed for comment with comments due January 14th. We offer the following comments:

**Ref #2021-18: VM-21 Scenario Consistency Update**

The Working Group exposed revisions, to SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees, as illustrated in the proposal. The revisions, which incorporate edits proposed from Life Actuarial (A) Task Force representatives, ensure consistency with revisions to VM-21 by removing reference to the standard scenario while adding reference to the conditional tail expectation 70 guidance. This agenda item has a shortened exposure period, ending Jan. 14, 2022, so that the Working Group may consider adoption for year-end 2021 reporting.

Interested parties do not object to these changes.

**Ref #2021-31: Life Reinsurance Disclosure Clarifications**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 61R, as in the proposal. These revisions intend to clarify, and in some cases, narrow the scope of certain disclosures. This agenda item also has a shortened exposure period, ending Jan. 14, 2022, so that the Working Group may consider adoption for year-end 2021 reporting.
Interested parties appreciate the exposure to clarify and narrow the scope of information requested in the SSAP No. 61R disclosures, specifically to paragraphs 78-83. Our understanding is that the original intent of these additional disclosures was to obtain information on ceded reinsurance. We note that the reference to “ceding” in paragraphs 79 and 80 should be “ceded” as is written in paragraph 81. For paragraph 81, we would suggest deleting “assumed or” so that the scope of disclosure remains consistent from 2020 to 2021 (with the extraneous disclosures clarified).

* * * * *

If you have any questions or would like to discuss these comments, please do not hesitate to contact us

Sincerely,

D. Keith Bell          Rose Albrizio

cc: Interested parties

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To: The Statutory Accounting Principles (E) Working Group

From: Selected members of the American Institute of Certified Public Accountants’ (AICPA) NAIC Task Force

Date: January 14, 2022

Thanks again for considering the comments we submitted in 2021 related to these new disclosures and in developing the Form A. The AICPA NAIC Task Force has two additional comments that we would also appreciate that you consider:

1. Several of our members pointed out it might be confusing and/or lead to inconsistent practice to allow the disclosures to be included in either the footnotes or a supplemental schedule, because footnotes and supplemental information provide different levels of auditor assurance. Therefore, it would be unusual to have the option to include the disclosures in either place. As a result, we are recommending the following revisions below as "friendly amendments" to maintain the disclosures in a supplemental schedule, consistent with 2020. (This is also consistent with the intent of our comments last year.)

   78. Disclosures for paragraphs 79-84 are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020, regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall be in accompanying supplemental schedules or the notes of the annual audit report beginning in year-end 2020. If the disclosures are not applicable, an affirmative statement that no such contracts were identified is acceptable in the notes to the financial statements. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

2. On a related issue and assuming the Working Group agrees to the changes above in paragraph 78 of SSAP No. 61R, we would like to comment on SAPWG’s conclusion that the life reinsurance supplemental schedule should be comparative. The other required schedules to the financial statements do not require comparable information. (A list of the schedules is below.) For these schedules, the annual statement instructions set out the form and content of the schedules which reflects a one year presentation. It would be useful to understand why this schedule would be different and if that was the intent of SAPWG. Do you know whether the decision to make the disclosure comparable considered that the other required schedules are not required to be comparable? In either case, we would like to request that the guidance in SSAP 61R (or in the 2022 annual statement instructions) state whether the schedule should be comparative.

With regard to the conclusion in the minutes that indicates that the change would be done prospectively, this seems like an accommodation to prevent companies from having to fix prior years (which we don’t want to discourage), but there could be some complexity in reporting on a comparative schedule that is not comparable because the guidance changed (e.g., the basis for preparing the schedule is not comparative) and could lead to diversity in approach in how individual companies and auditors deal with reporting in the current year.
Below is a list of current supplemental schedules which are not comparative (i.e. only the current year is presented)

- Supplemental schedule of assets and liabilities
- Supplemental schedule of Investment Risk Interrogatories
- Summary Investment Schedule
- Supplemental P/C Reinsurance Contracts Disclosures

Thanks

Kim

Kim Kushmerick
Director, Accounting Standards — Public Accounting

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Issue: VM-21 Scenario Consistency Update

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

Modify: P/C: ☒ Life: ☒ Health: ☒

Description of Issue:
This agenda item provides a revision to Statement of Statutory Accounting Principles (SSAP) No. 108—Derivatives Hedging Variable Annuity Guarantees (SSAP No. 108) to ensure consistency with the Valuation Manual. This agenda item was developed in response to comments from an actuarial firm identifying an existing reference in SSAP No. 108 to the standard scenario in VM-21: Requirements for Principle-Based Reserves for Variable Annuities (VM-21). The Life Actuarial (A) Task Force NAIC staff support confirmed that the reference to the standard scenario has been deleted from VM-21.

VM-21 previously applied the standard scenario to all contracts in scope to generate the standard scenario amount. Revisions to VM-21 following the adoption of the Variable Annuity Framework resulted in the elimination of the standard scenario amount. Instead, VM-21 uses the prescribed projections amount, based on either the Company Specific Market Path (CSMP) or Conditional Tail Expectations (CTE) with Prescribed Assumptions (CTEPA). The CSMP and the CTEPA use random sets of scenarios to generate a CTE70 (adjusted) amount. This agenda item proposes using the VM-21 permitted approach that produces the CSMP or CTEPA scenario reserve closest to the CTE70 (adjusted) as the replacement for the standard scenario when determining the Macaulay duration in paragraph 14 of SSAP No. 108.

Existing Authoritative Literature:

SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees provides the following (bolding added for emphasis)

13. Fair value fluctuations in the measurement of outstanding (non-expired) derivatives within a highly effective hedging strategy shall be reflected as follows:
   a. Fair value fluctuations in the hedging instruments attributable to the hedged risk that offset the current period change in the designated portion of the VM-21 reserve liability7 shall be

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7 Hedge effectiveness is determined by comparing fair value fluctuations between the hedging instruments and the hedged item. However, in determining recognition in the financial statements, the fair value fluctuation of the hedging instruments is compared to the change in the reported value of the designated portion of the VM-21 liability. The designated portion of the VM-21 liability is not reported at fair value in the statutory financial statements, as such, the offset reported as realized gains and losses is the portion of the fair value change in hedging instruments offset by the change in the reported value of the designated portion of the VM-21 reserve. In accordance with the documented hedging strategy, reporting entities shall compare the fair value fluctuations to the change in the designated portion of the reserve liability, after considering recognized derivative returns (including recognized derivative income), when determining the recognition of fair value fluctuations.
recognized as a realized gain or loss.

b. Fair value fluctuations in the hedging instruments attributable to the hedged risk that do not offset the current period change in the designated portion of the VM-21 reserve liability shall be recognized as deferred assets (admitted) and deferred liabilities. The ability to recognize a deferred asset and deferred liability is limited to only the portion of the fair value fluctuation in the hedging instruments that is attributed to the hedged risk and does not immediately offset changes in the designated portion of the VM-21 reserve liability.

(Drafting Note subparagraphs 13.c. through 13.e. omitted to conserve space.)

14. Deferred assets and deferred liabilities recognized under paragraph 13.b. shall be amortized using a straight-line method into realized gains or realized losses over a finite amortization period. The amortization timeframe shall equal the Macaulay duration of the guarantee benefit cash flows based on the VM-21 Standard Scenario, but shall not exceed a period of 10 years.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 108, paragraph 14 as illustrated below. The revision will ensure consistency with VM-21 as it no longer references the standard scenario. With exposure, it is recommended that the Life Actuarial (A) Task Force receive notice of the exposure as part of the coordination process.

14. Deferred assets and deferred liabilities recognized under paragraph 13.b. shall be amortized using a straight-line method into realized gains or realized losses over a finite amortization period. The amortization timeframe shall equal the Macaulay duration of the guarantee benefit cash flows based on the VM-21 Standard Scenario adjusted run scenario that produces the scenario reserve closest to conditional tail expectation (CTE) 70 (adjusted), but shall not exceed a period of 10 years. The CTE 70 (adjusted) and the scenario reserve closest to the CTE 70 (adjusted) are determined using the method (company specific market path (CSMP) or conditional tail expectations (CTE) with prescribed assumptions (CTEPA)) applied by the reporting entity to calculate the prescribed projections amount.

New Footnote:
VM-21 allows a reporting entity to choose whether to use the CSMP method or the CTEPA method. Once the choice is made the company cannot change the method without the approval of the commissioner. For

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8 Recognizing the fair value change for open derivative positions that offset the VM-21 change as a realized gain/loss (instead of an unrealized gain or loss) directly offsets the VM-21 reserve change in the income statement.

9 The change in fair value of the hedging instruments and hedged item is limited to changes driven by market factors. For example, periodic recognition of a cost owed to acquire the derivative from a counterparty (financing cost) shall not be captured as a change in the derivative instrument’s fair value. The fair value of the instrument shall be determined based on the underlying derivative without inclusion of acquisition costs (or other such contractual elements that may exist with the counterparty) that do not change based on the underlying derivative interests or market factors.
the purpose of determining the SSAP No. 108 amortization timeframe, the company shall apply its current method to determine the adjusted run scenario.

Staff Review Completed by: Robin Marcotte, NAIC Staff - October 2021

Status:
On October 25, 2021, in response to an e-vote to expose, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees to ensure consistency with revisions to VM-21, removing references to the standard scenario. The Working Group also provided notice of the exposure to the Life Actuarial (A) Task Force.

On December 11, 2021, Statutory Accounting Principles (E) Working Group exposed revisions, to SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees, as illustrated below. The revisions, which incorporate edits proposed from Life Actuarial (A) Task Force representatives, ensure consistency with revisions to VM-21 by removing reference to the standard scenario while adding reference to the conditional tail expectation 70 guidance. This agenda item has a shortened exposure period, ending Jan. 14, 2022, so that the Working Group may consider adoption for year-end 2021 reporting.

Exposed Revisions to SSAP No. 108

14. Deferred assets and deferred liabilities recognized under paragraph 13.b. shall be amortized using a straight-line method into realized gains or realized losses over a finite amortization period. The amortization timeframe shall equal the Macaulay duration of the guarantee benefit cash flows based on the VM-21 Standard Scenario Projection (new FN), but shall not exceed a period of 10 years.

New Footnote:
The VM-21 Standard Projection calculation shall be the prescribed assumption run for the scenario that produces the scenario reserve closest to conditional tail expectation (CTE) 70 (adjusted) and a discount rate equal to the valuation interest rate specified by the Standard Valuation Law for annuities valued on an issue year basis, using Plan Type A and a Guarantee Duration greater than 10 years but not more than 20 years. The VM-21 Standard Projection with prescribed assumption run is determined using the method (company specific market path (CSMP) or conditional tail expectations (CTE) with prescribed assumptions (CTEPA)) applied by the reporting entity to calculate the prescribed projections amount. For the CSMP method, the economic scenario is Path A, with the guarantee benefit cash flows from the run to calculate Prescribed Amount A. For the CTEPA method, the economic scenario is the scenario that produces the scenario reserve closest to the CTE70 (Adjusted) from the stochastic reserve calculation, with the guarantee benefit cash flows from the VM-21 Standard Projection with prescribed assumption run for this economic scenario.

On January 27, 2022, the Statutory Accounting Principles (E) Working Group adopted SAP clarifications which update SSAP No. 108 references to be consistent with the Valuation Manual, Section 21 with a December 31, 2021, effective date, as detailed below. The adopted revisions included additional changes to the exposed language as recommended by a member of the Life Actuarial (A) Task Force.

Adopted SSAP No. 108 revisions effective December 31, 2021:

14. Deferred assets and deferred liabilities recognized under paragraph 13.b. shall be amortized using a straight-line method into realized gains or realized losses over a finite amortization period. The amortization timeframe shall equal the Macaulay duration of the guarantee benefit cash flows based on the VM-21 Standard Scenario Projection (new FN), but shall not exceed a period of 10 years.
New Footnote: The VM-21 Standard Projection benefit cash flows shall be based on the prescribed assumptions run for the scenario that produces the scenario reserve closest to conditional tail expectation (CTE) 70 (adjusted). The VM-21 Standard Projection with prescribed assumptions run is determined using the method (company specific market path (CSMP) or conditional tail expectations with prescribed assumptions (CTEPA)) applied by the reporting entity to calculate the prescribed projections amount. For the CSMP method, the economic scenario is Path A, with the guarantee benefit cash flows from the run to calculate Prescribed Amount A. For the CTEPA method, the economic scenario is the scenario that produces the scenario reserve closest to the CTE70 (adjusted) from the stochastic reserve calculation, with the guarantee benefit cash flows from the VM-21 Standard Projection with prescribed assumptions run for this economic scenario. The discount rate for the Macaulay duration calculation shall be equal to the valuation interest rate specified by the Standard Valuation Law for annuities valued on an issue year basis, using Plan Type A and a Guarantee Duration greater than 10 years but not more than 20 years.
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

Issue: Life Reinsurance Disclosure Clarifications

Check (applicable entity):

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Description of Issue:
This agenda item is to address questions received from members of the American Institute of Certified Public Accountants (AICPA) NAIC Task Force regarding the life reinsurance disclosures and the related audited notes that were first effective in December 2020. The disclosures were adopted in SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance in agenda item 2017-28: Reinsurance Risk Transfer for Short Duration Contracts. Preparers and auditors have highlighted unclear elements in the disclosures that could use additional clarification. Requested clarifications and responses are detailed in the recommendation section, but they include items regarding whether the disclosures apply to ceding and assuming contracts, the format expected for the audited notes and how broadly to interpret the scope of certain disclosures. In the statutory annual statement filing the disclosures are in Note 23H and are not data captured. The proposed revisions to SSAP No. 61R narrow the scope of the disclosures and clarify what is required in the disclosures.

Existing Authoritative Literature:

SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance includes the following disclosures:

78. Disclosures for paragraphs 79-84 are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020, regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 2020. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

79. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

80. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk-limiting features.

81. Disclose if any reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:
Ref #2021-31

a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).

b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk-transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured events(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

   a. Accounted for that contract as reinsurance under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles (GAAP); or

   b. Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

84. If affirmative disclosure is required for paragraph 83, explain why the contract(s) is treated differently for GAAP and SAP.

The SSAP No. 61R disclosures were developed based on existing SSAP No. 62R—Property and Casualty Reinsurance disclosures with modifications for life and health reinsurance guidance. SSAP No. 62R includes the following disclosures:

113. Disclosures for paragraphs 114-119 represent annual statement interrogatories, which are required to be included with the annual audit report beginning with audit reports on financial statements as of and for the period ended December 31, 2006. The disclosures required within paragraphs 114-119 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 2006. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1994. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the reinsurance summary supplemental filing.

114. Disclose if any risks are reinsured under a quota share reinsurance contract with any other entity that includes a provision that would limit the reinsurer’s losses below the stated quota share percentage (e.g. a deductible, a loss ratio corridor, a loss cap, an aggregate limit or any similar provisions)? If yes, indicate the number of reinsurance contracts containing such provisions and if the amount of reinsurance credit taken reflects the reduction in quota share coverage caused by any applicable limiting provision(s).

115. Disclose if the reporting entity ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which during the period covered by the statement: (i) it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders or it reported calendar year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders; (ii) it accounted for that contract as reinsurance and not as a deposit; and (iii) the contract(s) contain one or more of the following features or other features that would have similar results:
a. A contract term longer than two years and the contract is noncancellable by the reporting entity during the contract term;

b. A limited or conditional cancellation provision under which cancellation triggers an obligation by the reporting entity, or an affiliate of the reporting entity, to enter into a new reinsurance contract with the reinsurer, or an affiliate of the reinsurer;

c. Aggregate stop loss reinsurance coverage;

d. A unilateral right by either party (or both parties) to commute the reinsurance contract, whether conditional or not, except for such provisions which are only triggered by a decline in the credit status of the other party;

e. A provision permitting reporting of losses, or payment of losses, less frequently than on a quarterly basis (unless there is no activity during the period); or

f. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

116. Disclose if the reporting entity during the period covered by the statement ceded any risk under any reinsurance contract (or under multiple contracts with the same reinsurer or its affiliates) for which it recorded a positive or negative underwriting result greater than 5% of prior year-end surplus as regards policyholders or it reported calendar year written premium ceded or year-end loss and loss expense reserves ceded greater than 5% of prior year-end surplus as regards policyholders. This disclosure is limited to reinsurance contracts with written premium cessions or loss and loss expense reserve cessions described in this paragraph that meet the criteria of paragraph 116.a. or paragraph 116.b. This disclosure excludes cessions to approved pooling arrangements or to captive insurance companies that are directly or indirectly controlling, controlled by, or under common control with (i) one or more unaffiliated policyholders of the reporting entity, or (ii) an association of which one or more unaffiliated policyholders of the reporting entity is a member.

a. The written premium ceded to the reinsurer by the reporting entity or its affiliates represents fifty percent (50%) or more of the entire direct and assumed premium written by the reinsurer based on its most recently available financial statement; or

b. Twenty-five percent (25%) or more of the written premium ceded to the reinsurer has been retroceded back to the reporting entity or its affiliates in separate reinsurance contract.

117. If affirmative disclosure is required for paragraph 115 or 116, provide the following information:

a. A summary of the reinsurance contract terms and indicate whether it applies to the contracts meeting paragraph 115 or 116;

b. A brief discussion of management's principal objectives in entering into the reinsurance contract including the economic purpose to be achieved; and

c. The aggregate financial statement impact gross of all such ceded reinsurance contracts on the balance sheet and statement of income.

118. Except for transactions meeting the requirements of paragraph 36, disclose if the reporting entity ceded any risk under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:
Ref #2021-31

a. Accounted for that contract as reinsurance (either prospective or retroactive) under statutory accounting principles (SAP) and as a deposit under generally accepted accounting principles (GAAP); or

b. Accounted for that contract as reinsurance under GAAP and as a deposit under SAP.

119. If affirmative disclosure is required for paragraph 118, explain in a supplemental filing why the contract(s) is treated differently for GAAP and SAP.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):
Agenda item 2017-28 adopted the SSAP No. 61R disclosures in paragraphs 78-84. The disclosures were developed at the request of the Financial Analysis (E) Working Group and were based on existing disclosures in SSAP No. 62R—Property and Casualty Reinsurance in paragraphs 114-119 that are designed to identify contracts with risk limiting features or other items that may need additional regulatory review. The disclosures had to be modified to meet the requirements of SSAP No. 61R and Appendix A-791- Life and Health Reinsurance Agreements

Information or issues (included in Description of Issue) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the revisions to SSAP No. 61R disclosures illustrated below. These items are recommended for a shortened comment period to allow for possible adoption in early 2022 with a year-end 2021 effective date. The proposed revisions provide clarifications and, in some cases, narrow the scope of disclosure. No additional disclosures are proposed. Having the disclosure revisions final for year-end 2021 will assist preparers and auditors.

1. Does the Statutory Accounting Principles (E) Working Group expect the disclosures to be filed as a supplemental schedule in the audited financial statements even when all answers are not applicable or none? (This is the most common question that the auditing firms received.)

Response: If there are no contracts with the applicable features, a narrative note would be sufficient. See suggested edit to paragraph 78 which provides that the information can be in a note or a supplemental schedule. NAIC staff notes that Note 23H is not data captured in the statutory annual statement filing.

2. Is the supplemental schedule specific to ceded reinsurance only?

Response: While some of the disclosures are primarily designed to identify ceding contracts which may require additional scrutiny to verify that too large of a reinsurance credit was taken by the ceding entity, the scope of the disclosures includes all reinsurance contracts unless specifically identified otherwise. See proposed clarifications to limit paragraphs 79 and 80 to ceding contracts. This clarification would be similar to corresponding paragraphs in SSAP No. 62. Also, a clarification also specifies that paragraph 81 is applicable to both assumed and ceding contracts.

3. With regard to paragraph 80, would a stop loss or excess of loss reinsurance agreement with a loss cap or with deductibles (which are common contractual provisions) be required to be disclosed?
Response: Paragraph 80 provides the following:

80. Disclose any reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer's assumption of risk. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk-limiting features.

Paragraph 80 is a modification of the following SSAP No. 62R disclosure:

114. Disclose if any risks are reinsured under a quota share reinsurance contract with any other entity that includes a provision that would limit the reinsurer’s losses below the stated quota share percentage (e.g. a deductible, a loss ratio corridor, a loss cap, an aggregate limit or any similar provisions)? If yes, indicate the number of reinsurance contracts containing such provisions and if the amount of reinsurance credit taken reflects the reduction in quota share coverage caused by any applicable limiting provision(s).

Response: Paragraph 80 was modified to capture contracts not subject to A-791 and not quota share contracts as shown in SSAP No. 62R, paragraph 114 because the requirements of A-791 do not allow significant risks which are required to be ceded to be limited. As currently drafted, the disclosure is written too broadly in that it may be capturing more nonproportional contracts with “standard” features than what is useful. See proposed clarification to paragraph 80 in the illustration below to remove stop loss or excess of loss reinsurance agreements with deductibles or loss caps that apply to the entire contract and are not adjustable based on other features from the disclosure.

4. Please clarify the intent and what information should be disclosed in subparagraphs 82.a. and 82.b.

a. We thought that for paragraph 82.a., the intent related to ceding companies with assumption reinsurance agreements (paragraph 60 of SSAP 61R) entered into during the current year for which indemnity reinsurance is being applied for policyholders who have not yet agreed to the transfer to the new insurer or for which the regulator has not yet approved the novation to the new insurer.

Response: Paragraph 82.a. is intended to reference assumption reinsurance agreements referenced in paragraph 60 of SSAP No. 61R entered into during the current year for which reinsurance credit is reported. It does not make a distinction regarding those that have or have not been approved by the policyholder. A simple reading of the disclosure is intended - to identify new assumption reinsurance agreements. This paragraph does not have a similar paragraph in SSAP No. 62R. See edits to SSAP No. 61R illustrated below which add reference to the contracts in paragraph 60.

b. With regard to paragraph 82.b., what is the concern related to non-proportionate contracts that do not provide significant surplus relief?

Response: Paragraph 82. b is proposed for deletion, as it does not provide useful information. This is because it would require disclosure of contracts which do not provide significant surplus relief and it is unclear what types of assumption reinsurance would be captured. This paragraph does not have a similar paragraph in SSAP No. 62R. See edits to SSAP No. 61R illustrated below.

5. How should an entity answer paragraphs 83-84 if no GAAP financial statements are prepared?
Response: If the reporting entity and or its holding company group does not prepare GAAP financials this is not an analysis that would be required. See proposed clarification in paragraph 83 below. AICPA representatives noted, and NAIC staff agrees, that because of A-791 differences there may be more life and health contracts reported differently for GAAP.

**Recommended Revisions to SSAP No. 61R:**

78. Disclosures for paragraphs 79-84 are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020, regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall can be included in accompanying supplemental schedules or the notes of the annual audit report beginning in year-end 2020. If not applicable, an affirmative statement that no such contracts were identified is acceptable. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

79. Disclose any ceding reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

80. Disclose any ceding reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. Note that a stop loss or excess of loss reinsurance agreement with deductibles or loss caps which apply to the entire contract and are not adjustable based on other features, do not require disclosure under this paragraph. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk-limiting features.

81. Disclose if any assumed or ceded reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

   a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).

   b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk-transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – as discussed in paragraph 60, which are new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured events(s) triggering contract coverage has been recognized.
83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

   a. Accounted for that contract as reinsurance under statutory accounting principles (SAP) and as a deposit under U.S. generally accepted accounting principles (GAAP); or

   b. Accounted for that contract as reinsurance under U.S. GAAP and as a deposit under SAP.

   If the reporting entity does not prepare U.S. GAAP financial statements or its financial statements are not part of upstream U.S. GAAP financial statements, this disclosure can be answered not applicable.

84. If affirmative disclosure is required for paragraph 83, explain why the contract(s) is treated differently for GAAP and SAP.

Staff Review Completed by: Robin Marcotte, NAIC Staff - November 2021

Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 61R, as illustrated above. These revisions intend to clarify, and in some cases, narrow the scope of certain disclosures. This agenda item has a shortened exposure period, ending Jan. 14, 2022, so that the Working Group may consider adoption for year-end 2021 reporting.

On January 27, 2022, the Statutory Accounting Principles (E) Working Group adopted SAP clarifications which update the SSAP No. 61R disclosures with a December 31, 2021, effective date, as detailed below. The adopted revisions included additional changes to the exposed language as recommended by members of the ACIPA’s NAIC Task Force and interested parties.

Adopted Revisions to SSAP No. 61R:

78. Disclosures for paragraphs 79-84 apply to reinsurance contracts in effect for the current period covered by the statement and are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020, regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 2020. If the disclosures are not applicable, an affirmative statement that no such contracts were identified is acceptable in the notes to the financial statements or the supplemental schedules. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

79. Disclose any ceded reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

80. Disclose any ceded reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. Note that a stop loss or
excess of loss reinsurance agreement with deductibles or loss caps which apply to the entire contract and are not adjustable based on other features, do not require disclosure under this paragraph. If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk-limiting features.

81. Disclose if any ceded reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

   a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).

   b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.

82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk-transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – as discussed in paragraph 60, which are new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured events(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

   a. Accounted for that contract as reinsurance under statutory accounting principles (SAP) and as a deposit under U.S. generally accepted accounting principles (GAAP); or

   b. Accounted for that contract as reinsurance under U.S. GAAP and as a deposit under SAP.

If the reporting entity does not prepare U.S. GAAP financial statements or its financial statements are not part of upstream U.S. GAAP financial statements, this disclosure can be answered not applicable.

84. If affirmative disclosure is required for paragraph 83, explain why the contract(s) is treated differently for GAAP and SAP.
### Comment Letters Received for Items Exposed for the Spring National Meeting

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February 18, 2022

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on December 11, 2021 with Comments due February 18

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group).

We offer the following comments:

Ref #2019-21: Proposed Bond Definition

Pursuant to the direction from the Working Group in October 2020, a small group of regulators and industry have been meeting regularly to draft a bond definition for consideration. The intent of this project is to clarify what should be considered a bond (whether captured in SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities) and reported on Schedule D-1: Long-Term Bonds. This exposure is specific to the proposed bond definition included in the exposed Form A, along with the glossary (page 5) and appendices (pages 6-12), but comments on future developments (such as reporting changes, accounting and reporting guidance for items that do not qualify as bonds, transition guidance, etc.) may also be submitted to assist in the development of these items.

Interested parties appreciate the collaborative effort, between NAIC staff, regulators and interested parties, on this significant and complex project. We note this exposure includes the following three separate and distinct components for which we will provide comments:

1) Sufficiency Discussion – Concept (Attachment N),
Interested parties are supportive of the proposed refinements to the sufficient credit enhancement concept. Interested parties believe the clear articulation of the intent of the required substantive credit enhancement provides for a more understandable and workable proposed bond definition. Likewise, interested parties are supportive of the revised examples, where the new substantive credit enhancement concept has been incorporated.

Interested parties also offer the following comments on the various possible reporting options for Schedule D-1.

1. Reporting Lines:

   With the principles-based bond definition, it is recommended that more granular reporting lines be established to capture investments in scope of SSAP No. 26R and SSAP No. 43R. From preliminary assessments, the current general categories are not used for analytical assessments / reports except for U.S. Govt – Full Faith and Credit. As such, this document proposes to replace the current general categories with the inclusion of more useful reporting lines based on the type of investment.

Exposure Request Detail provided on pages 2-5:

1. Information is requested on the potential removal of the general categories and whether the elimination would impact any tools or analyses currently performed.
   - Interested parties have no concerns currently with the proposed removal of the general categories.

2. Information is requested on the proposed reporting lines and whether additional categories would be beneficial. (Note – The proposal suggests dedicated reporting lines for certain securities that are now identified by codes. Comments on this approach are requested.)
   - Interested parties note that one of the challenges with the current Schedule D reporting categories and/or columns is ambiguity which leads to inconsistent reporting among companies. Interested parties recommends working together to ensure the instructions are clear and unambiguous to help prevent this problem with the new reporting schedules. This will benefit both companies and regulators.
   - Interested parties would like a better understanding of the unaffiliated/affiliated split of certain rows in the proposal; for example, are the rows not labelled with ‘Affiliated’ implied to be ‘Unaffiliated’? Or are the affiliated rows a subset of the former? Have you considered an alternative such as removing the lines identifying ‘Affiliated’ investments and utilizing a column to identify them instead? Blanks interested parties are suggesting that an Affiliated or Related Party indicator be utilized in a column for the investment schedules in the Blanks exposure 2021-22BWG (Related Party Reporting).
• Since investments in GNMA are RBC exempt, we recommend that additional lines be added to the ABS section to accommodate these for ease of identification (e.g., US Government Residential Mortgage-Backed Securities; US Government Commercial Mortgage-Backed Securities).
• Consider adding a new category in Issuer Credit Obligation for investments in Surplus Notes/Surplus Debentures which are currently reported on Schedule BA.

2. New Sub-Schedule D-1:

The bond project is currently proposing a new sub-schedule that details bond investments that have certain characteristics (e.g., ABS backed by financial assets that are not self-liquidating and ABS backed by cash-generating non-financial assets not captured within the practical expedient.)

Exposure Request:
1. Information is requested on how investments shall be categorized on this schedule.
   • Interested parties believe that the proposed ‘sub-schedule’ for Schedule D – Part I could be confusing, and the proposed data could be readily incorporated into electronic-only columns for the respective categories in the ‘Other Asset-Backed Securities’ section.
   • Clear instructions for each category under Other ABS will be extremely beneficial.
2. Information is requested on additional information / columns desired for these structures. Initial ideas that have been proposed include:
   a. Balloon payment as % of principal at acquisition
   b. Current loan-to-value
   c. PIK – Information on whether payment of interest is deferrable
   d. Amount of PIK interest to date
   e. Expected payoff date determined at acquisition
   f. Expected payoff date as of the financial statement date.

   • Currently, interested parties would support the proposed data elements for the ‘Other Asset-Backed Securities’ categories being reported in columns instead of in a ‘sub-schedule’. As changes to SSAP No. 26R and SSAP No. 43R are finalized for this project and further evaluation of these investments is done, modifications to the list may be warranted.
   • Interested Parties note that some of this data (e.g., Expected payoff date determined at acquisition) may not be readily available upon transition because it assumes a forward-looking analysis at a point in time that has already occurred (potentially decades in the past). Would a practical expedient be needed upon adoption to populate these types of fields?

3. Schedule D-1 Information:

As noted, with the change in reporting lines, it has been proposed a review of the columns and instructions also be considered. The following code columns have been potentially
identified.

- Column 3 – Code Column
- Column 5 – Bond Characteristics
- Column 26 – Collateral Type
- Column 34 – Capital Structure Code

Exposure Request– Detail provided on page 6:

1. Information is requested on whether other columns / reporting instructions should be clarified as part of the bond proposal project.
   - Interested parties are requesting additional time to address possible changes to the definitions of the columns indicated in the proposal. As rows are being changed, it could have a direct impact on what might be included in the columns as to minimize data redundancy.

2. Comments are welcome on the additional investment elements should be captured and/or whether certain elements are no longer beneficial to be captured. Potential elements related to asset‐backed securities include:
   a. Market Validation – This will be a code to identify situations where none of the issuance is owned by unrelated parties.
      - Currently, interested parties don’t have an issue with adding this field and we believe the answer could be either yes or no.
      - However, interested parties are not sure if the intent is to have the same meaning as the following – *This will be a code to identify situations where all of the issuance is owned by related parties.* If so, interested parties recommends removing the double negatives to be less confusing. If not, interested parties may not fully appreciate what is trying to be captured.

   b. Participation in residual tranche (Y/N)
      - Interested parties aren’t sure how to respond to this question. Should the insurer respond Yes if it currently owns a residual tranche of the same securitization (e.g., residual issued from the same vehicle that issued the bond it invested in) or if they have ever owned a participation in the residual tranche?

Ref #2021-20: Effective Derivatives – ASU 2017-12

The Working Group moved this agenda item to the active listing, categorized as substantive, and directed NAIC staff to work with regulators and industry in assessing and developing revisions to facilitate effective hedge assessments consistently between U.S. GAAP and statutory accounting.

ASU 2017-12 provided targeted improvements to the existing GAAP hedge accounting framework that helps reduce some of the cost and complexity of applying hedge accounting and allows for additional hedging strategies that better align with an entity's risk management practices. Substantive changes that weren’t initially adopted in SSAP No. 86 are addressing cross-currency basis spread as an excluded component, partial-term hedging for fair value.
hedges, ability to use the benchmark interest rate component of contractual cash flows to calculate the change in fair value of the hedged item in fair value hedges, last-of-layer/portfolio layer method for fair value hedges, and hedges of interest rate risk when the hedged item can be settled before scheduled maturity. Additionally, we are proposing clarifications to existing SSAP No. 86 for the accounting of forward points as an excluded component for currency forwards. Please refer to the attached appendix for proposed mark-ups to SSAP86 for these changes.

Summary of changes proposed to SSAP No. 86:

1. **Clarifications for the accounting of forward points as an excluded component for FX forwards** – Currently there is implicit inconsistency between paragraph 40 and Exhibit C for forward points as excluded components; this results in accounting that doesn’t align with companies’ risk management strategies. Application of the guidance in Paragraph 40 for a FX forward in an effective hedge relationship with an excluded component results in an impact to Surplus that is the same as if hedge accounting had not been applied. We propose resolving this matter by explicitly allowing the guidance in Exhibit C to be applied regardless of whether a component of the derivative is excluded from the assessment of effectiveness. When forward points are an excluded component from the assessment of hedge effectiveness, the forward points would be amortized into income. This would allow for the execution of FX forward effective hedge relationships, which interested parties would consider sound risk management strategies, to receive an accounting treatment that is more favorable relative to hedge accounting not being applied.

2. **Adding cross-currency basis spread as an excluded component** – We propose adding cross-currency basis spread as an excluded component. Doing so better aligns hedge accounting with companies’ risk management strategies, aligns the accounting for FX swaps where the cross-currency basis spread is an excluded component with the proposed accounting for FX forwards where forward points are an excluded component, and brings consistency between U.S. GAAP and Statutory accounting. Changes in the fair value of cross-currency basis spread have historically resulted in a less effective hedge or ineffective hedge because there is no corresponding offset in the hedged item. Excluding the cross-currency basis spread from the assessment of hedge effectiveness is beneficial for fair value hedges of foreign-denominated assets and liabilities. When the value of the cross-currency basis spread is excluded from the assessment of effectiveness, based on proposed changes to Paragraph 40 and Exhibit C, the excluded component would be held at amortized cost. With FX forwards, forward points as excluded components need to be amortized to be recognized in income. For FX swaps, the value of the cross-currency basis spread is embedded in the coupon payments of the swap, so the value is recorded in income each period through the typical swap accrual process.

3. **Adding ability to designate partial-term for fair value hedges** – We propose adding partial-term hedging for fair value hedges because it better aligns hedge accounting with companies’ risk management strategies for managing interest rate risk and brings consistency between U.S. GAAP and Statutory accounting. Currently SSAP No. 86 requires that the full contractual cash flows of the entire hedged item must be used to
calculate the change in the hedged item’s fair value attributed to the benchmark interest rate. With partial term an entity may designate only certain consecutive interest payments of a financial instrument as the hedged item and assume that the principal payment occurs at the end of the hedge term. Partial-term hedging allows entities to calculate the change in the fair value of the hedged item using an assumed term that begins when the first hedged cash flow begins to accrue and ends when the last hedged cash flow is due and payable. When using full contractual cash flows to calculate the change in the hedged item’s fair value attributed to changes in the benchmark rate, it can be difficult to achieve a highly effective hedge because the hedging instrument and the hedged item would react differently to changes in interest rates since the principal repayment occurs on different dates.

4. **Adding alternative to use the benchmark interest rate component of contractual cash flows to calculate the change in the fair value of the hedged item in fair value hedges** – We propose adding an alternative to use the benchmark interest rate component of contractual cash flows to calculate the change in the fair value of the hedged item in fair value hedges because it better aligns hedge accounting with companies’ risk management strategies for managing interest rate risk and brings consistency between U.S. GAAP and statutory accounting. Currently SSAP No. 86 requires that the full contractual cash flows of the entire hedged item be used to calculate the change in the hedged item’s fair value attributed to the benchmark interest rate. Calculating the change in fair value using only the benchmark rate component instead of the entire coupon may better reflect how an entity manages interest rate risk. In addition, it will provide a greater degree of offset between the changes in the fair values of the hedging instrument and the hedged item. Generally, the benchmark rate being hedged and the fixed rate on the hedging swap will match if the swap is “at-market” and executed at the inception of the hedging relationship.

5. **Adding last-of-layer/portfolio layer method for fair value hedges** – We propose adding last-of-layer/portfolio layer method for fair value hedges because it better aligns hedge accounting with companies’ risk management strategies for managing interest rate risk and brings consistency between U.S. GAAP and statutory accounting. Last-of-layer allows entities to designate as the hedged item the last dollar amount of a closed portfolio of prepayable financial assets, or one or more beneficial interests in a portfolio of prepayable financial instruments. When using this approach, it is assumed that as prepayments occur, they are first applied to the portion of the closed portfolio that are not part of the designated layer. At inception and on each assessment date, the entity would need to determine that the designated layer is expected to be outstanding until the end of the hedge. This approach simplifies the rigid nature of the similar asset test required for portfolio hedging for fair value hedges by allowing the ability to assess qualitatively instead of quantitatively by combining the partial-term fair value hedge election and the election to measure changes in the hedged item by using the benchmark rate component of the contractual coupon cash flows. This makes achieving hedge accounting for a portfolio of prepayable fixed rate assets easier. The similar asset test requirement for portfolio hedges often makes it difficult, if not impossible, for a group of disparate fixed-rate assets to qualify to be hedged on a portfolio basis. The FASB currently has tentative
conclusions for updates to last-of-layer method, so we will need a scope limitation to maintain consistency with GAAP. For example, last-of-layer would only be applicable to closed portfolios of assets, and companies would be prohibited from designating closed portfolios of liabilities.

6. **Adding hedges of interest rate risk when the hedged item can be settled before scheduled maturity** – We propose adding the ability to elect to only consider how changes in the benchmark rate affects the decision to prepay the instrument when it assesses hedge effectiveness and measures the change in the hedged item’s value attributable to the hedged risk because it better aligns hedge accounting with companies’ risk management strategies and brings consistency between U.S. GAAP and statutory accounting. If an entity makes this election, it does not consider how other factors (e.g. credit risk) might affect the decision to prepay the financial instrument.

**Ref #2021-21: Related Party Reporting**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 25 and SSAP No. 43R, as illustrated in the proposal, to clarify application of the existing affiliate definition and incorporate disclosure requirements for all investments that involve related parties, regardless of whether or not they meet the affiliate definition (“the Related Party Exposure”). In addition, draft annual statement reporting revisions were also exposed, in anticipation of incorporating those revisions into a Blanks (E) Working Group proposal.

Interested parties appreciate NAIC staff meeting with industry to better understand the regulatory concerns and intent of this proposal.

The Related Party Exposure has the following two main goals:

1. Clarify the reporting of affiliate transactions within existing reporting lines in the investment schedules. This clarification intends to be consistent with the definition of an “affiliate” pursuant to the *Insurance Holding Company System Regulatory Act* (Model #440), SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated (SCA) Entities.

2. Incorporate new reporting requirements for investment transactions with related parties. Pursuant to recent discussions, regulators desire additional information on investment transactions involving related parties, regardless of whether the related party is “affiliated” pursuant to Model #440. To preserve the affiliate definition and reporting categories, these additional proposed reporting elements will be captured outside of the current affiliate reporting requirements.

To accomplish these goals, the Related Party Exposure proposes to make changes to SSAP No 25 - Affiliates and Other Related Parties and SSAP No. 43R - Loan-backed and Structured Securities. We understand that one of the goals of the proposal is to identify investments that are originated, managed, sponsored or serviced (referred to as managed by affiliates for the
remainder of this letter) by an affiliate or related party of the insurer. Interested parties agree that this information can be useful for the regulators, but we believe that it is critical to differentiate investments where there is direct credit exposure to an affiliate from those investments that are only managed by affiliates with no underlying credit exposure to the affiliate or related parties of the insurer. The affiliate reporting distinction is very important for a number of reasons, including but not limited to the following:

a. **Rating Agencies** – Interested parties understand that the rating agencies may apply a higher risk factor to affiliated assets as there is a presumption that anything reported as affiliated has credit risk exposure to an SCA of the insurer.

b. **NAIC Designations** – Affiliated debt investments where there is credit exposure to an SCA of the insurer have to be filed with the SVO to obtain an NAIC designation. Affiliated equity investments in SCAs reported on Schedule D also require filing to confirm their reporting value on Schedule D. Debt investments in CLOs/CDOs that are managed by affiliates but that do not have any credit exposure to an affiliate are filing exempt because they are not deemed affiliated.

Our comments to the proposed changes to SSAP No. 25 and SSAP No. 43 are provided below:

1. **Removal of references to U.S. GAAP guidance from SSAP No. 25** - Interested parties agree with removing the U.S. GAAP reference to FASB Interpretation No. 35 as we agree that the statutory guidance uses a different threshold than US GAAP to determine if significant influence exists over an investee. In addition, the SSAP No. 25 guidance already includes a number of scenarios to rebut the presumption of control, which are similar to the examples provided in the GAAP guidance.

2. **The Working Group’s Proposed changes to SSAP No. 25 to add the following new paragraph:**

“For entities not controlled by voting interests, such as limited partnerships, trusts and other special purpose entities, control may be held by a general partner, servicer, or by other arrangements. The ability of the reporting entity or its affiliates to direct the management and policies of an entity through such arrangements shall constitute control as defined in paragraph 6. Additionally, a reporting entity or its affiliates may have indirect control of other entities through such arrangements. For example, if a limited partnership were to be controlled by an affiliated general partner, and that limited partnership held greater than 10% of the voting interests of another company, indirect control shall be presumed to exist. If direct or indirect control exists, whether through voting securities, contracts, common management or otherwise, the arrangement is considered affiliated under paragraph 5. Consistent with paragraph 8, a disclaimer of affiliation does not eliminate a “related party” distinction or disclosure requirements for material transactions pursuant to SSAP No. 25.”

We understand from conversations with staff that this paragraph is meant to clarify the guidance in paragraph 7 of SSAP No. 25 and paragraph 6 of SSAP No. 97- Investments
in Subsidiary, Controlled and Affiliated Entities. That guidance requires that investments in limited partnerships and other similar entities (i.e. investment funds) that are managed by a general partner that is affiliated to the insurer and where the insurer owns more than 10% of the investment fund’s equity be reported as affiliated investments.

Interested parties understand that the current SSAP No. 25 and SSAP No. 97 guidance already require equity investments in limited partnerships and similar entities to be reported as affiliated if the insurer owns more than 10% of the equity of the limited partnership and the insurer is affiliated to the general partner or managing member for limited liability company structures. One thing to note is that even if the insurer is affiliated to the general partner, the insurer would usually not have any credit exposure to its affiliates in these structures as the underlying assets of the investment fund are usually held with unrelated parties. For this reason, interested parties note that there is a diversity in practice in the reporting of these investment funds on Schedule BA, with some insurers reporting these investments in the affiliated section of Schedule BA and others reporting these investments as unaffiliated. If the intent is to report these types of equity investments as affiliated when the presumption of control cannot be overcome, this will require some reporting changes by some insurers.

In regard to debt investments in investment funds or securitization vehicles managed by the insurer affiliates or related parties as well as mortgage loans managed by affiliates, we note that most insurers currently report those investments as unaffiliated on Schedule D, Schedule BA and Schedule B if there is no underlying credit exposure to affiliates of the insurer. Interested parties would like to highlight again that just because the insurer is affiliated with the manager or servicer of an investment vehicle such as a securitization, if the underlying assets in the structure do not have affiliated credit exposure, the investment itself should not be reported as affiliated as that would not be accurate reporting. See further comments on the SSAP No. 43R proposed changes in item No. 4 below.

The new proposed paragraph also includes a look-through requirement of these investment funds to identify instances where the investment fund owns more than 10% of the common stock of its underlying investees. Interested parties have concerns with this look-through review. Doing a look-through of the underlying investments of investment funds managed by affiliates of the insurer could potentially create a very significant operational burden that may have little or no benefit. The reason why there is potentially little benefit to this is because if these investment funds have purchased an equity investment that represents more than 10% but less than 50% of the voting stock of one of their investees, this would almost never give control to the investment fund. For most entities capitalized with common stock (i.e. voting entities), the parties that control are the ones that own more than 50% of the voting shares. If the Working Group feels that this look-through is necessary, interested parties will need time to get this process implemented. Interested parties believe that the earliest this look-through requirement can be implemented is for year-end 2023 as time will be needed to set up a process with all affiliated funds so that the funds provide a listing of underlying equity investments in
other entities along with the percentage ownership. In addition, we suggest some wording changes, as shown below in the underlined text to the new paragraph, to link the new paragraph back to the examples in paragraph 7 to incorporate the examples of when the presumption of control can be overcome:

“For entities not controlled by voting interests, such as limited partnerships, trusts and other special purpose entities, control may be held by a general partner, servicer, or by other arrangements. The ability of the reporting entity or its affiliates to direct the management and policies of an entity through such arrangements shall constitute control as defined in paragraph 6. Additionally, a reporting entity or its affiliates may have indirect control of other entities through such arrangements. For example, if a limited partnership were to be controlled by an affiliated general partner, and that limited partnership held greater than 10% of the voting interests of another company, indirect control shall be presumed to exist unless the presumption of control can be overcome as detailed in paragraph 7. If direct or indirect control exists, whether through voting securities, contracts, common management or otherwise, the arrangement is considered affiliated under paragraph 5. Consistent with paragraph 8, a disclaimer of affiliation does not eliminate a “related party” distinction or disclosure requirements for material transactions pursuant to SSAP No. 25.”

Interested parties also ask for clarification regarding what the implications are of identifying an underlying investee of an investment fund as an affiliate. We believe that any other transactions carried out with the indirect affiliate need to be disclosed in the related party footnote, but we are unclear as to the impacts to Schedule Y and any other reporting schedules. The unit of account in this case would be the direct investment in the affiliated investment fund, not the underlying investments of the investment fund. It is not clear to us whether the indirect affiliates would also need to be reported on Schedule Y and/or any other reporting schedules.

3. **Proposed changes under paragraph 6 (a) of SSAP No. 43R regarding insurers’ investments in securitization vehicles where the underlying assets of the securitization predominantly relate to assets with credit exposure to affiliates/related parties of the insurer** – Interested parties agree that when the insurer has credit exposure to its SCAs, even if there are intermediaries as part of the transaction, such investment should be reported as affiliated in the investment schedules.

4. **Proposed changes to SSAP No. 43R to clarify that investments managed by affiliates are viewed as affiliated even if the underlying assets in the structure do not have any credit exposure to an affiliate** - Many insurers own asset management subsidiaries which manage securitization transactions. There is no question that the asset manager itself is an SCA of the insurer and such asset managers are reported on Schedule Y as affiliates of the insurer. However, when any debt tranches purchased from those securitization vehicles do not have any credit exposure to SCAs of the insurer, the debt tranches are not reported in the affiliated section of Schedule D even if the securitization vehicle is managed by an affiliate.
It is very important to interested parties that this distinction is understood for Schedule D bond investments. Schedule D bond investments should not be reported as affiliated if they do not have credit exposure to SCAs of the insurer.

We understand from conversations with NAIC staff that this clarification is not intended to change the reporting lines in which investments are currently reported. The expectation is that these investments will now have a new code that will identify these investments as being managed by a related party of the insurer but have no credit exposures to related parties.

Interested parties agree with adding new codes to differentiate investments that are simply managed by a related party (including SCAs) from those that in fact have credit exposure to a related party (including SCAs) of the insurer. See further comments to the proposed codes in item 5 below.

5. **Proposed annual statement changes to add a new electronic-only column to the investment schedules to identify investments involving related parties** – Interested Parties have no objection to the proposed new codes to specify the type of relationship with the manager/sponsor/servicer of an investment vehicle. However, we offer the following comments to provide better clarity as to the applicability of the codes:

   a. Most if not all of an insurer’s general account investments are managed by an affiliated asset manager. The affiliated asset manager makes decisions as to when to buy and sell a specific investment, including reviewing the investment for potential credit losses. We do not believe that it is the intent of the proposal to flag all investments as affiliated only because an affiliated asset manager makes investment decisions over the investment. Insurers already report their relationship with affiliated asset managers in the related party footnote. We believe that the intent of this proposal is to identify investment vehicles that are managed by related parties (including SCAs) as well as investments with direct exposure to related parties (including SCAs) of the insurer. To that end, we believe the codes would predominantly apply to the following types of investments:

      i. CLOs/CDOs or special purpose entities set up to create a securitization vehicle that are managed by related parties (including SCAs) of the insurer.

      ii. Mutual funds/ETFs and other similar funds where the asset manager is a related party of the insurers (including SCAs of the insurer).

      iii. Limited partnerships, limited liability companies or trusts set up as investment vehicles where the general partner or managing member is a related party of the insurer (including SCAs of the insurer).

      iv. Debt and equity investments in affiliates where there is direct credit risk exposure to a related party (including SCAs of the insurer).
b. Codes 2, 3 and 4 of the Related Party Exposure refer to “securitizations and other similar investments” which may imply to some that the codes only apply to Schedule D assets since Schedule D is where debt investments in securitizations are reported. If the codes are expected to apply to all investment vehicles, perhaps the wording can be made clearer by saying “securitizations and other investment vehicles such as mutual funds, limited partnerships and limited liability companies.”

Ref #2021-22: Schedule D-6-1, Supplemental Reporting

The Working Group moved this item to the active listing and exposed proposed revisions to be incorporated into a Blanks (E) Working Group proposal which would supplement the reporting of SCA investments reported in Schedule D-6-1, as illustrated in the proposal. The supplemental electronic data to be captured is consistent with current requirements in SSAP No. 97 and as a result, the agenda item did not propose statutory accounting revisions.

Interested parties have the following observations regarding this proposal:

• The nature of the NAIC valuation adjustments can be broad and include a range of possibilities. But in looking back to the reductions from the 2020 filings, there are notes for items such as: going concern, lack of audit, audit not provided in English, lack of a U.S. GAAP reconciliation, or other errors, etc. It appears that the most prevalent, by far, is a reduction to match the equity reflected in the audit.

• The adjustment is not intended to match the approved amount, but to adjust subsequent valuations to reflect the current equity that factors in the noted adjustment / issue by NAIC staff from the filing submission. For example, if an insurer didn’t adjust for a surplus note, and staff adjusted their approved year end value to remove the surplus note, the insurer should make sure that a similar adjustment is reflected going forward when reporting the current equity amount.

• In addition, since this is gathering prior year information, we note that regulators will be able to easily identify significant swings in equity values for any particular SCA.

In summary, interested parties recommend that there be a formal process for communicating the adjustment to the state of domicile and a clearly articulated instruction for how the adjustment is to be reported to ensure that the adjustments are communicated to insurers by the state of domicile and that insurers clearly understand how the adjustments are to be reflected.

Ref #2021-23: SSAP No. 43R – Financial Modeling – Updated Guidance

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed two options for possible revision, as illustrated in the proposal, to update the summarized financial modeling guidance in SSAP No. 43R. The first option will retain existing guidance, with updates to reflect Valuation of Securities (E) Task Force adopted edits. The
second option removes the summarized financial modeling guidance and refers users to the Purposes and Procedures Manual of the NAIC Investment Analysis Office, which is the source document for financial modeling guidance.

Interested parties support option one as presented in the exposure. While there are advantages and disadvantages to each option, option 1 provides meaningful holistic view of how these securities are treated in one spot, and without reference to the P&P manual, which we believe will be useful for financial and annual statement preparers. Interested parties note the following grammatical error in paragraph 27 a – third sentence (tracked changed suggestion):

“For a modeled non-legacy security, meaning one which closed after December 31, 2012, the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used.”

**Ref #2021-24: General Interrogatory for Cryptocurrencies**

The Working Group moved this item to the active listing and exposed proposed revisions to be incorporated into a Blanks (E) Working Group proposal to add a new general interrogatory to the annual blanks, requiring disclosure of when cryptocurrencies are directly held or permitted for the remittance of premiums. This agenda item did not propose statutory revisions.

Interested parties have no comment on this item.

**Ref #2021-25: Leasehold Improvements After Lease Termination**

NAIC staff received a question about the treatment of leasehold improvements in situations where a leased property is purchased by the lessee during the lease term and noted that there is no explicit guidance for these situations in SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements nor SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities. In these scenarios, it was identified that the reporting entity had acquired the property that was initially subject to a lease; however regardless of the scenario, amortization of leasehold improvements is only permitted over the shorter of the estimated useful life of the improvement or the lease term (as defined in SSAP No. 22R). In a normal lease termination, one where the lessee does not acquire said property, any remaining leasehold improvements shall be immediately expensed. This agenda item has been drafted to clarify this guidance, to eliminate future questions and ensure consistent application.

Interested parties agree that, in most cases, unamortized lessee owned leasehold improvements should be immediately expensed if the lease is terminated. However, in the situation where the reporting entity purchases a property that it was previously leasing, the immediate expensing may not be appropriate in all circumstances.

SSAP No. 19, Furniture, Fixtures, Equipment and Leasehold Improvements, paragraph 4 defines leasehold improvements as (bolded for emphasis) “lessee expenditures that are permanently attached to an asset” that a reporting entity is leasing under an operating lease.”
In defining this issue, NAIC Staff referred to paragraphs 18 and 31 of SSAP No. 40R, Real Estate Investments, which relate to the sale of real estate. Within the guidance of these paragraphs, it is emphasized by Staff that the sale of real estate includes property improvements or integral equipment, which are defined as any physical structure or equipment attached to the real estate that cannot be removed and used separately without incurring significant costs, such as an office building. Interested parties agree if a reporting entity sells real estate, the asset, including property improvements and integral equipment, should be derecognized and a gain or loss on the sale be realized. However, as noted above, this issue relates to when a reporting entity acquires, not sells, a property that it was leasing.

SSAP No. 40R paragraph 8 states (bolded for emphasis), “The cost of real estate represents the fair value of the consideration exchanged plus any costs incurred to place the real estate asset in usable condition, including but not limited to, brokerage fees, legal fees, demolition, clearing and grading, fees of architects and engineers, any additional expenditures made for equipment and fixtures that are made a permanent part of the structure…” Therefore, under SSAP No. 40R, leasehold improvements are admitted assets.

The proposed revisions to SSAP No. 19 and SSAP No. 73 both state (bolded for emphasis; italics to denote reference to the appropriate party acquiring the leased real estate):

The amortization of leasehold improvements (including property improvements and integral equipment) shall cease, with any remaining amount immediately expensed, in any event in which the lease is terminated in advance of the lease term. This includes situations in which leased real estate is acquired by the reporting entity (lessee) lessor. If leased real estate is acquired, recognition of the real estate shall follow the provisions in SSAP No. 40R—Real Estate Investments.

It is noted in the Staff Recommendation that “[i]t is presumed that the purchase of a property from a third party would include the leasehold improvements as part of the full purchase price.” Under this presumption it is logical that the previously recognized leasehold improvements should be immediately expensed, otherwise, the reporting entity would be double counting the assets and related expense. In practice, however, interested parties generally believe this to be an unlikely scenario.

Lease agreements with purchase options can be complex and structured in a myriad of ways depending on how the reporting entity lessee negotiated with the lessor. There may be circumstances that the reporting entity negotiates a reduced price to acquire the real estate formerly leased to compensate for the permanent improvements it previously made. In other situations, the sales price is determined based on the then current fair or appraised value. In this situation, the lessee and lessor will engage a third-party appraiser to establish the sales price. Appraisers generally use the cost, sales comparison, or income approaches to establish the value. Generally, those approaches may not contemplate the specific lessee owned leasehold improvements unless those improvements generate material utility (e.g., expansion of the building itself, or in a ground lease, land improvements or a constructed building, etc.). Accordingly, the reporting entity would not be including in the cost of the acquired real estate.
any additional expenditures made for equipment and fixtures that are made a permanent part of the structure as required/allowed by SSAP No. 40R if the amendments to SSAP No. 19 and 73 require them to be written off at acquisition.

Additionally, interested parties believe it would generally be economically punitive to a reporting entity to provide consideration to purchase a leased asset to the landlord (seller) that includes significant costs that the reporting entity lessee already incurred for the leasehold improvements. Also, many States require material purchases of real estate (particularly for HMOs) to be approved by the Department of Insurance. Barring any unique circumstances, it is unlikely a regulator would approve a transaction that requires the reporting entity to pay additional amounts to a lessor for costs it already incurred.

Interested parties are also concerned with the additional complexity the exposure draft will add in applying SSAP No 22R versus ASC 842 for GAAP. As it stands today, there is already a cost basis difference between GAAP and SAP when purchasing the underlying leased asset. SSAP No 22R implies that any deferred rent liability upon termination of a lease would be adjusted off to the P&L (i.e., a gain). For GAAP under ASC 842, any remaining lease liability upon purchase of the leased asset is adjusted to the cost basis of the asset (i.e., effectively deferring the gain) along with the unamortized portion of the lessee owned leasehold improvements. Expensing unamortized leasehold improvements in all circumstances for terminated leases for SAP creates further cost basis differences that will artificially and significantly distort earnings and will be extremely difficult to operationalize.

It is also worth noting that for some interested parties, external auditors and regulators have audited these transactions and have been comfortable that duplication is not occurring.

Interested parties suggest that the following amendments be revised guidance of SSAP No. 19 and 73:

The amortization of leasehold improvements (including property improvements and integral equipment) shall cease, with any remaining amount immediately expensed, in any events in which the lease is terminated in advance of the lease term. **When leased real estate is purchased by the reporting entity lessee resulting in termination of the lease, any unamortized lessee owned leasehold improvements should be added to the cost basis of the acquired real estate and recognized in accordance with SSAP No. 40R – Real Estate Investments.** Any unamortized leasehold improvements owned by the reporting entity lessee that have no future economic benefit upon purchase of the leased real estate asset or those included in the purchase price of the acquired real estate should be immediately expensed. This includes situations in which leased real estate is acquired by the reporting entity lessor. If leased real estate is acquired, recognition of the real estate shall follow the provisions in SSAP No. 40R—Real Estate Investments.

**Ref #2021-26EP: Editorial and Maintenance Update**

The Working Group moved this item to the active listing, categorized as nonsubstantive, and
exposed revisions to certain, remaining terminology references of “substantive” and “nonsubstantive,”

In response to an Aug. 14 referral from the Financial Condition (E) Committee, the edits are proposed to update the terminology references of “substantive” and “nonsubstantive,” which have historically been used to describe statutory accounting revisions being considered by the Working Group to the NAIC Accounting Practices & Procedures Manual. The Committee recommended terminology updates to alleviate concerns that users who are not familiar with the historical definitions of these terms may incorrectly perceive that the terms reflect potential financial impact rather than their intended definitions.

Accordingly, where applicable, the current concept/term of:

1) a “substantive” revision is proposed to be replaced with the phraseology of a “New SAP or New SAP concept in an existing SSAP,” and,
2) a “nonsubstantive” revision is proposed to be replaced with the phraseology of a “SAP clarification.”

Interested parties agree that the distinction between substantive (proposed to change to “development of new SSAPs or New SAP Concepts in an Existing SSAPs”) and non-substantive (proposed to change to “Development of SAP Clarifications”) can be confusing and that there would be more clarity in the development process if the distinction were eliminated.

Instead, we recommend that all new standards be handled similarly but that the effective date for each new standard be determined by evaluating the complexity of implementation (e.g., the extent that systems or process changes are required) and the availability of data to insurers to implement the new standard. This determination would be made as guidance is completed and with feedback from industry as to the time needed to adopt proposed reporting and/or disclosure.

Ref #2021-27: ASU 2021-04 - Issuer's Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions, as illustrated in the proposal, to incorporate guidance related to the accounting for the changes in fair value when exchanging equity-classified written call options, while rejecting the remainder of ASU 2021-04 in SSAP No. 72.

Interested parties have no comment on the approach taken in the exposed revisions but recommend that the revisions be expanded to provide more detail to clarify what guidance from GAAP is adopted and what is not (similar to the description generally provided in an SSAP).

Ref #2021-28: ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—Business Combinations and Goodwill to reject ASU 2021-
Statutory Accounting Principles Working Group
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03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting.

Interested parties have no comment on this item.

Ref #2021-29: ASU 2021-05 - Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to reject ASU 2021-05 in SSAP No. 22R.

Interested parties have no comment on this item.

Ref #2021-30: ASU 2021-06—Amendments to SEC Paragraphs in Topic 205, Topic 942 and Topic 946

The Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2021-06 as not applicable to statutory accounting.

Interested parties have no comment on this item.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell  Rose Albrizio

cc: NAIC staff
Interested parties

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/2022 naic meetings/spring national meeting/committee meetings/financial condition (e) committee/accounting practices and procedures (e) tf/sapwg/1c_cmt ltrs/dkb2358 final.docx
APPENDIX

Suggested Modification to SSAP 86 for Discussions Related to FX Hedging / Excluded Components

Proposed Modifications to the Main Body of SSAP No. 86

40. The gain or loss on a derivative designated as a hedge and assessed to be effective is reported consistently with the hedged item. If an entity’s defined risk management strategy for a particular hedging relationship excludes a specific component of the gain or loss, or related cash flows, on the hedged derivative from the assessment of hedged effectiveness (as discussed in Exhibit B), that excluded component of the gain or loss shall be recognized in accordance with Appendix C, as an unrealized gain or loss. For example, if the effectiveness of a hedge with an option contract is assessed based on changes in the option’s intrinsic value, the changes in the option’s time value would be recognized in unrealized gain or losses. Time value is equal to the fair value of the option less its intrinsic value.

Proposed Modifications to Exhibit B

2. In defining how hedge effectiveness will be assessed, an entity must specify whether it will include in that assessment all of the gain or loss on a hedging instrument. As discussed in paragraph 33, this statement permits (but does not require) an entity to exclude all or a part of the hedging instrument’s time value from the assessment of hedge effectiveness, as follows:

   a. If the effectiveness of a hedge with an option contract is assessed based on changes in the option’s intrinsic value, the change in the time value of the contract would be excluded from the assessment of hedge effectiveness.

   b. If the effectiveness of a hedge with an option contract is assessed based on changes in the option’s minimum value, that is, its intrinsic value plus the effect of discounting, the change in the volatility value of the contract would be excluded from the assessment of hedge effectiveness.

   c. If the effectiveness of a hedge with a forward or futures contract is assessed based on changes in fair value attributable to changes in spot prices, the change in the fair value of the contract related to the changes in the difference between the spot price and the forward or futures price would be excluded from the assessment of hedge effectiveness.

   d. If the effectiveness of a hedge with a foreign currency swap is assessed based on changes in fair value attributable to changes in spot rates, only the change in value of the foreign currency notional amount due to fluctuations in spot prices would be included in the assessment of effectiveness.

In each circumstance above, changes in the excluded component would be recognized in accordance with Appendix C, included in unrealized gains or losses. As noted in paragraph 1 of this Exhibit, the effectiveness of similar hedges generally should be assessed similarly; that includes whether a component of the gain or loss on a derivative is excluded in assessing effectiveness. No other components of a gain or loss on the designated hedging instrument may be excluded from the assessment of hedge effectiveness.

Proposed Modifications to Exhibit C

2. Swaps, Collars, and Forwards (see also discussion to Introduction above)

b. Statement Value

   iii. Open foreign currency swap and forward contracts hedging foreign currency exposure on items denominated in a foreign currency and translated into U.S. dollars where fair value accounting is not being used.
(a) **For forward contracts**, the foreign exchange premium (discount) on the currency contract shall be amortized into income over the life of the contract or hedge program. The foreign exchange premium (discount) is defined as the foreign currency (notional) amount to be received (paid) times the net of the forward rate minus the spot rate at the time the contract was opened.

Amortization is not required if the contract:

1) was entered into within a year of maturity; or
2) is a foreign currency swap. For foreign currency swaps, the equivalent of a forward contract’s premium (discount) is the cross-currency basis spread, which is amortized into income through the foreign currency swap’s periodic interest accruals.

(b) A foreign currency translation adjustment shall be reflected as an unrealized gain/loss (unassigned funds (surplus) adjustment) using the same procedures as done to translate the hedged item;

(c) The unrealized gain/loss for the period equals the foreign currency (notional) amount to be received (paid) times the net of the current spot rate minus the prior period end spot rate;

(d) The statement value of the derivative equals:

1) **For forward contracts**, the amortized (premium) discount plus the cumulative unrealized gains/(loss) on the contract.
2) **For foreign currency swaps**, the cumulative unrealized gains/(loss) on the contract. Amortization of the cross-currency basis spread is recorded on the balance sheet as Receivables (Payable) for Investment Income Due & Accrued or Other Liabilities, as a component of the foreign currency swap’s periodic interest accrual.

The cumulative unrealized gain/(loss) equals the foreign currency (notional) amount to be received (paid) times the net of the current spot rate minus the spot rate at the time the contract was opened.

(e) Recognition of unrealized gains/losses and amortization of foreign exchange premium/discount on derivatives hedging forecasted transactions or firm commitments shall be deferred until the hedged transaction occurs. These deferred gains/losses will adjust the basis or proceeds of the hedged transaction when it occurs;

(f) For hedges where the cost of the foreign currency contract is combined with the hedged item, the statement value on Schedule DB is zero. The fair value of the derivative and hedged item shall be determined and reported separately, either individually or in the aggregate;

(g) If during the life of the currency contract it or a designated portion of the currency contract is not effective as a hedge, the hedge relationship shall be discontinued and the derivative shall be recorded at fair value pursuant to paragraph 22—valuation at amortized cost shall cease. To the extent it ceased to be an effective hedge, a cumulative unrealized gain/loss (surplus adjustment) will be recognized equal to the difference between the carrying value of the derivative on the balance sheet (at the time of de-designation) and the fair value of the derivative (at the time of de-designation) notional amount or designated notional amount times the difference between the forward rate available for the remaining maturity of the contract (i.e., the forward rate as of the balance sheet date) and the forward rate at the time it ceased to be an effective hedge.
Proposed changes to Reporting

Updated to SSAP 86.62.vi:

86.62.vi net gain or loss recognized in unrealized gains or losses during the reporting period representing the component of the derivative instruments’ gain or loss, if any, excluded from the assessment of hedge effectiveness;

The change in fair value of derivative components excluded from the assessment of effectiveness (pursuant to paragraph 2 in Exhibit B). These changes in fair value that occurred during the period and cumulatively over the life to date of the hedge relationship shall be disclosed by derivative type.

Example disclosure

**Two examples to choose from - year to date or cumulative**

For the years ended December 31, 2021 and 2020 there were derivative fair value changes excluded from the assessment of hedge effectiveness of $3M and $5M, respectively, related to foreign exchange swaps and $6M and $13M, respectively, related to foreign currency forwards.

At December 31, 2021 and 2020 there were derivative fair value changes excluded from the assessment of hedge effectiveness of $8M and 10M, respectively, related to foreign exchange swaps and $4M and $10M, respectively, related to foreign currency forwards.

**Proposed Schedule DB changes for identifier:**

Add an “X” to the Code column 15 indicating the qualifying derivative has a difference between BACV and FV due to an excluded component.
Suggested Modification to SSAP 86 for Discussions Related to Alignment of Interest Rate Hedging with GAAP (Topic 815/ASU 2017-12)

Proposed Modifications to the Main Body of SSAP 86

26. Fair value hedges qualify for hedge accounting if all of the following criteria are met:

d. The hedged item is specifically identified as either all or a specific portion or partial term of a recognized asset or liability or of an unrecognized firm commitment. The hedged item is a single asset or liability (or a specific portion or partial term thereof) or is a portfolio of similar assets or a portfolio of similar liabilities (or a specific portion thereof) or closed portfolio of assets where assumed layer is anticipated to be outstanding (or a specific portion thereof). For partial term one or more consecutive selected contractual cash flows where the hedged item begins when the first hedge cash flow begins to accrue and ends when the last hedged cash flow is due and payable, the assumed maturity of the hedged item occurs on the date in which the last hedged cash flow is due and payable;

e. If similar assets or liabilities are aggregated and hedged as a portfolio, the individual assets or individual liabilities must share the risk exposure for which they are designated as being hedged. The change in fair value attributed to the hedged risk for each individual item in a hedged portfolio must be expected to respond in generally proportionate manner to the overall change in the fair value of the aggregate portfolio to the hedged risk;

f. For a closed portfolio of prepayable financial assets or one or more beneficial interests secured by a portfolio of prepayable financial instruments, an entity may designate as the hedged item a stated amount of the asset or assets that are not expected to be affected by prepayments, defaults, and other factors affecting the timing and amount of cash flows if the designation is made in conjunction with the partial-term hedging election in paragraph (this designation is referred to throughout as the “last-of-layer method” or “portfolio layer method”).

   a. For last-of-layer, an analysis shall be completed and documented to support the entity’s expectation that the hedged item (that is, the designated last of layer) is anticipated to be outstanding as of the hedged item’s assumed maturity date in accordance with the entity’s partial-term hedge election. That analysis shall incorporate the entity’s current expectations of prepayments, defaults, and other events affecting the timing and amount of cash flows associated with the closed portfolio of prepayable financial assets or beneficial interest(s) secured by a portfolio of prepayable financial instruments.

   b. For purposes of its analysis, the entity may assume that as prepayments, defaults, and other events affecting the timing and amount of cash flows occur, they first will be applied to the portion of the closed portfolio of prepayable financial assets or one or more beneficial interests that is not part of the hedged item (that is, the designated last of layer); and

g. If the hedged item is a financial asset or liability, a recognized loan servicing right, or a nonfinancial firm commitment with financial components, the designated risk being hedged is:

   i. The risk of changes in the overall fair value of the entire hedged item;

   ii. The risk of changes in its fair value attributed to changes in benchmark interest rate risk;

   iii. The risk of changes in its fair value attributed to change in the related foreign currency exchange rates; or

   iv. The risk of changes in its fair value attributable to both change in the obligor’s creditworthiness and changes in the spread over the benchmark interest rate with respect to the financial asset’s or liability’s credit sector at inception of the hedged (referred to as credit risk).
If the risk designated as being hedged is not the risk in paragraph 26.f.i, two or more of the other risks (benchmark interest rate risk, foreign currency exchange risk, and credit risk) may simultaneously be designated as being hedged.

The benchmark interest rate being hedged in a hedge of interest rate risk must be specifically identified as part of the designation and documentation at the inception of the hedge relationship. In calculating the change in the hedged item’s fair value attributable to changes in the benchmark interest rate, the estimated cash flows used in calculating fair value must be based on all of the contractual cash flows of the entire hedged item or the benchmark rate component of the contractual coupon cash flows of the hedged item determined at hedge inception. An entity may designate a fair value hedge of interest rate risk in which the hedged item is a prepayable instrument. The entity may consider only how changes in the benchmark interest rate affect the decision to settle the hedged item before its scheduled maturity (for example, an entity may consider only how changes in the benchmark interest rate affect an obligor’s decision to call a debt instrument when it has the right to do so). The entity need not consider other factors that would affect this decision (for example, credit risk) when assessing hedge effectiveness. Excluding some of the hedged item’s contractual cash flows (for example the portion of the interest rate coupon in excess of the benchmark interest rate) from the calculation is not permitted. An entity may not simply designate prepayment risk as the risk being hedged for a financial asset. However, it can designate the option component of a prepayable instrument as the hedged item in a fair value hedge of the entity’s exposure to changes in the fair value of that “prepayment” option, perhaps thereby achieving the objective of its desire to hedge prepayment risk. The effect of an embedded derivative of the same risk class must be considered in designating a hedge of an individual risk. For example, the effect of an embedded prepayment option must be considered in designating a hedge of benchmark interest rate risk.

**Proposed Modifications to Exhibit B**

8. Conditions applicable to fair value hedges only
   f. The expiration date of the swaps matches the maturity date or assumed maturity date of the interest-bearing asset or liability.
   g. There is no floor or cap on the variable interest rate of the swap
   h. The interval between repricing of the variable interest in the swap is frequent enough to justify an assumption that the variable payment or receipt is at a market rate (generally three to six months or less).
   i. For last-of-layer If both of the following conditions exist, the quantitative test described for similar asset test may be performed qualitatively and only at hedge inception:

   a. The hedged item is a closed portfolio of prepayable financial assets or one or more beneficial interests.
   b. An entity measures the change in fair value of the hedged item based on the benchmark rate component of the contractual coupon cash flows.

Using the benchmark rate component of the contractual coupon cash flows when all assets have the same assumed maturity date and prepayment risk does not affect the measurement of the hedged item results in all hedged items having the same benchmark rate component coupon cash flows.

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/membermeetings/2022 naic meetings/spring national meeting/committee meetings/financial condition (e) committee/accounting practices and procedures (e) tf/sapwg/1c_cmt ltrs/appendix ssap86.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: General Interrogatory for Cryptocurrencies

Check (applicable entity):

- Modification of Existing SSAP
- New Issue or SSAP
- Interpretation

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<th>Health</th>
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Description of Issue: On May 20, 2021, the Statutory Accounting Principles (E) Working Group adopted INT 21-01: Accounting for Cryptocurrencies, which addressed the statutory accounting treatment for cryptocurrencies, and established that directly held cryptocurrencies do not meet the definition of an admitted asset for statutory accounting. While researching this topic, it was noted that some insurance companies held cryptocurrencies, but that these were not always easy to identify in the statutory financial statements. Additionally, as the use of cryptocurrencies by insurance companies evolves, regulators expressed a desire to better understand how companies are using cryptocurrencies. NAIC staff were directed by the Working Group to look at possible ways to get a better view of how cryptocurrencies are currently directly held and used by insurance companies.

NAIC staff have proposed a new general interrogatory within the annual reporting blanks with several questions specific to cryptocurrencies. This is proposed as a new general interrogatory as this is information that has not been previously disclosed and does not fit well with any existing disclosures.

There are no proposed changes to statutory accounting, however the agenda item does result in a sponsored blanks proposal to the Blanks (E) Working Group to incorporate the general interrogatory and related instructions. NAIC staff from the Statutory Accounting Principles (E) Working Group will work directly with the Blanks (E) Working Group staff support.

Existing Authoritative Literature: As articulated in the “description of issue” section, INT 21-01 established that directly held cryptocurrencies do not meet the definition of an admitted asset and are therefore nonadmitted for statutory accounting.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): INT 21-01, discussed in the prior section.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): The IFRS Interpretations Committee issued a statement in June 2019 concluding that cryptocurrencies are not financial assets, however that they do meet the definition of an intangible asset.

Staff Recommendation:
NAIC staff recommends that the Working Group forward a sponsored blanks proposal to the Blanks (E) Working Group to add a new general interrogatory to the annual statement blanks to capture information about cryptocurrencies directly held or permitted for the remittance of premiums. Note, this agenda item does
not propose statutory revisions. The proposed additions to the reporting blanks and the blanks instructions are shown below.

Annual Statement Instructions, General Interrogatories, Investment Section: (All Types):

38.1 Answer “YES” if the company directly owns cryptocurrencies. Answer “NO” if the company does not directly own cryptocurrencies or only holds cryptocurrencies indirectly through funds (ETFs, Mutual Funds, etc.) INT 21-01: Accounting for Cryptocurrencies established that directly held cryptocurrencies do not meet the definition of cash or an admitted asset and are therefore considered to be a nonadmitted asset for statutory accounting.

38.2 If the answer to 38.1 is “YES”, specify on which schedule they are reported. (e.g., Schedule BA, etc.)

39.2 If the answer to 39.1 is “YES”, indicate if it is the policy of the reporting entity to directly hold cryptocurrency accepted as payment for premiums or immediately convert to U.S. dollars. Select “YES” for both questions if some cryptocurrencies are held directly and others are immediately converted to U.S. dollars.

39.21 Answer “YES” if it is the policy of the reporting entity to directly hold cryptocurrency that was accepted as payment for premiums.

39.22 Answer “YES” if it is the policy of the reporting entity to immediately convert cryptocurrency accepted as payment for premiums to U.S. dollars.

39.3 If the answer to 38.1 or 39.1 is “YES”, complete Columns 1 through 3 for each cryptocurrency accepted for payments of premiums or held directly.

Name of Cryptocurrency:

Provide the name of each cryptocurrency accepted for payments of premiums or held directly.

Immediately Converted to USD, Directly Held, or Both:

For each cryptocurrency listed, provide one of the following responses:

• Immediately converted to USD
• Directly held,
• Both.

Accepted for Payment of Premiums:

If the cryptocurrencies are accepted for the payment of premiums provide the response of “YES” in the column otherwise the response in the column should be “NO”.
Annual Statement Blanks, General Interrogatories, Investment Section: (All Types):

38.1 Does the reporting entity directly hold cryptocurrencies?  
Yes [ ] No [ ]

38.2 If the response to 38.1 is yes, on what schedule are they reported?  

39.1 Does the reporting entity directly or indirectly accept cryptocurrencies as payment for premiums on policies?  
Yes [ ] No [ ]

39.2 If the response to 39.1 is yes, are the cryptocurrencies held directly or are they immediately converted to U.S. dollars?  
39.21 Held directly  
Yes [ ] No [ ]

39.22 Immediately converted to U.S. dollars  
Yes [ ] No [ ]

39.3 If the response to 38.1 or 39.1 is yes, list all cryptocurrencies accepted for payments of premiums or that are held directly.

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<thead>
<tr>
<th>1</th>
<th>Name of Cryptocurrency</th>
<th>2</th>
<th>Immediately Converted to USD, Directly Held, or Both</th>
<th>3</th>
<th>Accepted for Payment of Premiums</th>
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Staff Review Completed by: Jake Stultz, NAIC Staff, November 2021

Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing and exposed proposed revisions to be incorporated into a Blanks (E) Working Group proposal to add a new general interrogatory to the annual blanks, requiring disclosure of when cryptocurrencies are directly held or permitted for the remittance of premiums. This agenda item did not propose statutory revisions.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted this agenda item, which did not result in statutory accounting revisions, however adoption expressed support of the corresponding Blanks (E) Working Group proposal (2022-01BWG), which incorporates a new general interrogatory to detail if cryptocurrencies are directly held or permitted for the remittance of premiums.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1D_21-24_CryptocurrencyGI.docx
Ref #2021-28

Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events

**Check (applicable entity):**

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**Description of Issue:**

In March 2021, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) 2021-03, Intangibles – Goodwill and Other – Accounting Alternative for Evaluating Triggering Events to provide private companies and not-for-profit entities with an optional accounting alternative for the performance of a goodwill impairment triggering evaluation. Goodwill impairment guidance requires entities to evaluate if the fair value of a reporting entity (that possesses goodwill) is less than its carrying value. Under guidance prior to this ASU, if it were deemed that it was more likely than not that goodwill was impaired, goodwill was tested for impairment using the triggering event date as the measurement date.

Several concerns regarding triggering event evaluations were raised by certain entities, specifically that the cost and complexity to evaluate interim triggering events was burdensome and operationally many private entities likely only evaluate impairment at the end of a reporting period. With these circumstances, the ASU referenced that it may be unduly difficult for these entities to determine a specific triggering date or even identify that a triggering event had occurred. Additionally, the temporary variability in values as a result of the COVID-19 pandemic likely exacerbated this issue.

Accordingly, the amendments in this ASU allow an accounting alternative to perform a goodwill impairment triggering event evaluation only as of the end of a reporting period, regardless of if that is an interim or an annual period. If an entity elects this alternative, they will only evaluate goodwill for impairment as of each reporting date. As a key note, this election is permitted for private and not-for-profit entities regardless of which U.S. GAAP accounting treatment was elected for goodwill (i.e., impairment only or straight-line amortization).

**Existing Authoritative Literature:**

**Staff note** – while the calculation of goodwill differs between U.S. GAAP and Statutory Accounting, the foundation of goodwill is similar. For completeness of this document, applicable goodwill references, as well as impairment guidance, have been included herein. Certain relevant items have been bolded for emphasis.

**SSAP No. 68—Business Combinations and Goodwill**

**Statutory Purchases of SCA Investments**

3. The statutory purchase method of accounting is defined as accounting for a business combination as the acquisition of one entity by another. It shall be used for all purchases of SCA entities including partnerships, joint ventures, and limited liability companies. The acquiring reporting entity shall record its investment at cost. Cost is defined as the sum of: (a) any cash payment, (b) the fair value of other assets distributed, (c) the fair value of any liabilities assumed, and (d) any direct costs of the acquisition.\(^{[\text{INT 00-28}]}\) Contingent consideration issued in a purchase business combination that is embedded in a security or that
is in the form of a separate financial instrument shall be recorded by the issuer at fair value at the acquisition date.

4. For those acquired SCA entities accounted for in accordance with paragraphs 8.b.i., 8.b.ii., 8.b.iii. or 8.b.iv. of SSAP No. 97, and joint venture, partnership or limited liability company entities accounted for in accordance with paragraph 8 of SSAP No. 48, goodwill is defined as the difference between the cost of acquiring the entity and the reporting entity’s share of the book value of the acquired entity. When the cost of the acquired entity is greater than the reporting entity’s share of the book value, positive goodwill exists. When the cost of the acquired entity is less than the reporting entity’s share of the book value, negative goodwill exists. Goodwill resulting from assumption reinsurance shall be recorded as a separate write-in for other-than-invested assets. All other goodwill shall be reported in the carrying value of the investment.

5. A business combination accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with paragraphs 8.b.ii., 8.b.iii. or, 8.b.iv. of SSAP No. 97 shall determine the amount of positive goodwill or negative goodwill created by the combination using the reporting entity’s share of the GAAP net book value of the acquired entity, adjusted to a statutory basis of accounting in accordance with paragraph 9 of SSAP No. 97 in the case of acquired entities valued in accordance paragraphs 8.b.ii. or 8.b.iv. of SSAP No. 97. Business combinations accounted for under the statutory purchase method and in which the acquired entity is valued in accordance with, paragraph 8.b.i. of SSAP No. 97 shall determine the amount of positive or negative goodwill created by the business combination using the insurer’s share of the statutory book value of the acquired entity.

6. For those acquired SCA entities accounted for in accordance with paragraph 8.b.i. of SSAP No. 97 under the statutory purchase method, the historical bases of the acquired entity shall continue to be used in preparing its statutory financial statements. Therefore, pushdown accounting is not permitted.

7. Positive goodwill recorded under the statutory purchase method of accounting shall be admitted subject to the following limitation: Positive goodwill from all sources, including life, accident and health, and deposit-type assumption reinsurance and goodwill resulting from the acquisition of an SCA by the insurance reporting entity that is reported on the SCA’s financial statements (resulting from the application of pushdown accounting), is limited in the aggregate to 10% of the acquiring entity’s capital and surplus as required to be shown on the statutory balance sheet of the reporting entity for its most recently filed statement with the domiciliary state commissioner adjusted to exclude any net positive goodwill, EDP equipment and operating system software, and net deferred tax assets. Additionally, all positive goodwill shall be nonadmitted when the underlying investment in the SCA or partnership, joint venture and limited liability company is nonadmitted. When negative goodwill exists, it shall be recorded as a contra-asset.

8. Positive or negative goodwill resulting from the purchase of an SCA, joint venture, partnership or limited liability company shall be amortized to unrealized capital gains and losses on investments over the period in which the acquiring entity benefits economically, not to exceed 10 years. Positive or negative goodwill resulting from life, accident and health, and deposit-type assumption reinsurance shall be amortized to operations as a component of general insurance expenses over the period in which the assuming entity benefits economically, not to exceed 10 years. Goodwill shall be evaluated separately for each transaction. (INT 01-18)

Impairment

9. For any decline in the fair value of an entity, acquired through a purchase, that is other than temporary, the investment shall be written down to fair value as the new cost basis and the amount of the write down shall be accounted for as a realized loss. The write down shall first be considered as an adjustment to any portion of the investment that is nonadmitted (e.g., nonadmitted goodwill). The new cost basis shall not be changed for subsequent recoveries in fair value. Future declines in fair value, which are determined to be other than temporary, shall be recorded as realized losses. A long-
lived asset shall be tested for recoverability whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. The following are examples of such triggering events or changes in circumstances:

a. A significant decrease in the fair value of a long-lived asset

b. A significant adverse change in the extent or manner in which a long-lived asset is being used or in its physical condition

c. A significant adverse change in legal factors or in the business climate that could affect the value of a long-lived asset, including an adverse action or assessment by a regulator

d. An accumulation of costs significantly in excess of the amount originally expected for the acquisition or construction of a long-lived asset

e. A current period operating or cash flow loss combined with a history of operating or cash flow losses or a projection or forecast that demonstrates continuing losses associated with the use of a long-lived asset

f. A current expectation that, more likely than not, a long-lived asset will be sold or otherwise disposed of significantly before the end of its previously estimated useful life

10. An impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to recover the carrying amount of the investment or there is evidence indicating inability of the investee to sustain earnings which would justify the carrying amount of the investment. A fair value of an investment that is below the carrying amount based on the statutory equity method or the existence of investee operating losses may indicate a loss in value; however, they are not necessarily indicative of a loss in value that is other than temporary.

Staff note: In addition to the guidance in SSAP No. 68, INT 06-07: Definition of Phrase “Other Than Temporary” also provides authoritative guidance for when an impairment has occurred. While INT 06-07 has been included below, with certain relevant items bolded for emphasis, the requirement for impairment is an assessment - if an impairment indicator is present. Thus, it does not permit the delaying of an impairment assessment until a reporting period, nor does it permit assessment differentiation based on entity type (public vs. private or a not-for-profit entity).

INT 06-07: Definition of Phrase “Other than Temporary”

1. The Accounting Practices and Procedures Manual contains guidance for determining when an investment is considered impaired within each of the above identified statements. Those statements should also be used to determine the measurement of an impairment loss. Each of the above statements also makes reference to an “other than temporary” decline in fair value. This interpretation is designed to address questions related to that phrase, as well as summarize the statutory accounting process for determining when an investment is considered impaired.

Step 1: Determine Whether an Investment Is Impaired

2. The decision for determining when an investment is considered impaired is dictated by the applicable SSAP and the respective impairment indicators included in each of the SSAPs. If an impairment indicator is present, the determination of an impairment shall be assessed at the individual security or investment level as reported in the annual statement and supporting schedules. For those SSAPs that require the reporting entity to use the fair value to determine if an impairment has occurred, the determination of that value shall be consistent with how the term fair value is defined within SSAP No. 100—Fair Value. Once a reporting entity has determined that an impairment indicator is present, the reporting entity shall continue to evaluate whether the investment is impaired each subsequent reporting
period until either (a) the investment experiences a recovery of the fair value up to (or beyond) its carrying value or (b) the investor recognizes an other-than-temporary impairment loss.

**Step 2: Evaluate Whether an Impairment Is Other Than Temporary**

3. There are numerous factors to be considered when determining whether an impairment is other than temporary and their relative significance will vary from case to case. The Emerging Accounting Issues (E) Working Group (Working Group) has been asked if the phrase “other than temporary” should be interpreted to mean “permanent.” The Working Group believes the Statutory Accounting Principles (E) Working Group consciously chose the phrase “other than temporary” as the analysis was not intended to determine whether an individual security or investment was “permanently impaired.” **The fair value of assets may decline for various reasons. The market price may be affected by general market conditions, which reflect prospects for the economy as a whole, or by specific information pertaining to an industry or an individual company. Such declines require further investigation by management. Acting upon the premise that a write-down may be required, management should consider all available evidence to evaluate the fair value of its investment.**

4. The Working Group believes that the following items are only a few examples of the factors, which, individually or in combination, indicate that a security’s decline in value is specific to an issuer’s fundamental credit difficulties, or that a non-interest related decline is other than temporary and that a write-down of the carrying value is required:

   a. The length of time and the extent to which the fair value has been less than cost;

   b. The financial condition and short-term prospects of the issuer, including any specific events that may influence the operations of the issuer, such as changes in technology, that may impair the earnings potential of the asset or the discontinuance of a segment of the business that may affect the future earnings potential; or

   c. The intent and ability of the holder to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in value.

5. **An interest related impairment should be deemed other-than-temporary when an investor has the intent to sell an investment, at the reporting date, before recovery of the cost of the investment.** The investor should consider whether its cash or working capital requirements and contractual or regulatory obligations indicate that the investment may need to be sold before the forecasted recovery occurs. The term “interest related” includes a declining value due to both increases in the risk free interest rate and general credit spread widening. Credit spreads can widen or contract for a variety of reasons, including supply/demand imbalances in the marketplace or perceived higher/lower risk of an entire sector. If the declining value is caused, in whole or in part, due to credit spreads widening, but not due to fundamental credit problems of the issuer, the change in credit spreads is deemed to be interest related. Fundamental credit problems exist with the issuer when there is evidence of financial difficulty that may result in the issuer being unable to pay principal or interest when due.

6. **Unless evidence exists to support the assertion that the decline in fair value below carrying value is temporary, a write-down, accounted for as a realized loss, should be recorded.** In accordance with the guidance of the SSAPs, such loss should be recognized in income for the period in which other than temporary impairment is determined to have occurred. The adjusted carrying value reflecting the impairment loss of the individual security or investment shall be the new cost basis of the individual security or investment.

7. The Working Group has also been asked if it is appropriate for reporting entities, independent auditors or state examiners to apply predefined thresholds to the phrase “other than temporary”? The Working Group is aware that certain insurers, independent auditors and state examiners, over time, have developed quantitative thresholds as “rules of thumb” to assist in the evaluation of asset impairment. One
rule of thumb in particular suggests that if the fair value is less than its carrying value by 20 percent or more, then it is considered to be other than temporarily impaired. Another suggests that an asset is other than temporarily impaired if the fair value has been less than cost for more than 6 months. The use of a numerical threshold may provide the basis for a preliminary assumption that – without considering all relevant circumstances – an impairment may have occurred. Identifying the impairment is only the beginning of the analysis; it cannot appropriately be used as a substitute for a full analysis of all relevant qualitative considerations. Exclusive reliance on such thresholds removes the ability of management to apply its judgment, a concept inherent to the impairment model.

**Step 3: If the Impairment is Other Than Temporary, the Cost Basis of the Individual Asset Shall Be Written Down to a New Cost Basis and the Amount of the Write-Down Is Accounted for as a Realized Loss**

8. If an impairment is considered other than temporary, the cost or carrying value of the asset should be written down to reflect its value in accordance with the relevant SSAP. A company’s management should follow the impairment guidance in the SSAP pertaining to that particular asset class while considering various factors on a case-by-case basis in determining the amount of the realized loss that should be recorded.

**Activity to Date** (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None


**Staff Recommendation:**

NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 68 —*Business Combinations and Goodwill* to reject ASU 2021-03, *Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting*. Rejecting this ASU will result with continuation of existing guidance from INT 06-07, which does not permit delays in impairment assessment or variations in assessment based on type of entity.

Proposed revisions to SSAP No. 68 (Relevant Literature section – paragraph 22):


**Staff Review Completed by:** Jim Pinegar, NAIC Staff – October 2021
Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 68—Business Combinations and Goodwill to reject ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to SSAP No. 68—Business Combinations and Goodwill rejecting ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1E_21-28_ASU2021-03.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments

Check (applicable entity):

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<td>Interpretation</td>
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Description of Issue: In July 2021, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments. This ASU was issued as part of FASB's post-implementation review to address issues that have been found during the implementation of the new lease guidance from ASU 2016-02, Leases (Topic 842). The guidance in ASU 2021-05 applies to lessors with lease contracts that: 1) have variable lease payments that do not depend on a reference index or rate, and/or 2) would have resulted in the lessor being required to recognize a day one selling loss (at lease commencement) if those leases were classified as sales-type or direct financing. The changes to Topic 842 will require a lessor to classify a lease with variable lease payments that do not depend on an index or a rate as an operating lease at lease commencement if classifying the lease as a sales-type lease or a direct financing lease would result in the recognition of a selling loss. SSAP No. 22R—Leases requires nearly all leases to be treated as operating leases for statutory accounting, so adoption of this guidance would be redundant and unnecessary.

Existing Authoritative Literature:
The ASUs related to Topic 842 have previously been rejected in SSAP No. 22R—Leases.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): ASC Topic 842 was the result of a joint project between FASB and the International Accounting Standards Board.

Recommendation: Staff recommends the Working Group move this agenda item to the active listing, categorized as nonsubstantive and expose revisions to reject ASU 2021-05 in SSAP No. 22R—Leases. Under statutory accounting almost all leases are classified as operating leases, thus this U.S. GAAP guidance is not necessary.

Proposed Revision to SSAP No. 22R (Relevant Literature section – paragraph 52):

i. ASU 2020-02, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments (Rejected in its entirety.)

Staff Review Completed by: Jake Stultz, NAIC Staff – August 2021
**Status:**
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to reject ASU 2021-05 in SSAP No. 22R.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated above, to reject *ASU 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments* in *SSAP No. 22R—Leases.*

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1F_21-29_ASU2021-05.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: ASU 2021-06—Amendments to SEC Paragraphs in Topic 205, Topic 942 and Topic 946

Check (applicable entity):

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Description of Issue:
The Financial Accounting Standards Board issued Accounting Standard Update (ASU) 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants, which effects only SEC paragraphs in Topic 205, Topic 942 and Topic 946. These edits are predominantly formatting and paragraph references, with new guidance duplicated from SEC requirements on the presentation of financial statements for funds acquired or to be acquired.

Existing Authoritative Literature:
Generally, all SEC guidance from ASUs is rejected as not applicable for statutory accounting in Appendix D—Nonapplicable GAAP Pronouncements.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): None

Staff Recommendation: NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive, and expose revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants as not applicable to statutory accounting.

This item is proposed to be rejected as not applicable as ASU 2021-06 is specific to deletion and modification of SEC paragraphs, which are not applicable for statutory accounting purposes.

Staff Review Completed by: Jake Stultz, November 2021
Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject ASU 2021-06 as not applicable to statutory accounting.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to *Appendix D—Nonapplicable GAAP Pronouncements* to reject ASU 2021-06 as not applicable to statutory accounting.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1G_21-30_ASU2021-06.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 43R – Financial Modeling – Updated Guidance

Check (applicable entity):

- Modification of Existing SSAP: ☒
- New Issue or SSAP: ☐
- Interpretation: ☐

P/C | Life | Health
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Description of Issue: This agenda item reflects updated NAIC designation/NAIC designation category guidance recently adopted by the Valuation of Securities (E) Task Force (VOSTF) to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS).

On October 20, 2021, the VOSTF adopted instructions to the P&P Manual to designate that 1) modeled RMBS/CMBS tranches that do not have expected losses will be assigned an NAIC 1 Designation and a NAIC 1.A. Designation Category, and 2) financial modeling for “legacy” RMBS/CMBS securities (those that closed prior to January 1, 2013), shall continue to utilize the insurer’s carrying value for said modeling.

This agenda item has been drafted to ensure the financial modeling guidance summarized in SSAP No. 43R—Loan-Backed and Structured Securities reflects the practices as directed by the P&P Manual. (Note, while the Accounting Practices and Procedures Manual is higher than the P&P manual in the statutory hierarchy, the primary source of authoritative guidance for financial modeling is the P&P manual as only a general description of the modeling process is included in SSAP No. 43R).

Existing Authoritative Literature:

SSAP No. 43R—Loan-Backed and Structured Securities

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A, respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A., regardless of the carrying value. The three-step process for modeled securities is as follows:
i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. The final designation is mapped to an NAIC designation category according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), loan-backed and structured securities, and mortgage-referenced securities with SVO assigned NAIC designations. [NAIC staff note, it is anticipated that the revisions shown above in this paragraph will be reflected when agenda item 2021-11: SSAP No. 43R – CTL is adopted. As these edits do not impact this agenda item, they are shown here for reference and accordingly, are not shown below in the options presented for possible exposure.]

Specific Interim Reporting Guidance Financially Modeled Securities

28. For securities that will be financially modeled under paragraph 27, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.

b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.
c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).

SSAP No. 43R - EXHIBIT A – Question and Answer Implementation Guide

Index to Questions

<table>
<thead>
<tr>
<th>Questions 8-10 are specific to securities subject to the financial modeling process. (This process is limited to qualifying RMBS/CMBS securities reviewed by the NAIC Structured Securities Group.) The guidance in questions 8-10 shall not be inferred to other securities in scope of SSAP No. 43R.</th>
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8. **Question** – Do LBSS purchased in different lots result in a different NAIC designation for the same CUSIP? Can reporting entities use a weighted average method determined on a legal entity basis?

8.1 Under the financial modeling process (applicable to qualifying RMBS/CMBS reviewed by the NAIC Structured Securities Group), the amortized cost of the security impacts the “final” NAIC designation used for reporting and RBC purposes. As such, securities subject to the financial modeling process acquired in different lots can result in a different NAIC designation for the same CUSIP. In accordance with the current instructions for calculating AVR and IMR, reporting entities are required to keep track of the different lots separately, which means reporting the different designations. For reporting purposes, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. (For example, all acquisitions of the identical CUSIP resulting with an NAIC 1 designation may be aggregated, and all acquisitions of the identical CUSIP resulting with an NAIC 3 designation may be aggregated.)

9. **Question** – The NAIC Designation process for LBSS subject to the financial modeling process may incorporate loss expectations that differ from the reporting entity’s expectations related to OTTI conclusions. Should the reporting entities be required to incorporate recovery values obtained from data provided by the service provider used for the NAIC Designation process for impairment analysis as required by SSAP No. 43R?
In accordance with INT 06-07: Definition of Phrase “Other Than Temporary,” reporting entities are expected to “consider all available evidence” at their disposal, including the information that can be derived from the NAIC designation.

**Question** - For companies that have separate accounts, can the NAIC designation be assigned based upon the total legal entity or whether it needs to be calculated separately for the general account and the total separate account?

10.1 The financial modeling process for qualifying RMBS/CMBS securities is required for applicable securities held in either the general or separate account.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):**

- To be consistent with the P&P Manual revisions, agenda item 2018-19 eliminated the multi-step designation guidance for modified filing exempt (MFE) securities. The elimination of MFE was effective March 31, 2019, with early application permitted for year-end 2018. With the elimination of MFE, for securities that are filing exempt, the NAIC designation reported will correspond to the CRP rating without adjustment based on carrying value. Also, in agenda item 2018-03, the Working Group clarified that securities acquired in lots shall not be reported with weighted average designations. With the adopted guidance, if a SSAP No. 43R security (by CUSIP) has different NAIC designations by lot, the reporting entity shall either 1) report the aggregate investment with the lowest applicable NAIC designation or 2) report the investment separately by purchase lot on the investment schedule. If reporting separately, the investment may be aggregated by NAIC designation. With the elimination of MFE, the instances of different designations by lot is not expected to be prevalent, but could still occur with the financial modeling process for RMBS and CMBS.

- In November 2020, the Working Group adopted edits to SSAP No. 43R from agenda item 2020-21: SSAP No. 43R – Designation Categories for RMBS/CMBS investments, incorporating newly adopted VOSTF guidance to the P&P manual detailing the use and mapping of NAIC designations to NAIC designation categories. Reporting entities were to then utilize the new NAIC designation categories for accounting and reporting purposes.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:**

None

**Convergence with International Financial Reporting Standards (IFRS):** Not Applicable

**Staff Recommendation:** NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 43R—Loan-backed and Structured Securities to reflect the updated financial modeling guidance for RMBS/CMBS securities. These revisions reflect the guidance recently adopted for the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual).

NAIC staff note - Two options for incorporating the newly revised P&P manual guidance are presented below. Option 1 retains the past approach to summarize the financial modeling approach. Option 2 removes the summary and instead refers to the P&P Manual. When the modeling guidance was first adopted, it was identified as necessary to summarize in the AP&P. However, as the concept is no longer new, NAIC staff requests feedback on the extent
the guidance needs to be retained. Since the P&P Manual governs this process, the AP&P guidance must currently be updated anytime they incorporate a change.

Proposed Revisions to SSAP No. 43R—Loan-Backed and Structured Securities

OPTION #1 – Retain existing guidance in SSAP No. 43R with updates to reflect recent actions of the VOSTF. (If this option is preferred, further updates are likely forthcoming as the VOSTF considers additional modifications to the financial modeling guidance.)

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process or the NAIC designation assigned by the NAIC Securities Valuation Office. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. For a modeled legacy security, meaning one which closed prior to January 1, 2013, the NAIC designation is based on financial modeling incorporating the insurers’ carrying value. For the security a modeled on-legacy security, meaning one which closed after December 31, 2012, the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used. For those legacy securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, a modeled legacy security RMBS or CMBS tranche that has no expected loss, as compiled and published by the NAIC Securities Valuation Office, under any of the selected modeling scenarios would be assigned an NAIC 1 designation and NAIC 1.A designation category regardless of the insurer’s book/adjusted carrying value. Securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A, respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A, regardless of the carrying value. The three-step process for modeled legacy securities is as follows:

i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to each the six (6) NAIC designations and NAIC designation category for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined, as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations and NAIC designation category for each CUSIP or. The final designation is mapped to an NAIC designation category, according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes.
Ref #2021-23

and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.

Specific Interim Reporting Guidance Financially Modeled Securities

28. For securities that will be financially modeled under paragraph 27, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year-end.

b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.

c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPS, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).

OPTION #2 – Remove summarized financial modeling guidance from SSAP No. 43R and refer to the guidance in the P&P Manual. (If this option is preferred, further updates to financial modeling guidance are expected to be isolated to the P&P Manual, which is the governs the designation process.)

Designation Guidance

27. NAIC designations are determined in accordance with the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). The NAIC designations shall be applicable for statutory accounting and reporting purposes (including determining the carrying value and establishing the AVR charges). For RMBS/CMBS securities within the scope of this statement may be subject to the financial modeling process. The P&P Manual shall be consulted for the specific process for obtaining or determining the NAIC designation. The initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is
determined using a multi-step process. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. **Financial Modeling:** Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP-specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A., respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A., regardless of the carrying value. The three-step process for modeled securities is as follows:

i. **Step 1: Determine Initial Designation** – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. **Step 2: Determine Carrying Value Method** – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. **Step 3: Determine Final Designation** – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP-specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. The final designation is mapped to an NAIC designation category according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes, and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. **All Other Loan-Backed and Structured Securities:** For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.

**Specific Interim Reporting Guidance Financially Modeled Securities**

27. For securities that will be financially modeled under paragraph 27, the guidance in this paragraph shall be applied in determining the reporting method for such securities acquired in the current year for quarterly financial statements. Securities reported as of the prior-year end shall continue to be reported under the prior-year end methodology for the current-year quarterly financial statements. For year-end reporting, securities shall be reported in accordance with paragraph 27, regardless of the quarterly methodology used.

a. Reporting entities that acquired the entire financial modeling database for the prior-year end are required to follow the financial modeling methodology (paragraph 27.a.) for all
Ref #2021-23

securities acquired in the subsequent year that were included in the financial modeling data acquired for the prior year end.

b. Reporting entities that acquired identical securities (identical CUSIP) to those held and financially modeled for the prior year-end are required to follow the prior year-end financial modeling methodology (paragraph 27.a.) for these securities acquired subsequent to year-end.

c. Reporting entities that do not acquire the prior-year financial modeling information for current-year acquired individual CUSIPs, and are not captured within paragraphs 28.a. or 28.b., are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate). Reporting entities that do acquire the individual CUSIP information from the prior-year financial modeling database shall use that information for interim reporting.

d. Reporting entities that acquire securities not previously modeled at the prior year-end are required to follow the analytical procedures for non-financially modeled securities (paragraph 27.b. as appropriate).

Staff Review Completed by: Jim Pinegar, NAIC Staff – October 2021

Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed two options for possible revision, as illustrated above, to update the summarized financial modeling guidance in SSAP No. 43R. The first option will retain existing guidance, with updates to reflect Valuation of Securities (E) Task Force adopted edits. The second option removes the summarized financial modeling guidance and refers users to the Purposes and Procedures Manual of the NAIC Investment Analysis Office, which is the source document for financial modeling guidance.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions, as illustrated below, retaining, but updating summarized financial modeling guidance for residential mortgage-backed securities and commercial mortgage-backed securities in SSAP No. 43R—Loan-Backed and Structured Securities. The revisions incorporate a minor grammatical edit as proposed by interested parties.

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process or the NAIC designation assigned by the NAIC Securities Valuation Office. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. For a modeled legacy security, meaning one which closed prior to January 1, 2013, the NAIC designation is based on financial modeling incorporating the insurers' carrying value. For the security a modeled non-legacy security, meaning one which closed after December 31, 2012, the NAIC designation and NAIC designation category assigned by the NAIC Securities Valuation Office must be used. For those legacy securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, a modeled legacy security RMBS or CMBS tranche that has no expected loss, as compiled and published by the NAIC Securities Valuation Office, under any of the selected modeling scenarios would be assigned an NAIC 1 designation and NAIC 1.A designation category regardless of the insurer’s book/adjusted carrying value.
value, securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A., respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A., regardless of the carrying value. The three-step process for modeled legacy securities is as follows:

i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to each the six (6) NAIC designations and NAIC designation category for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations and NAIC designation category for each CUSIP, or. The final designation is mapped to an NAIC designation category, according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26.
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual* (AP&P Manual), such as editorial corrections, reference changes and formatting.

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<th>SSAP/Appendix</th>
<th>Description/Revision</th>
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| Various       | Pursuant to an Aug. 14 referral from the Financial Condition (E) Committee, the edits propose herein update the terminology references of “*substantive*” and “*nonsubstantive*,” which have historically been used to describe statutory accounting revisions being considered by the Statutory Accounting Principles (E) Working Group to the AP&P Manual. The Committee recommended terminology updates to alleviate concerns that users who are not familiar with the historical definitions of the aforementioned terms may incorrectly perceive that the terms reflect potential financial impact rather than their intended definitions. Accordingly, where applicable, the current concept/term of:

1) a “*substantive*” revision is proposed to be replaced with the phraseology of a “New SAP or New SAP concept in an existing SSAP,” and,

2) a “*nonsubstantive*” revision is proposed to be replaced with the phraseology of a “SAP clarification.”

Agenda item 2021-14: SAP Terminology, which was previously exposed by the Working Group on Aug. 26, addresses the proposed terminology/phraseology changes in the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* (Appendix F). This editorial agenda item identifies all remaining uses of the terms in the current AP&P manual for change consideration.

Please note, it is anticipated that terminology changes will generally only occur on a go-forward basis as amendments to previously adopted SSAPs, issue papers, agenda items or other historical documents will not occur. As such, the terms used in previously adopted guidance will remain, with the new terms being used prospectively when considering future revisions to statutory accounting.

**Recommendation:**
NAIC staff recommend that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorize as nonsubstantive, and expose editorial revisions as illustrated below.

**Status:**
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing, categorized as nonsubstantive, and exposed revisions to certain, remaining terminology references of “*substantive*” and “*nonsubstantive*,” as illustrated below.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed editorial revisions as shown below.
Various SSAPs in response to terminology changes of “Substantive” and “Nonsubstantive”
(Note: for a review of every use “substantive and nonsubstantive,” as well documentation as to proposed modifications, if any, please see pages see attachment G.1.)

Edit 1: Table of Contents (How to use this Manual), Volume I, Page xvii

Summary of Changes:
The Summary of Changes outlines changes made to the prior edition of the Manual to create the current year’s version. It is divided into three sections: 1) the development of new SSAPs or new SAP concepts to existing SSAPs; substantive revisions to statutory accounting principles; 2) SAP clarifications; nonsubstantive revisions to statutory accounting principles; and 3) revisions to the appendices included in the Manual. The Summary of Changes is a key resource for readers who are looking to identify changes from the prior edition.

Edit 2: Table of Contents (How to use this Manual), Volume I, Page xviii

Statements of Statutory Accounting Principles:
As indicated by the Statutory Hierarchy, the Statements of Statutory Accounting Principles (SSAPs) are the primary authoritative statutory accounting practices and procedures promulgated by the NAIC. These statements are the result of issue papers that have been exposed for public comment and finalized. Finalized issue papers are found in Appendix E and ARE NOT authoritative. While it is not intended that there be any significant differences between an underlying issue paper and the resultant SSAP, if differences exist, the SSAP prevails and shall be considered definitive. Readers may use the NAIC website to keep abreast of adopted revisions; substantive and nonsubstantive changes to the SSAPs. Completely superseded SSAPs that are no longer authoritative are moved from the printed Manual into Appendix H – Superseded SSAPs and Nullified Interpretations, which is posted for public reference on the Statutory Accounting Principles (E) Working Group web page at https://content.naic.org/cmte_e_app_sapwg.htm.

Edit 3: Table of Contents (How to use this Manual), Volume I, Page xviii

New paragraph proposed (To be inserted between the paragraphs starting with "As indicated by the Statutory Hierarchy..." and "The cover page of each SSAP...")

Prior to (adoption date), the term used to describe a new SAP concept or a new SAP concept in an existing SSAP was “substantive” and the term used to describe a SAP clarification was “nonsubstantive.” The new terms will be reflected in materials to describe revisions to statutory accounting principles on a prospective basis and historical documents will not be updated to reflect the revised terms.

Edit 4: Table of Contents (How to use this Manual), Volume I, Page xviii

AFFECTS/AFFECTED BY – A useful tool for tracking relationships between statements and interpretations is contained within these sections. The “affects” section is used when a SSAP has previously been substantively amended to reflect new SAP concepts or superseded by other or superseded previously issued SSAPs. Nullified INTs are also noted in this section. Readers are referenced to another SSAP in the “affected by” section if the SSAP has been substantively amended or superseded or amended with a new SAP concept or with the issuance of a new SSAP. Text within paragraphs substantively amended with new SAP concepts or superseded may also be “shaded” to notify readers that revised guidance is available.

Edit 5: Table of Contents (How to use this Manual), Volume I, Page xviii

Refer to the Relevant Literature and Effective Date and Transition sections of each SSAP for details of the development of new SSAPs or new SAP concepts, as well as changes as the result of SAP clarifications; substantive and nonsubstantive changes.
**Edit 6: Summary of Changes, Volume I, Page xxiii**

Section 1 summarizes substantive revisions that result with a new SSAP or new SAP concept to statutory accounting principles. Substantive revisions that introduce original or modified accounting principles and can be reflected in an existing or new SSAP. When substantive revisions that result in a new SAP concept are made to an existing SSAP, the effective date is identified in the Status section, and the revised text within is depicted by underlines (new language) and strikethroughs (removed language). This tracking will not be shown in subsequent manuals. New SSAPs and new SAP concepts that revise existing substantively revised SSAPs are commonly accompanied by a corresponding issue paper that reflects the revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or substantively revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

**Edit 7: Summary of Changes, Volume I, Page xxiii**

Section 2 summarizes the nonsubstantive revisions that clarify existing to statutory accounting principles. Nonsubstantive revisions are characterized as language clarifications which do not modify the original intent of a SSAP, or changes to reference material. Nonsubstantive revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Nonsubstantive revisions that clarify existing statutory accounting principles are effective when adopted unless a specific effective date is noted.

**Edit 8: Summary of Changes (heading in table), Volume I, Page xxiii**

1. Substantive Revisions that resulted in a new SSAP or a new SAP concept – Statutory Accounting Principles

**Edit 9: Summary of Changes (heading in table), Volume I, Page xxiii**

2. Nonsubstantive Revisions that resulted in a SAP clarification – Statutory Accounting Principles

**Edit 10: Preamble, Volume I, Page P-5**

23. The Accounting Practices and Procedures (E) Task Force will accomplish its mission through charges assigned to the following working groups:

- Statutory Accounting Principles (E) Working Group: Responsible for developing and adopting substantive and nonsubstantive revisions to the Statements of Statutory Accounting Principles (SSAPs). Statutory accounting principles provide the basis for insurers to prepare financial statements for financial regulation purposes, and SSAPs are considered level 1 (highest authority) in the statutory accounting hierarchy. Refer to the Statutory Accounting Principles (E) Working Group Web page (http://www.naic.org/cmte_e_app_sapwg.htm) for specific information and charges.

- Blanks (E) Working Group: Considers improvements and revisions to various annual/quarterly statement blanks to conform to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers and develop reporting formats for other entities subject to the jurisdiction of state insurance departments. Refer to the Blanks (E) Working Group webpage (http://www.naic.org/cmte_e_app_blanks.htm) for specific information and charges.

**Edit 11: Preamble, Volume I, Page P-9**

47. Once promulgated, statements will only be amended or superseded through the issuance of new SSAP pronouncements. If it is necessary to introduce a new SAP concept that will substantially modify or augment the guidance in an existing SSAP, a new statement will be promulgated and/or the statement will be reissued with “revised” in the title. Nonsubstantial changes as a result of clarifying an existing SAP will be included in the existing statement with changes tracked (i.e., new text will be underlined and deleted text as strikethrough) in
the next printing of the Manual. Then no changes will be shown after the initial year. A useful tool for tracking of the relationships between statements is contained in the “Status” section of each statement which includes sections labeled “Affects” and “Affected By.” As SSAPs are issued in the future that modify or augment the guidance previously provided, these sections will identify the relationships between statements.

**Edit 12: Table of Contents (How to use this Manual), Volume II, Page xvii**

**Summary of Changes:**
The Summary of Changes outlines changes made to the prior edition of the Manual to create the current year’s version. It is divided into three sections: 1) the development of new SSAPs or new SAP concepts to existing SSAPs; substantive revisions to statutory accounting principles; 2) SAP clarifications; nonsubstantive revisions to statutory accounting principles; and 3) revisions to the appendices included in the Manual. The Summary of Changes is a key resource for readers who are looking to identify changes from the prior edition.

**Edit 13: Table of Contents (How to use this Manual), Volume II, Page xviii**

**Statements of Statutory Accounting Principles:**
As indicated by the Statutory Hierarchy, the Statements of Statutory Accounting Principles (SSAPs) are the primary authoritative statutory accounting practices and procedures promulgated by the NAIC. These statements are the result of issue papers that have been exposed for public comment and finalized. Finalized issue papers are found in Appendix E and ARE NOT authoritative. While it is not intended that there be any significant differences between an underlying issue paper and the resultant SSAP, if differences exist, the SSAP prevails and shall be considered definitive. Readers may use the NAIC website to keep abreast of adopted revisions to the SSAPs. Completely superseded SSAPs that are no longer authoritative are moved from the printed Manual into Appendix H – Superseded SSAPs and Nullified Interpretations, which is posted for public reference on the Statutory Accounting Principles (E) Working Group web page at https://content.naic.org/cmte_e_app_sapwg.htm.

**Edit 14: Table of Contents (How to use this Manual), Volume II, Page xviii**

New paragraph proposed (To be inserted between the paragraphs starting with "As indicated by the Statutory Hierarchy..." and "The cover page of each SSAP...")
Prior to (adoption date), the term used to describe a new SAP concept or a new SAP concept in an existing SSAP was “substantive” and the term used to describe a SAP clarification was “nonsubstantive.” The new terms will be reflected in materials to describe revisions to statutory accounting principles on a prospective basis and historical documents will not be updated to reflect the revised terms.

**Edit 17: Summary of Changes, Volume II, Page xxiii**

Section 1 summarizes substantive revisions that result with a new SSAP or new SAP concept to statutory accounting principles. Substantive Revisions that introduce original or modified accounting principles and can be reflected in an existing or new SSAP. When substantive revisions that result in a new SAP concept are made to an existing SSAP, the effective date is identified in the Status section, and the revised text within is depicted by underlines (new language) and strikethroughs (removed language). This tracking will not be shown in subsequent manuals. New SSAPs and new SAP concepts that revise existing substantively revised SSAPs are commonly accompanied by a corresponding issue paper that reflects the revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or substantively revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

**Edit 18: Summary of Changes, Volume II, Page xxiii**

Section 2 summarizes the nonsubstantive revisions that clarify existing to statutory accounting principles. Nonsubstantive These revisions are characterized as language clarifications which do not modify the original
intent of a SSAP, or changes to reference material. Nonsubstantive revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Nonsubstantive revisions that clarify existing statutory accounting principles are effective when adopted unless a specific effective date is noted.

**Edit 19: Summary of Changes (heading in table), Volume II, Page xxiii**

1. **Substantive** Revisions that resulted in a new SSAP or a new SAP concept – Statutory Accounting Principles

**Edit 20: Summary of Changes (heading in table), Volume II, Page xxiii**

2. **Nonsubstantive** Revisions that resulted in a SAP clarification – Statutory Accounting Principles


3. Information and issues can be presented to the Working Group in a variety of ways. Issues can be recommended or forwarded from 1) other NAIC committees, task forces or working groups; 2) interested parties; 3) interested regulators; and 4) NAIC staff. Also, if any guidance within the Generally Accepted Accounting Principles (GAAP) Hierarchy (see § V of the Preamble to the Accounting Practices and Procedures Manual (AP&P Manual)) is added or revised, those changes must be considered by the Working Group for potential revisions to SAP. In order for an issue to be placed on the Pending Listing, the recommending party must complete a Statutory Accounting Principles Maintenance Agenda Submission Form (Form A) and submit it to the Working Group support staff no later than 20 business days prior to the next scheduled Working Group meeting. NAIC staff will prepare a submission form for all GAAP pronouncements that have not been previously addressed by the Working Group. NAIC staff will update the Pending Listing before each national meeting and will notify the recommending party of such action. If the Working Group does not wish to address the issue (e.g., issue deemed not applicable to statutory accounting) or rejects the position presented, then the Working Group may move the item to the Rejected Listing. Should the Working Group choose to address an issue, it is moved to the Active Listing where it is prioritized and categorized as a new SSAP concept, clarification of an existing SSAP, Substantive, Nonsubstantive or an Interpretation agenda item.


4. The **Active Listing** identifies agenda items that are in the process of development and includes the following:

   a. **New SAP Concept Substantive:** These agenda items address the development of new SSAPs and/or the introduction of a new and substantially revised SSAP's concept as defined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles.

   b. **Clarification of an Existing SSAP Nonsubstantive:** These agenda items address the development of nonsubstantive revisions which clarify an existing SAP as defined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles.
c. **Interpretations**: These agenda items address the development of interpretations to SAP as defined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles. If SSAP revisions are subsequently deemed necessary, the Working Group shall re-categorize the agenda item as either a *new SAP concept*, or a *clarification of an existing SSAP substantive or nonsubstantive*, as applicable, and follow the appropriate process to consider and adopt revisions.


5. After review of the agenda item (including any interested party comments), at its discretion, the Working Group makes the ultimate determination of whether an agenda item is categorized (or re-categorized) as a *new SAP concept*, *clarification of an existing SSAP substantive* (either as a *new SSAP* or *substantively-revised SSAP*), *nonsubstantive* or an interpretation.


8. NAIC staff will maintain the following on the Working Group Web page (http://naic.org/cmte_e_app_sapwg.htm): 1) A blank Form A (Attachment A to this policy statement); 2) The current Maintenance Agenda, and 3) Current *statutory substantive, nonsubstantive* and/or interpretation revisions exposed for public comment. Attachment B to this policy statement will be attached to all exposures with proposed *substantive* revisions that *result in a new SAP concept* and serves as the request for written comment and notice of a public hearing.
**Statutory Accounting Principles (E) Working Group**

**Maintenance Agenda Submission Form**

**Form A**

**Issue:** *ASU 2021-04 - Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options*

**Check (applicable entity):**

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<th>Modification of Existing SSAP</th>
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<th>Health</th>
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<table>
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<tr>
<th>New Issue or SSAP Interpretation</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
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**Description of Issue:** In May 2021, the Financial Accounting Standards Board (FASB) issued *Accounting Standard Update (ASU) 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options*. The amendments in this ASU impact all entities that issue freestanding written call options, that are then modified in connection with either an equity issuance, debt origination or a debt modification.

The amendments affect those entities for when a freestanding equity-classified written call option is modified, or exchanged, and the instrument remains classified as equity after the modification or exchange. This topic is discussed in *SSAP No. 72—Surplus and Quasi-Reorganization*, paragraph 10. If the warrant is modified as part of a debt modification and the warrant is held by the creditor involved in the debt modification, the issuer would treat the warrant’s change in value as a fee to or from the creditor, based on if it is an increase or a decrease. If the modification of the warrant is connected to a debt modification where the debt is held by a third-party, the increase in fair-value of the warrant will be treated as third-party cost, and any decreases would be disregarded. Guidance for debt issuance costs is in *SSAP No. 15—Debt and Holding Company Obligations*.

The main provisions of this ASU are:

1. An entity should treat a modification of the terms or conditions or an exchange of a freestanding equity-classified written call option that remains equity classified after modification or exchange as an exchange of the original instrument for a new instrument.

2. An entity should measure the effect of a modification or an exchange of a freestanding equity-classified written call option that remains equity classified after modification or exchange as follows:

   a. For a modification or an exchange that is a part of or directly related to a modification or an exchange of an existing debt instrument or line-of-credit or revolving-debt arrangements (hereinafter, referred to as a “debt” or “debt instrument”), as the difference between the fair value of the modified or exchanged written call option and the fair value of that written call option immediately before it is modified or exchanged.

   b. For all other modifications or exchanges, as the excess, if any, of the fair value of the modified or exchanged written call option over the fair value of that written call option immediately before it is modified or exchanged.
3. An entity should recognize the effect of a modification or an exchange of a freestanding equity-classified written call option that remains equity classified after modification or exchange on the basis of the substance of the transaction.

An entity should recognize the effect of a modification or an exchange of a freestanding equity-classified written call option to compensate for goods or services in accordance with the guidance in Topic 718, Compensation—Stock Compensation. In a multiple-element transaction (for example, one that includes both debt financing and equity financing), the total effect of the modification should be allocated to the respective elements in the transaction.

**Existing Authoritative Literature:** The guidance for the issuance of stock purchase warrants is in **SSAP No. 72—Surplus and Quasi-Reorganization**, paragraph 10, and guidance for debt issuance costs is included in **SSAP No. 15—Debt and Holding Company Obligations**, paragraph 5.

**SSAP No. 72:**

10. Stock purchase warrants issued in return for cash shall be credited to gross paid-in and contributed surplus. When debt instruments are issued with conversion features, no value shall be assigned to the conversion features unless the conversion feature is clearly separable from the debt obligation in the form of a detachable stock purchase warrant. In such instances the relative fair value of the detachable stock purchase warrant at time of issue shall be credited to gross paid-in and contributed surplus. For instances in which a reporting entity has issued puttable warrants or mandatorily redeemable warrants, such items shall be reflected as liabilities as the warrants obligate the reporting entity to ultimately transfer cash or other assets to the holder in order to repurchase the shares.

**SSAP No. 15:**

5. Debt issuance costs (e.g., loan fees and legal fees) do not meet the definition of an asset as defined in **SSAP No. 4—Assets and Nonadmitted Assets**. Accordingly, these costs shall be charged to operations in the period incurred.

**Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups):** None

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:** None

**Convergence with International Financial Reporting Standards (IFRS):** None.

**Staff Review Completed by:** Jake Stultz -NAIC staff, September 2021

**Staff Recommendation:**

NAIC staff recommends that the Working Group move this item to the active listing and expose revisions to **SSAP No. 72—Surplus and Quasi-Reorganization** to reject ASU 2021-04 for statutory accounting. However, NAIC staff recommends that the FASB guidance related to accounting for the changes in fair value regarding the exchange of a free-standing equity-classified written call option be incorporated into SSAP No. 72.

**Proposed revisions to SSAP No. 72:**

10. Stock purchase warrants issued in return for cash shall be credited to gross paid-in and contributed surplus. **An entity shall treat a modification of the terms or conditions or an exchange of a freestanding...**
equity-classified written call option as an exchange of the original instrument for a new instrument. In substance, the entity repurchases the original instrument by issuing a new instrument. The total effect of the modification or exchange shall be allocated to the respective elements in the transaction. When debt instruments are issued with conversion features, no value shall be assigned to the conversion features unless the conversion feature is clearly separable from the debt obligation in the form of a detachable stock purchase warrant. In such instances, the relative fair value of the detachable stock purchase warrant at time of issue shall be credited to gross paid-in and contributed surplus. For instances in which a reporting entity has issued puttable warrants or mandatorily redeemable warrants, such items shall be reflected as liabilities as the warrants obligate the reporting entity to ultimately transfer cash or other assets to the holder in order to repurchase the shares.

29. This statement also rejects Accounting Research Bulletin No. 43, Restatement and Revision of Accounting Research Bulletins, “Chapter 1, Prior Opinions,” paragraph 12 of APB 10, and FASB Technical Bulletin No. 85-6, Accounting for a Purchase of Treasury Shares at a Price Significantly in Excess of the Current Market Price of the Shares and the Income Statement Classification of Costs Incurred in Defending against a Takeover Attempt, and Accounting Standard Update (ASU) 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options.

Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions, as illustrated above, to incorporate guidance related to the accounting for the changes in fair value when exchanging equity-classified written call options, while rejecting the remainder of ASU 2021-04 in SSAP No. 72.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted SAP clarifications to SSAP No. 72—Surplus and Quasi-Reorganizations to reject ASU 2021-04 for statutory accounting while incorporating guidance that clarifies that an entity shall treat a modification of the terms or conditions or an exchange of a freestanding equity-classified written call options shall be treated as an exchange, as detailed below. The adopted revisions included additional changes to the exposed language as recommended interested parties.

29. This statement also rejects Accounting Research Bulletin No. 43, Restatement and Revision of Accounting Research Bulletins, “Chapter 1, Prior Opinions,” paragraph 12 of APB 10, and FASB Technical Bulletin No. 85-6, Accounting for a Purchase of Treasury Shares at a Price Significantly in Excess of the Current Market Price of the Shares and the Income Statement Classification of Costs Incurred in Defending against a Takeover Attempt, and Accounting Standard Update (ASU) 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options, while incorporating guidance that clarifies that an entity shall treat a modification of the terms or conditions or an exchange of a freestanding equity-classified written call option as an exchange of the original instrument for a new instrument.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1J_21-27_ASU2021-04.docx

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Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

**Issue: Schedule D-6-1, Supplemental Reporting**

**Check (applicable entity):**

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Issue or SSAP</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Interpretation</td>
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**Description of Issue:** SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities defines the specific criteria for when an investment is considered a subsidiary, controlled or affiliated entity (SCA) for statutory accounting purposes. Broadly defined, SCAs are entities that are 1) directly or indirectly owned or controlled by a reporting entity (i.e., a subsidiary), or 2) within a holding company system or a party that is directly or indirectly, through one or more intermediaries, in which controls, is controlled by, or is under common control with a reporting entity (i.e., an affiliate). While SSAP No. 97 offers varying classifications of SCAs with differing valuation methods, all SCAs are ultimately reported on Schedule D – Part 6 – Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Entities.

The reporting requirements for SCAs is defined in SSAP No. 97, Exhibit A, however in general, the process is as follows: (note: the following comments are not applicable for domestic SCA insurance companies)

- All SCA entities, regardless of if they are nonadmitted, have a zero value, or are immaterial to the reporting entity, must file a “Sub-1” within 90 days of the acquisition or formation of the investment. The Sub-1 filing is to gather basic information about the SCA and is used to determine if the transaction meets certain specific criteria specified within SSAP No. 97.

- Annually, but no later than August 31 (or one month after the audit report is issued for an SCA – for entities who routinely received their audit reports after August 31), SCAs must file a “Sub-2” filing. This filing details the valuation method utilized; the value claimed in Schedule D-6-1 and includes all required supporting documentation. (Nonadmitted assets are not required to file a Sub-2 if they are nonadmitted, or had a zero value, for the full reporting period). The Sub-2 filing is then reviewed by the NAIC for verification of the claimed value. If required, valuation adjustments are made. As directed in SSAP No 97, if the insurance company has reported a value for a SCA investment on its financial statement blank that differs from the value approved by the NAIC, the insurer is required to adjust the reported value in its next quarterly financial statement blanks, unless otherwise directed by the insurer’s state of domicile. (Note, the SCA review process occurs in arrears. As such, when a value is adjusted, the concepts for the adjustment shall be applied to the next year-end. For example, if a company did not incorporate required SSAP No. 97 adjustments in determining the reported value as of Dec. 31, 2020, those adjustments should be considered when determining the value reported as of Dec. 31, 2021 (or earlier if known when the quarterly financials are completed). When the adjustment is material, then the guidance in SSAP No. 3—Accounting Changes and Corrections of Errors would be applicable.)

In 2019, the NAIC reviewed 824 SCA filings (which includes both Sub-1 and Sub-2 filings). Of the total, 720 were Sub-2 filings (the filing in which a value is approved). Of the 720 Sub-2 filings, 125 (approx. 17%) resulted in **valuation decreases.** Presumably, per SSAP No. 97, entities (unless directed by their state of domicile) adjusted the reported values in their next quarterly financial statements, however NAIC staff have found that it is not
uncommon for the same entities, year after year, to have approved values that vary significantly from their reported balances. It is also important to note that while the NAIC does send monthly reports on SCA activity to state regulators, the process of reviewing the activity reports and verifying compliance with SSAP No. 97, for state regulators (and NAIC staff) is operationally onerous. Accordingly, this agenda item has been drafted to propose new supplemental reporting (in electronic only columns) to assist state regulators to 1) ensure Sub-1 and Sub-2 filings are being submitted by reporting entities, and 2) identify situations where the NAIC approved value varies significantly from the value reported on Schedule D-6-1.

Existing Authoritative Literature:

**Staff note** – For completeness of the document, the authoritative guidance defining SCA’s in scope of SSAP No. 97 has been included herein. Certain relevant items have been bolded for emphasis.

**SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**

**Definition [of a SCA]**

1. Parent and subsidiary are defined as follows:
   a. Parent—An entity that directly or indirectly owns and controls the reporting entity;
   b. Subsidiary—An entity that is, directly or indirectly, owned and controlled by the reporting entity.

2. An affiliate is defined as an entity that is within the holding company system or a party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the reporting entity. An affiliate includes a parent or subsidiary and may also include partnerships, joint ventures, and limited liability companies as defined in SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies. Those entities are accounted for under the guidance provided in SSAP No. 48, which requires an equity method for all such investments.

3. Control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the investee, whether through the (a) ownership of voting securities, (b) by contract other than a commercial contract for goods or nonmanagement services, (c) by common management, or (d) otherwise. Control shall be presumed to exist if a reporting entity and its affiliates directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting interests of the entity.

4. Control as defined in paragraph 5 shall be measured at the holding company level. For example, if one member of an affiliated group has a 5% interest in an entity and a second member of the group has an 8% interest in the same entity, the total interest is 13% and therefore each member of the affiliated group shall be presumed to have control. This presumption will stand until rebutted by an evaluation of all the facts and circumstances relating to the investment based on the criteria in FASB Interpretation No. 35, Criteria for Applying the Equity Method of Accounting for Investments in Common Stock, an Interpretation of APB Opinion No. 18. The corollary is required to demonstrate control when a reporting entity owns less than 10% of the voting securities of an investee. The insurer shall maintain documents substantiating its determination for review by the domiciliary commissioner. An investment in an SCA entity may fall below the level of ownership described in paragraph 5, in which case, the reporting entity would discontinue the use of the equity method, as prescribed in paragraph 13.g. Additionally, through an increase in the level of ownership, a reporting entity may become qualified to use the equity method of accounting (paragraph 8.b.), in which case, the reporting entity shall add the cost of acquiring additional interest to the current basis of the previously held interest and shall apply the equity method prospectively, as of the date the
investment becomes qualified for equity method accounting. Examples of situations where the presumption of control may be in doubt include the following:

a. Any limited partner investment in a limited partnership, unless the limited partner is affiliated with the general partner.

b. An entity where the insurer owns less than 50% of an entity and there is an unaffiliated individual or group of investors who own a controlling interest.

c. An entity where the insurer has given up participating rights as a shareholder to the investee.

5. Investments in SCA entities meet the definition of assets as defined in SSAP No. 4—Assets and Nonadmitted Assets and are admitted assets to the extent they conform to the requirements of this statement.

EXHIBIT A – SCA REPORTING PROCESS

50. SCA entities, except for domestic SCA insurance company investments accounted for under paragraph 8.b.i of this statement, in which the reporting entity has an equity interest (common or preferred stock), are required to be filed with the NAIC. Nonadmitted assets are not required to be filed in a Sub-2 as long as they were nonadmitted, or had a zero value, for the full reporting period (all interim and annual reporting). Immaterial asset SCAs do not have an automatic exclusion from filing, as immateriality of an SCA will be ascertained by the state of domicile of the insurance reporting entity, but companies are allowed to request an exemption from the domiciliary state to not file an SCA on the basis that it is immaterial. The filing process does not include investments within the scope of SSAP No. 48.

51. Except for domestic SCA insurance company investments accounted for under paragraph 8.b.i., all SCA investments within the scope of this statement, purchased during any one calendar year, shall be reported to the NAIC on a Sub-1 form within 90 days of the acquisition or formation of the investment; this includes nonadmitted, zero-valued and immaterial SCAs. The NAIC will process that filing in the same year but will not at that time approve or disapprove a value for the SCA investment. By August 31 of each year, the insurance company shall submit a Sub-2 filing for the previously purchased SCA investment reported on a Sub-1 form and later that year, the NAIC will approve a value for the transaction. For SCAs that routinely receive their audit reports after the August 31 deadline, a filing deadline of one month after the audit report date shall be applied. Filers must provide previous years’ audit reports to verify an audit report dated after August 31 in order to not be charged a late fee for a Sub-2 filing that is filed after the August 31 deadline. The value approved by the NAIC at the conclusion of the Sub-2 form filing is reported by the insurance company on its financial statement blank. If the insurance company has reported a value for the SCA investment on its financial statement blank that differs from the value approved by the NAIC, the insurer is required to adjust the reported value in its next quarterly financial statement blank unless otherwise directed by the insurer’s state of domicile.

52. Insurance companies shall use one of the valuation methods described in paragraph 8 to calculate the value of their investments in insurance and non-insurance SCA companies. An insurance company shall calculate the value of its investments in foreign insurance and all non-insurance company SCA entities and report the value to the NAIC no later than August 31, or one month after the audit report date for SCAs that routinely receive their audits after August 31 for existing SCA investments, and within 90 days of the acquisition or formation of a new SCA investment.
Initial Reporting of SCA Investments

53. Reporting the acquisition or formation of a new investment is accomplished by submitting a completed Sub-1 form for each investment, disclosing (i) the valuation reported or to be reported by the insurance company on its latest or next quarterly financial statement blank, (ii) which method of those described in paragraph 8 was used to arrive at the valuation, (iii) the factual context of the transaction and (iv) economic and business motivations for the transaction. The submission will be processed by the NAIC only if the NAIC determines it has been provided with all material information with respect to all SCA companies of the reporting insurance company that require valuation.

54. The purpose of a Sub-1 filing is to gather basic information about the SCA. If the NAIC determines that the reported transaction meets the tests specified, it will complete the filing in the VISION database. If the NAIC determines that the transaction does not meet the tests specified, it will not complete the filing in the VISION database and instead shall notify the reporting insurance company and the state of domicile in writing of its determination.

Subsequent Reporting of SCA Investments

55. By August 31 or one month after the audit report date of each year and subsequent to the reporting of an SCA investment on the Sub-1 form, the insurance company shall submit a Sub-2 form filing, with all supporting documentation for foreign SCAs provided in English, for the same SCA investment. Additionally, by August 31 or one month after the audit report date of each year, any insurance company that has made a Sub-2 form filing in a previous year must update the information by filing an updated Sub-2 form filing.

56. Each year the NAIC shall compile a list of all SCA investments (excluding insurance company SCAs (paragraph 8.b.i.) nonadmitted and zero-value SCAs) reported as Sub-1 form filings for which a Sub-2 form filing has not yet been received. For these transactions, the NAIC will notify the responsible reporting insurance company and its state of domicile that it has not received a Sub-2 filing for the SCA investment.

57. The purpose of the Sub-2 filing is to determine whether the value calculated by the reporting insurance company for the SCA investment is appropriate and to approve that or some other value for reporting on the insurer's financial statement blank.

58. An insurance company that concludes an SCA transaction at year-end may be unable to file a Sub-1 form prior to the time it would be required to file a Sub-2 form. Where this is the case, the NAIC is authorized to accept and review a Sub-1 filing from such an insurance company and to accept and review the Sub-2 filing after the Sub-1 filing review has been completed.

59. No filing of an investment in a domestic SCA insurance company valued under paragraph 8.b.i. shall be required to be made with the NAIC.

Assessment and Review of Sub-2 Form

64. By August 31 or one month after the audit report date of each year, the NAIC shall initiate a review of all SCA investments for which new Sub-2 form filings have been received as well as an annual update review of Sub-2 SCA investments already logged in the VISION database. The NAIC review shall encompass a review of the most recent annual statutory reporting by the parent insurance company's Schedule Y (to ascertain the identity of the members of the holding company system and to ensure that information for all SCA companies has been submitted), a review of the parent's financial statement blank to review the last reported value for the SCA investments and a review of the VISION database to determine whether SCA debt and SCA preferred securities have been assigned NAIC designations. As part of its analysis, the NAIC shall review the portion of the bond...
investments carried by the parent or a subsidiary insurer with a Z notation. If the NAIC determines that the portion of the Z bonds shown on the documentation is significant, the NAIC shall not process the Sub-2 filing until the insurance company reports the bonds to permit removal of the Z notation. Beginning with year-end 2019, two new suffixes will apply: YE and IF. YE means that the security is a properly filed annual update that the SVO has determined will not be assigned an NAIC designation by the close of the year-end reporting cycle. The symbol YE is assigned by the SVO pursuant to the carryover administrative procedure described in Part One, Section 3 f) (iii) of the Purposes and Procedures Manual of the NAIC Investment Analysis Office. When the SVO assigns the symbol YE it also assigns the NAIC designation in effect for the previous reporting year. IF means that the security is an initial filing that has been properly filed with the SVO but which the SVO has determined will not be assigned an NAIC designation by the close of the year-end reporting cycle. The symbol IF is assigned by the SVO and communicates that the insurer should self-designate the security for year-end and identify it with the symbol IF. IF, therefore, also communicates to the regulator that the NAIC designation reported by the insurance company was not derived by or obtained from the SVO, but has been determined analytically by a reporting insurance company.

65. Upon completion of the procedures described above, the NAIC will determine whether the value reported by the insurance company on the current SCA filing was calculated in accordance with the instructions for the valuation method chosen and verify that the filed value reflects the adjustments required by paragraph 9.

66. Upon approval of a value (including making necessary adjustments), the NAIC will complete the Sub-2 filing with the approved value in the status field of the VISION database.

67. The NAIC shall report its determination to the insurance company. If a significant discrepancy exists between the value claimed by the reporting insurance company and the value approved by the NAIC, the NAIC shall communicate the discrepancy with the company. If the NAIC cannot come to a conclusion based on the support provided, the filing can be rejected in VISION, and written notification will be provided to the reporting insurance company and the company's state of domicile of this action. This correspondence will be sent to the domiciliary state. Filers are able to download their review information from the NAIC filing system.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation: NAIC staff recommends that the Working Group forward a proposal to the Blanks (E) Working Group to supplement the identification of SCA investments in Schedule D – Part 6 – Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Entities. The supplemental data to be captured is consistent with current requirements in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, however this improved reporting granularity will significantly assist regulators to 1) ensure Sub-1 and Sub-2 filings are being submitted by reporting entities, and 2) identify situations where the NAIC approved value varies significantly from the value reported on Schedule D-6-1.

The proposed (electronic column) additions to Schedule D – Part 6 – Section 1 are shown below. (Note: for brevity, the included blanks instructions, which do not have proposed edits, have been abbreviated and should not be used for blanks filing purposes.)
### SCHEDULE D – PART 6 – SECTION 1
Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

<table>
<thead>
<tr>
<th>CUSIP Identification</th>
<th>Description Name of Subsidiary, Controlled or Affiliated Company</th>
<th>Foreign</th>
<th>NAIC Company Code</th>
<th>ID Number</th>
<th>NAIC Valuation Method</th>
<th>Book/Adjusted Carrying Value</th>
<th>Total Amount of Goodwill Included in Book/Adjusted Carrying Value</th>
<th>Nonadmitted Amount</th>
<th>Stock of Such Company Owned by Insurer on Statement Date Number of Shares</th>
<th>% of Outstanding</th>
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</thead>
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<td>XXX</td>
</tr>
</tbody>
</table>

1. Total amount of goodwill nonadmitted $__________________________

### Reporting Instructions for Schedule D, Part 6, Section 1

- **Column 1** – CUSIP Identification
- **Column 2** – Description
- **Column 3** – Foreign
- **Column 4** – NAIC Company Code
- **Column 5** – ID Number
- **Column 6** – NAIC Valuation Method
- **Column 8** – Total Amount of Goodwill
- **Column 9** – Nonadmitted Amount
- **Column 10** – Stock of Such Company Owned by Insurer on Statement Date Number of Shares
- **Column 11** – Stock of Such Company Owned by Insurer on Statement Date % of Outstanding

**Column 12 through 159 will be electronic only.**

- **Column 12** – Legal Entity Identifier (LEI)
- **Column 13** – Issuer
- **Column 14** – Issue
- **Column 15** – ISIN Identification
- **Column 16** – Prior Year BACV
- **Column 17** – Prior Year Nonadmitted Amount

*Provide the amount nonadmitted, if any, included in Column 4 of the Asset page.*
Column 18 – Prior year Sub-2 Verified Value

If per SSAP No. 97 or by direction of the domiciliary regulator, the SCA is required to be filed with the NAIC, provide the prior year’s Sub-2 'Total Value Claimed.'

Column 18 – Prior year VISION Filing Number

If per SSAP No. 97 or by direction of the domiciliary regulator, the SCA is required to be filed with the NAIC, provide the prior year NAIC VISION filing number.

Staff Review Completed by: Jim Pinegar, NAIC Staff – November 2021

Status:
On December 11, 2021, the Statutory Accounting Principles (E) Working Group moved this item to the active listing and exposed proposed revisions to be incorporated into a Blanks (E) Working Group proposal which would supplement the reporting of SCA investments reported in Schedule D-6-1, as illustrated above. The supplemental data to be captured is consistent with current requirements in SSAP No. 97 and as a result, the agenda item did not propose statutory revisions.

On April 4, 2022, the Statutory Accounting Principles (E) Working Group adopted this agenda item, which did not result in statutory accounting revisions, however adoption expressed support of the corresponding Blanks (E) Working Group proposal (2022-02BWG), which incorporates new electronic only columns in Schedule D-6-1. The supplemental data to be captured is consistent with current requirements in SSAP No. 97.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/SAPWG/Att1K_21-22_SchD-6-1.docx
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met March 29, 2022. The following Working Group members participated: Pat Gosselin, Chair (NH); Kim Hudson, Vice Chair (CA); William Arfanis (CT); Philip Barlow and N. Kevin Brown (DC); Tom Hudson (DE); Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Dan Schaefer (MI); Debbie Doggett (MO); Lindsay Crawford (NE); Nakia Reid (NJ); Dale Bruggeman and Tracy Snow (OH); Holly Mills (OK); Kimberly Rankin (PA); Shawn Frederick and Jamie Walker (TX); Jake Garn (UT); Steve Drutz (WA); Adrian Jaramillo (WI); and Michael Crum (WV). Also participating was: Anna Krylova (NM).

1. **Adopted its Nov. 16, 2021, Minutes**

Ms. Gosselin referenced the Blanks (E) Working Group’s Nov. 16 minutes, where the sponsor withdrew the previously exposed agenda item 2021-21BWG. During this meeting, the Working Group took the following action: 1) deferred proposal 2021-13BWG to allow for additional discussion; 2) adopted deferred proposal 2021-14BWG with editorial revisions; 3) rejected proposal 2021-11BWG, which was previously deferred; 4) exposed seven new proposals for a public comment period ending March 4; 5) adopted its editorial listing; and 6) approved the state filing checklists.

Mr. Hudson made a motion, seconded by Ms. Crawford, to adopt the Working Group’s Nov. 16, 2021, minutes (see NAIC Proceedings – Fall 2021, Accounting Practices and Procedures (E) Task Force, Attachment Two). The motion passed unanimously.

2. **Withdrew an Item Previously Deferred**

   a. **Agenda Item 2021-13BWG**

Ms. Gosselin stated that this proposal adds a new supplement, Exhibit of Premiums and Losses (State Page) – Other Liability, to the property/casualty (P/C) blank to capture premium and loss data for annual statement line 17.1, line 17.2 and line 17.3. There were numerous interested party comments received for this proposal. Taking those into consideration, Ms. Gosselin requested the withdrawal of this proposal, and a new proposal is being submitted for exposure incorporating interested parties’ suggested revisions. She said the new proposal is 2022-04BWG, and it is to be exposed during this meeting.

3. **Adopted Items Previously Exposed**

   a. **Agenda Item 2021-15BWG**

Mr. Bruggeman stated that this blanks agenda item results from the Statutory Accounting Principles (E) Working Group’s adoption of its related agenda item 2021-16, which is to increase the transparency of Federal Home Loan Bank (FHLB) borrowings classified as a funding agreement within the scope of *Statement of Statutory Accounting Principles (SSAP) No. 52—Deposit-Type Contracts* reported in Exhibit 7 – Deposit-Type Contracts. Exhibit 7 includes columnar reporting of various types of deposit-type contracts, including guaranteed interest contracts (GICs), annuities certain, supplemental contracts, etc. Due to the varied nature of reporting based on policy form, FHLB borrowings classified as a deposit-type contract and reported in Exhibit 7 are not readily identifiable to financial statement users. Mr. Bruggeman stated that the recommendation from the Statutory Accounting Principles (E)
Working Group was to include a new footnote detailing the FHLB borrowings associated with every column in Exhibit 7.

Mr. Bruggeman stated that the comments from interested parties suggested adding a new line in Exhibit 7, rather than a footnote, stating that the new line would be easier to align to the associated FHLB borrowings with the respective deposit type contract columns. When this agenda item was drafted by NAIC staff, interested parties indicated preference for the footnote. While the footnote proposed by the Statutory Accounting Principles (E) Working Group was envisioned to be below the table, it deferred to the Blanks (E) Working Group support staff on the format of the footnote.

Mr. Bruggeman made a motion, seconded by Mr. Garn, to adopt the proposal (Attachment Two-A). The motion passed unanimously.

b. Agenda Item 2021-16BWG

Mr. Bruggeman stated that this blanks agenda item proposes revisions to Note 9–Income Taxes and Note 15–Leases. For Note 9, specifically 9C, the agenda item addresses differences between the portable document format (PDF) reporting of Note 9C and the data capture element of the disclosure. The data capture element has a single “Other” line for deferred tax asset (DTA) and deferred tax liability (DTL) components, whereas the instructions for Note 9C ask that additional lines be added to the illustration for additional components over 5% in the PDF document. The additional lines in the PDF were intended to be temporary to identify if there were other specific lines that needed to be added based on what companies were reporting as additional lines in the PDF. With no additional items identified, the instruction for adding these lines is now being removed.

Mr. Bruggeman stated that for Note 15, the proposal adds minor modifications by including a “thereafter” row in the minimum aggregate rental commitment table and adjusts the total formula accordingly. The comments from interested parties recommended a couple of minor editorial revisions to the formulas to reflect the removal of the lines in the income tax PDF, which NAIC staff agree with and are reflected in the final proposal.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the proposal (Attachment Two-B). The motion passed unanimously.

c. Agenda Item 2021-17BWG

Mr. Drutz stated that this proposal modifies the Analysis of Operations by Lines of Business in the health blank to include all of health lines of business included in the life/fraternal blank Analysis of Operations by Lines of Business – Accident and Health. It adds instructions for the new columns and adjusts the column references. It adds the Health Blank Analysis of Operations by Lines of Business as a supplement to the life/fraternal blank with the appropriate instructions and crosschecks. It adds crosschecks to the Health Blank Analysis of Operations by Lines of Business to the life/fraternal Analysis of Operations by Lines of Business – Accident and Health instructions.

Mr. Drutz stated that there were interested party comments received. With regards to the request to change the effective date, this proposal was changed to a supplement to accommodate interested parties’ previous request and input. There does not appear to be a need to postpone this proposal to annual 2023. Regarding the identical descriptions comment, those will remain in the instructions for now as they appear in the proposal. Mr. Drutz stated that both the life/fraternal and health statement instructions have duplication of definitions of Lines of Business. NAIC staff will put together a proposal to concentrate the definitions in the Appendix of the instructions. The P/C instructions have the Lines of Business in the Appendix, and the instructions for the individual pages refer to the Appendix.
Mr. Drutz stated that the request to change the name of the supplement was included in the modifications highlighted in the proposal. Interested parties pointed out some issues with the crosschecks, which have been discussed with them and resolved. The crosscheck for the Analysis of Operations – Accident and Health, line 13, language will be added to include the change in the reserve that is reported in Exhibit 6, column 1. Language will be added to line 19 to clarify that the line should include the increase in policy reserves and the change in premium deficiency reserves. This language is consistent with the same line reported in the health blank. The crosschecks for line 19 and line 20 of the page will be deleted and replaced with one adding line 19 and line 20 to match up in total with the supplement lines 21 through 24, column 1. A crosscheck is being added from the Supplement, column 1 minus column 14, line 24 should equal the total in the Analysis of Operations Summary, column 6 (accident and health [A&H]), line 29. This is similar to the other crosschecks of the Analysis of Operations pages to the summary. Interested parties asked for an instruction added to the supplement to indicate that life companies that do not write any health business or hold any health reserves are not required to file the supplement.

Mr. Drutz made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. Tip Tipton (Thrivent Financial) stated that interested parties would like the effective date to be an annual 2023. He stated that companies have indicated that they are adjusting to the previous changes to Schedule H and the changes to the Accident and Health Policy Experience Exhibit, which is also effective this year. He stated that those efforts, especially for smaller companies, will make it difficult to implement this change for annual 2022. He stated that this proposal, being effective for annual 2022, would require companies to retroactively report the data back to the first of the year.

Mr. Hudson made a subsequent motion, seconded by Mr. Drutz, to adopt the modifications, including the change in effective date to annual 2023 to accommodate interested parties’ request. The motion passed unanimously. Mr. Drutz made a motion, seconded by Mr. Hudson, to adopt the modified proposal (Attachment Two-C). The motion passed.

d. **Agenda Item 2021-18BWG**

Ms. Walker stated that this proposal modifies the Life Insurance exhibit (State Page) to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Two new Schedule T style pages, Exhibit of Claims Settled During the Current Year and Policy Exhibit, are created to include detail captured by state on the existing Life Insurance exhibit (State Page) that could not be included due to space restrictions. This proposal adds definitions for life and annuity products to the lines of business definitions in the health appendix. She stated that considering the interested party comments, she would like to defer this proposal to allow time for further discussion and review by other regulatory groups.

Ms. Walker made a motion, seconded by Ms. Doggett, to defer the proposal for a public comment period ending April 25. The motion passed unanimously.

e. **Agenda Item 2021-19BWG**

Mr. Drutz stated that this proposal adds columns and lines to Underwriting and Investment Exhibits, Parts 1, 2, 2A, 2B, and 2D and the Exhibit of Premiums, Enrollment and Utilization in the annual statement bringing the lines of business reporting in line with Life/Fraternal and Property. It adds columns and lines to the Exhibit of Premiums, Enrollment and Utilization and Underwriting and Investment analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made.
Mr. Drutz made a motion, seconded by Mr. Hudson to adopt the modifications to the proposal. The motion passed unanimously. Mr. Garn made a motion, seconded by Mr. Drutz to adopt the modified proposal (Attachment Two-D). The motion passed unanimously.

f. Agenda Item 2021-20BWG

Mr. Garn stated that this proposal, beginning at line 72 of the Life/Fraternal Five-Year Historical, adds or deletes lines to pull in the specific lines of business reported on the Life/Fraternal Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and Accident and Health (line 33 of those pages).

Mr. Garn stated that the changes to the life/fraternal Analysis of Operations by Lines of Business were made in the 2019 filing. The effective date of 2023 was recommended to accommodate the five years of data to coincide with this adoption. Companies have reported the five-year historical page for three years using the lines as they currently exist. As it should not be a hardship for companies to report in the current lines for one additional year and complete the full five years of data in 2023, it is recommended that the proposal remain with a 2023 effective date.

Mr. Garn said the A&H claim reserves adequacy lines are not part of the current proposal. They will remain and can be discussed further as to whether they should remain in the future. The crosscheck references will be adjusted in a future editorial listing as these may no longer work with the recent changes to Schedule H. The other editorial suggestions from the interested parties have been made and are highlighted in the proposal as modifications.

Mr. Garn made a motion, seconded by Mr. Eft to adopt the modifications to the proposal. The motion passed unanimously. Mr. Garn made a motion, seconded by Mr. Eft to adopt the modified proposal (Attachment Two-E). The motion passed unanimously.

g. Agenda Item 2021-21BWG

Mr. Bruggeman stated that this blanks agenda item results from the Statutory Accounting Principles (E) Working Group’s adoption of agenda item 2021-15, which specified that residual tranches shall be reported on Schedule BA - Other Long-Term Investments and valued at the lower of amortized cost or fair value. The effective date of this required reporting is year-end 2022. This blanks item added instructions to the Investment Schedules General Instructions to exclude residual tranches or interests from being reported as bonds on Schedule D, Part 1 and added lines to Schedule BA for the reporting of those investments. He stated that the comments from interested parties recommended adding a notation that the proposal should also apply to separate accounts, as these types of investments could exist in separate account investment holdings. This change was not deemed necessary as the general account instructions are relevant for this type of investment.

Mr. Bruggeman stated that interested parties recommended modifying the title of residual tranches or interests to include the phrase “with underlying assets having characteristics of.” This change has been made to the proposal. Interested parties also suggested splitting the Common Stock subcategory between Preferred Stock and Common Stock, which would require renumbering of the lines for the subsequent categories/subcategories. They state that this change would support the efforts of the newly formed Risk-Based Capital Investment Risk and Evaluation (E) Working Group as it evaluates possible changes to the RBC factors for these types of investments. While NAIC staff support this suggestion, this item has not yet been reflected in the proposal. However, it could be considered, as long as the revisions can be implemented for year-end 2022 reporting.
Finally, interested parties proposed adding instructions that the investment in Residual Tranches or Interests should be assigned to the subcategory with the highest underlying asset concentration as there should not be any bifurcation of the underlying assets among the subcategories. NAIC staff conferred with state insurance regulators, who indicated support for these revisions. Mr. Bruggeman recommended adoption of proposal 2021-21BWG, incorporating the suggestions of interested parties, which: 1) split the common stock subcategory between preferred and common stock; and 2) add instructions that residual tranches should be assigned to the subcategory with the highest underlying asset concentration.

Ms. Doggett and Mr. Hudson indicated that they agreed with the breakout of the preferred stock and common stock lines. Mr. Tipton stated that interested parties approved of the breakout of preferred stock and common stock as well.

Mr. Bruggeman made a motion, seconded by Mr. Eft to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. Eft, to adopt the modified proposal (Attachment Two-F). The motion passed unanimously.

h. **Agenda Item 2021-22BWG**

Mr. Bruggeman stated that this blanks agenda item is in response to the Statutory Accounting Principles (E) Working Group’s agenda item 2021-21 regarding related party reporting. The Working Group’s agenda item had two main goals: 1) to clarify reporting of affiliate transactions within existing reporting lines in the investment schedules; and 2) to incorporate new reporting requirements for investment transactions with related parties. Pursuant to recent discussions, state insurance regulators desire additional information on investment transactions involving related parties, regardless of whether the related party is “affiliated” pursuant to the *Insurance Holding Company System Regulatory Act* (#440).

Mr. Bruggeman stated that the identification of certain investments/transactions would be identified through the use of a reporting code in the 2022 year-end investment schedules: 1) direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure; 2) securitization or similar investment involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties; 3) securitization or similar investment involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties; 4) securitization or similar investment in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role; and 5) the investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1–4.

Mr. Bruggeman stated that during its April 4 meeting at the Spring National Meeting, the Statutory Accounting Principles (E) Working Group plans to expose its related agenda item with modifications to the reporting proposal that considers comments from interested parties. The exposure will include modifications to the original proposed SSAP No. 25—*Affiliates and Other Related Parties* clarifications and revisions to the proposed annual statement reporting instructions. Accordingly, it is recommended that the Blanks (E) Working Group expose this blanks item incorporating the new language that will be concurrently exposed by the Statutory Accounting Principles (E) Working Group.
Mr. Bruggeman made a motion, seconded by Mr. Hudson, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Mr. Drutz to re-expose the modified proposal (Attachment Two-G) for a public comment period ending April 25. The motion passed unanimously.

i. Agenda Item 2021-23BWG

Mr. Bruggeman stated that this blanks agenda item assumes adoption of 2021-21BWG. With the new reporting lines proposed for residuals in Schedule BA, additional revisions are needed to map those reporting lines to the asset valuation reserve (AVR) schedule. The proposed revisions will separately capture these items in a new category within AVR as they are items that are not comparable to other investments.

The comments from interested parties, similar to 2021-21BWG, recommended adding a notation that the proposal should also apply to separate accounts, as these types of investments could exist in separate account investment holdings. This change was not deemed necessary as the general account instructions are relevant for this type of investment. However, interested parties also suggested other editorial updates, and those items have been corrected in the final proposal. Mr. Bruggeman recommend adoption of 2021-21BWG, incorporating the editorial suggestions of interested parties.

Mr. Bruggeman made a motion, seconded by Ms. Doggett, to adopt the modifications to the proposal. The motion passed unanimously. Mr. Bruggeman made a motion, seconded by Ms. Doggett to adopt the modified proposal (Attachment Two-H). The motion passed unanimously.

John DuBois (MassMutual) stated that the Working Group may need to look at the risk-based capital (RBC) impact. Mr. Bruggeman stated that the factors will stay the same for this year. It will be broken out in the AVR categories. They may go in a different category of risk, so there may be a covariance difference, but the factors should not have an impact for 2022. There may need to be an editorial comment in the new RBC instructions to account for that.

4. Exposed New Items

   a. Agenda Item 2022-01BWG

Mr. Bruggeman stated that this blanks agenda item is in response to Statutory Accounting Principles (E) Working Group agenda item 2021-24, which the Working Group exposed in December 2021 and is up for consideration of adoption during the Spring National Meeting. The Blanks (E) Working Group’s agenda item proposes a new general interrogatory within the annual reporting blanks, specific to the use or acceptance of cryptocurrencies. Examples of inquiries within the interrogatory include the identification regarding: 1) if cryptocurrencies are held by an insurance reporting entity (and if so, which reporting schedules are the cryptocurrencies reported); and 2) if cryptocurrencies are accepted for the payment of premiums. This general interrogatory was requested by regulators after the Statutory Accounting Principles (E) Working Group’s May 2021 adoption of Interpretation (INT) 21-01: Accounting for Cryptocurrencies, which established that directly held cryptocurrencies do not meet the definition of an admitted asset for statutory accounting.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

   b. Agenda Item 2022-02BWG

Mr. Bruggeman stated that this blanks agenda item is in response to Statutory Accounting Principles (E) Working Group agenda item 2021-22, which the Working Group exposed in December 2021 and is up for consideration of
adoption during the Spring National Meeting. The agenda item is to expand, through electronic-only columns, the reporting on Schedule D – Part 6 – Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Entities (Schedule D-6-1). Schedule D-6-1 captures investments that are defined in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities. The proposed expansion in reporting would capture items consistent with current requirements in SSAP No. 97 and include items such as prior year’s book/adjusted carrying value (BACV), nonadmitted amount, sub-2 verified value, and VISION filing number. The addition of these items to the Schedule D, Part 6, Section 1 tables were proposed as they will assist state insurance regulators to: 1) ensure Sub 1 and Sub 2 filings are being submitted by reporting entities; and 2) identify situations where the NAIC approved value varies significantly from the value reported on Schedule D, Part 6, Section 1.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

c. Agenda Item 2022-03BWG

Mary Caswell (NAIC) stated that this affects only the P/C quarterly filing with effective date of first-quarter 2023. This proposal is to fix the reporting of line 5 to be reported as line 5.1 – Commercial multiple peril (non-liability portion) and line 5.2 – Commercial multiple peril (liability portion) on the Quarterly Part 1 and Part 2 pages to be consistent with the annual reporting. This change was missed on proposal 2020-33BWG. This is a big enough change to warrant a proposal rather than an editorial correction.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

d. Agenda Item 2022-04BWG

Ms. Gosselin stated that this proposal adds a new supplement to capture premium and loss data for the P/C blank for annual statement line 17.1, line 17.2 and line 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business. She stated that after discussions with interested parties and state insurance regulators and reviewing their input, this proposal was drafted to replace 2021-13BWG.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

e. Agenda Item 2022-05BWG

Ms. Caswell stated that this proposal adds line numbers to the status data points of the life/fraternal, health. and P/C Schedule T footnote for ease in electronic data capture of the lines and clarification of reporting.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

f. Agenda Item 2022-06BWG

Mr. Drutz stated that this proposal is sponsored by the Health Risk-Based Capital (E) Working Group. After much discussion of the Health Test Ad Hoc Group members, and approval by the Health Risk-Based Capital (E) Working Group, the proposal was drafted to amend the health test language annual statement instructions in an effort to move those filers who write predominantly health business and file on the life blank to begin filing on the health blank.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.
g. **Agenda Item 2022-07BWG**

Eric King (NAIC) stated that this proposal is sponsored by the Health Actuarial (B) Task Force. It modifies the Health Actuarial Opinion Instructions to add definitions of “actuarial asset” and “actuarial liability” and modifies Section 4 (Identification), Section 5 (Scope), and Section 7 (Opinion) to clarify that the actuary’s opinion covers actuarial assets, as well as actuarial liabilities. It modifies Section 9 to clarify that the guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

h. **Agenda Item 2022-08BWG**

Ms. Krylova stated that this proposal modifies the instructions in Section 1, Section 3, and Section 8 of the Property/Casualty Actuarial Opinion Instructions to reflect the changes adopted by the Actuarial Opinion (C) Working Group. She stated that the first change is deletion of the paragraph on continuing education log procedures because this is no longer needed as the Task Force has ended its project of studying the continuing education logs. The second change came about as a request for guidance from industry. In consultation with the financial examiner, the technical group developed guidance on documenting the review of the qualification documentation for companies that are part of a larger group. The third change regarding the directly appointed actuaries to include an additional requirement is added in the Identification paragraph for appointed actuaries to confirm that qualification documentation has been provided to the board of directors. This statement in the Identification paragraph will assist state insurance regulators in determining whether this requirement has been met. The fourth change clarifies that the signature block requirements apply to the Statement of Actuarial Opinion only.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

i. **Agenda Item 2022-09BWG**

Jennifer Frasier (NAIC) stated that this proposal is sponsored by the Life Actuarial (A) Task Force with an effective date of annual 2022. She stated that the *Valuation Manual* allows for an ongoing exemption, which means that a company can file once for a life principles-based reserve (PBR) exemption, and for subsequent years, the company could just attest to its ongoing qualification. The proposal changes are meant to sync up the blanks requirements with the new allowance for an ongoing exemption. It changes to the Life/Fraternal VM-20 Reserves Supplement blank part 2, adding a question 3, a disclosure of the year that the Life PBR Exemption was actively filed, and a confirmation of the eligibility criteria in the case of ongoing exemptions. It corrects references to a state “granting” an exemption, since this is often not the case (e.g., the exemption may be allowed). For the VM-20 Reserves Supplement Instructions, it adds instructions for the new disclosure item, question 3. It corrects the references to a state “granting” an exemption. For the Supplemental Exhibits and Schedules Interrogatories (Quarterly Statement), for question 8, it adds instructions for how to respond if the company is using the ongoing exemption. The same instructions can also be found in the *Valuation Manual*, Section II, Subsection 1.G.1.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

j. **Agenda Item 2022-10BWG**

Mr. Bruggeman stated that this blanks agenda item is in response to Statutory Accounting Principles (E) Working Group agenda item 2022-03, which the Working Group expects to consider for exposure during the Spring National Meeting. The Statutory Accounting Principles (E) Working Group’s agenda item was drafted to propose
blanks instructional changes primarily to Schedule T, which reflects premiums, allocated by states and territories. NAIC staff received inquiries from three states in the fourth quarter of 2021 regarding a minor number of entities that primarily wrote health business related to the federal Affordable Care Act (ACA), which are believed to have not properly allocated premium adjustments by jurisdiction on the statutory financial statement. In summary, the agenda item directs that all premium adjustments (both increases and decreases), including but not limited to ACA premium adjustments related to the risk adjustment program, shall be allocated as premium in the respective jurisdiction.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

k. Agenda Item 2022-11BWG

Mr. Barlow stated that this proposal updates the Life/Fraternal AVR factors to correspond with the adopted RBC factors for the expanded bond designation categories. This is strictly a mechanical update. The maximum reserve factor is set to the after-tax RBC factor, and the basic contribution and reserve objective factors are a percentage of those updated maximum reserve factors.

Hearing no objection, Ms. Gosselin stated that the proposal will be considered exposed.

5. Adopted the Editorial Listing

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the Blanks (E) Working Group editorial listing. The motion passed unanimously (Attachment Two-I).

6. Received the Statutory Accounting Principles (E) Working Group Memorandum

Mr. Bruggeman stated that this is a standardized year-end memorandum from the Statutory Accounting Principles (E) Working Group. It is intended to notify the Blanks (E) Working Group of revisions to the “Notes to the Financial Statements” that have been adopted for year-end 2021 reporting. It is recommended that this memorandum, detailing instructional revisions and changes to existing disclosure requirements, be posted to the NAIC website. If deemed necessary, specific proposals, if not yet submitted, will be submitted to the Blanks (E) Working Group to formalize the instruction revisions. It is requested that this information be included in the next update to the Annual Statement Instructions. A year-end review identified that the instructions in Schedule D, Part 2 on preferred stock need to be updated to be consistent with the SSAP No. 32R—Preferred Stock revision, because the valuation of perpetual preferred stock is no longer based on the NAIC designation.

Mr. Bruggeman made a motion, seconded by Mr. Hudson, to receive the Statutory Accounting Principles (E) Working Group memorandum (Attachment Two-J). The motion passed unanimously.

Having no further business, the Blanks (E) Working Group adjourned.
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

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<td>ON BEHALF OF:</td>
</tr>
<tr>
<td>NAME: Dale Bruggeman</td>
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<tr>
<td>TITLE: Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION: Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS: 50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
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## FOR NAIC USE ONLY

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<td>New Reporting Requirement [ ]</td>
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## REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact [ X ] |
| Modifies Required Disclosure [ ] |

## DISPOSITION

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ X ] Adopted Date 03/29/2022 |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ ] Other (Specify) |

## BLANK(S) TO WHICH PROPOSAL APPLIES

| [ X ] ANNUAL STATEMENT |
| [ ] QUARTERLY STATEMENT |
| [ X ] INSTRUCTIONS |
| [ X ] CROSSCHECKS |
| [ X ] Life, Accident & Health/Fraternal |
| [ ] Property/Casualty |
| [ ] Separate Accounts |
| [ ] Protected Cell |
| [ X ] Health |
| [ X ] Health (Life Supplement) |

Anticipated Effective Date: Annual 2022

## IDENTIFICATION OF ITEM(S) TO CHANGE

Add a footnote to Exhibit 7 in the Life/Fraternal Statement and the Health Statement (Life Supplement) to capture amount of FHLB Funding Agreements reported in Columns 1 through 6 of the exhibit.

## REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to provide regulators the amount of FHLB Funding Agreements in the individual columns of Exhibit 7. (2021-16 SAPWG)

## NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _____________________________________________________________________________

Other Comments: _____________________________________________________________________________

** This section must be completed on all forms. Revised 7/18/2018
### EXHIBIT 7 – DEPOSIT-TYPE CONTRACTS

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<td>Total</td>
<td>Guaranteed Interest Contracts</td>
<td>Annuities Certain</td>
<td>Supplemental Contracts</td>
<td>Dividend Accumulations or Refunds</td>
<td>Premium and Other Deposit Funds</td>
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<td>1.</td>
<td>Balance at the beginning of the year before reinsurance</td>
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<td>2.</td>
<td>Deposits received during the year</td>
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<td>3.</td>
<td>Investment earnings credited to the account</td>
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<td>4.</td>
<td>Other net change in reserves</td>
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<td>5.</td>
<td>Fees and other charges assessed</td>
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<td>6.</td>
<td>Surrender charges</td>
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<td>7.</td>
<td>Net surrender or withdrawal payments</td>
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<td>8.</td>
<td>Other transfers to or (from) Separate Accounts</td>
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<td>9.</td>
<td>Balance at the end of current year before reinsurance (a) (Lines 1+2+3+4-5-6-7-8)</td>
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<td>10.</td>
<td>Reinsurance balance at the beginning of the year</td>
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<td>11.</td>
<td>Net change in reinsurance assumed</td>
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<td>Net change in reinsurance ceded</td>
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<td>13.</td>
<td>Reinsurance balance at the end of the year (Lines 10+11-12)</td>
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<td>14.</td>
<td>Net balance at the end of current year after reinsurance (Lines 9+13)</td>
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(a) FHA/B Funding Agreements

1. Reported as a GICs (captured in column 2): $__________
2. Reported as an Annuities Certain (captured in column 3): $__________
3. Reported as Supplemental Contracts (captured in column 4): $__________
4. Reported as Dividend Accumulations or Refunds (captured in column 5): $__________
5. Issued as Premium or Other Deposit Funds (captured in column 6): $__________
6. Total Issued as Deposit-Type Contracts (captured in column 1); (Sum of Lines 1 through 6): $__________
# NAIC BLANKS (E) WORKING GROUP

## Blanks Agenda Item Submission Form

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<tr>
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<td>[ X ]</td>
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<tr>
<td>New Reporting Requirement</td>
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**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**

| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |

**DISPOSITION**

| Rejected For Public Comment | [ ] |
| Referred To Another NAIC Group | [ ] |
| Received For Public Comment | [ ] |
| Adopted Date | 03/29/2022 |
| Rejected Date | |
| Deferred Date | |
| Other (Specify) | |

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<td>[ X ] ANNUAL STATEMENT</td>
</tr>
<tr>
<td>[ ] QUARTERLY STATEMENT</td>
</tr>
<tr>
<td>[ X ] INSTRUCTIONS</td>
</tr>
<tr>
<td>[ X ] CROSSCHECKS</td>
</tr>
<tr>
<td>[ X ] Life, Accident &amp; Health/Fraternal</td>
</tr>
<tr>
<td>[ X ] Property/Casualty</td>
</tr>
<tr>
<td>[ X ] Health</td>
</tr>
<tr>
<td>[ ] Separate Accounts</td>
</tr>
<tr>
<td>[ ] Protected Cell</td>
</tr>
<tr>
<td>[ ] Health (Life Supplement)</td>
</tr>
</tbody>
</table>

Anticipated Effective Date: Annual 2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

***See next page for details***

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

***See next page for details***

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:__________________________

Other Comments:__________________________________________

** This section must be completed on all forms.  

Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Note 9 – Income Taxes:

- Modify the instructions for 9C to eliminate the instruction for adding additional lines for DTA and DTL components to the PDF/printed version of the notes not specifically detailed in the illustration that are greater than 5% to bring in line with the data capture element of the note that can’t accommodate variable lines.

- Add formulas for calculation of total and subtotal on the illustration for 9C that are not already present.

Note 15 – Leases:

- Modify the illustrations to add a “Thereafter” line.

- Add formula for “Total” line.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

For Note 9 – Income Taxes, address differences between the PDF reporting of Note 9C and the data capture element of the disclosure. The data capture element has a single “Other” line for DTA and DTL components where the instructions for 9C asks that additional lines be added to the illustration for additional components over 5% in the PDF document. The additional lines on the PDF were intended to be temporary to identify if there were other specific lines needed to be added based on what companies were reporting as additional lines on the PDF. With no additional items identified to be added the instruction for adding these lines is being removed. The proposal also specifically clarifies calculation of total and subtotal lines where that calculation has not already been provided for clarification.

For Note 15 – Leases, there should have been a line for aggregating the amounts for the remaining years after the five years specifically shown in the illustration. This proposal adds those lines as Line 6 – Thereafter. In addition, formula for calculating the total line has been added to the illustration for clarification.
9. Income Taxes

Instruction:

C. Disclose the significant components of income taxes incurred (i.e., current income tax expenses) and the changes in DTAs and DTLs. These components would include, for example:

- Current tax expense or benefit;
- The change in DTAs and DTLs (exclusive of the effects of other components listed below);
- Investment tax credits;
- The benefits of operating loss carry forwards;
- Adjustments of a DTA or DTL for enacted changes in tax laws or rates or a change in the tax status of the reporting entity; and
- Adjustments to gross deferred tax assets because of a change in circumstances that causes a change in judgment about the realizability of the related deferred tax asset, and the reason for the adjustment and change in judgment.

NOTE: The illustration below for this disclosure reflects the setup for the data capture of the electronic notes. Reporting entities should disclose those items included as “Other” (Lines 2a13, 2e4, 3a5 and 3b3) as additional lines for those items greater than 5% in the printed/PDF filing document.
C. Current income taxes incurred consist of the following major components:

<table>
<thead>
<tr>
<th>Component</th>
<th>12/31/2021</th>
<th>12/31/2020</th>
<th>(Col 1-2) Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Current Income Tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Federal</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(b) Foreign</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(c) Subtotal (1a+1b)</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(d) Federal income tax on net capital gains</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(e) Utilization of capital loss carry-forwards</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(f) Other</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(g) Federal and foreign income taxes incurred (1c+1d+1e+1f)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(2) Deferred Tax Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Ordinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Discounting of unpaid losses</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(2) Unearned premium reserve</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(3) Policyholder reserves</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(4) Investments</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(5) Deferred acquisition costs</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(6) Policyholder dividends accrual</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(7) Fixed assets</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(8) Compensation and benefits accrual</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(9) Pension accrual</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(10) Receivables – nonadmitted</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(11) Net operating loss carry-forward</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(12) Tax credit carry-forward</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(13) Other (excluding items &lt;5% of total ordinary tax assets)</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(99) Subtotal [sum of 2a1 through 2a13]</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(b) Statutory valuation allowance adjustment</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(c) Nonadmitted</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(d) Admitted ordinary deferred tax assets (2a99 – 2b – 2c)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(e) Capital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Investments</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(2) Net capital loss carry-forward</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(3) Real estate</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(4) Other (excluding items &lt;5% of total capital tax assets)</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(99) Subtotal [2e1+2e2+2e3+2e4]</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(f) Statistical valuation allowance adjustment</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(g) Nonadmitted</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(h) Admitted capital deferred tax assets (2e99 – 2f – 2g)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(i) Admitted deferred tax assets (2d + 2h)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(3) Deferred Tax Liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Ordinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Investments</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(2) Fixed assets</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(3) Deferred and uncollected premium</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(4) Policyholder reserves</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(5) Other (excluding items &lt;5% of total capital tax liabilities)</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(99) Subtotal [3d1+3d2+3d3+3d4]</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(b) Capital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Investments</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(2) Real estate</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(3) Other (excluding items &lt;5% of total capital tax liabilities)</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(99) Subtotal [3b1+3b2+3b3]</td>
<td>$_________</td>
<td>$_________</td>
<td></td>
</tr>
<tr>
<td>(c) Deferred tax liabilities (3d09 + 3b99)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>(4) Net deferred tax assets/liabilities (2i – 3c)</td>
<td>$_________</td>
<td>$_________</td>
<td>$_________</td>
</tr>
</tbody>
</table>
15. Leases

Instruction:

A. Disclose the following items related to lessee leasing arrangements (refer to SSAP No. 22R—Leases):

(2) For leases having initial or remaining noncancelable lease terms in excess of one year:

a. Future minimum rental payments required as of the date of the latest balance sheet presented, in the aggregate and for each of the five succeeding years.

b. The total of minimum rentals to be received in the future under noncancelable subleases as of the date of the latest balance sheet presented.

B. When leasing is a significant part of the lessor’s business activities in terms of revenue, net income or assets, disclose the following information with respect to leases:

(1) For operating leases:

a. A general description of the lessor’s leasing arrangements;

b. The cost and carrying amount, if different, of property on lease or held for leasing by major classes of property according to nature or function, and the amount of accumulated depreciation in total as of the date of the latest balance sheet presented;

c. Minimum future rentals on noncancelable leases as of the date of the latest balance sheet presented, in the aggregate and for each of the five succeeding years; and

d. Total contingent rentals included in income for each period for which an income statement is presented.

(2) For leveraged leases:

a. A description of the terms including the pretax income from the leveraged leases. For purposes of presenting the investment in a leveraged lease in the lessor’s balance sheet, the amount of related deferred taxes shall be presented separately (from the remainder of the net investment);

b. Separate presentation (from each other) shall be made of pretax income from the leveraged lease, the tax effect of pretax income, and the amount of investment tax credit recognized as income during the period; and

c. When leveraged leasing is a significant part of the lessor’s business activities in terms of revenue, net income, or assets, the components of the net investment balance in leveraged leases shall be disclosed.
Illustration:

A. Lessee Operating Lease

Detail Eliminated to Conserve Space

THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.

(2)  

a. At December 31, 20___, the minimum aggregate rental commitments are as follows:

<table>
<thead>
<tr>
<th>Year Ending December 31</th>
<th>Operating Leases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>2. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>3. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>4. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>5. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>6. Thereafter</td>
<td>$ ____________</td>
</tr>
<tr>
<td><strong>Total (sum of 1 through 6)</strong></td>
<td>$ ____________</td>
</tr>
</tbody>
</table>

(3) The company is not involved in any material sales – leaseback transactions.

B. Lessor Leases

Detail Eliminated to Conserve Space

THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.

(3)  

c. Future minimum lease payment receivables under noncancelable leasing arrangements as of December 31, 20___ are as follows:

<table>
<thead>
<tr>
<th>Year Ending December 31</th>
<th>Operating Leases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>2. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>3. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>4. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>5. 20__</td>
<td>$ ____________</td>
</tr>
<tr>
<td>6. Thereafter</td>
<td>$ ____________</td>
</tr>
<tr>
<td><strong>Total (sum of 1 through 6)</strong></td>
<td>$ ____________</td>
</tr>
</tbody>
</table>
d. Contingent rentals included in income for the years ended December 31, 20__ and 20__ amounted to $__________ and $__________, respectively. The net investment is classified as real estate.

THIS EXACT FORMAT MUST BE USED IN THE PREPARATION OF THIS NOTE FOR THE TABLE BELOW. REPORTING ENTITIES ARE NOT PRECLUDED FROM PROVIDING CLARIFYING DISCLOSURE BEFORE OR AFTER THIS ILLUSTRATION.

(NOTE: THIS DOES NOT INCLUDE THE BEGINNING NARRATIVE.)

(2) Leveraged Leases

b. The Company’s investment in leveraged leases relates to equipment used primarily in the transportation industries. The component of net income from leveraged leases at December 31, 20__ and December 31, 20__ were as shown below:

<table>
<thead>
<tr>
<th>Component</th>
<th>20__</th>
<th>20__</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Income from leveraged leases before income tax including investment tax credit</td>
<td>$ ______</td>
<td>$ ______</td>
</tr>
<tr>
<td>2. Less current income tax</td>
<td>$ ______</td>
<td>$ ______</td>
</tr>
<tr>
<td>3. Net income from leveraged leases (1-2)</td>
<td>$ ______</td>
<td>$ ______</td>
</tr>
</tbody>
</table>

Detail Eliminated to Conserve Space

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/BWG/Att2B_2021-16BWG_Modified.doc
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 10/19/2021

CONTACT PERSON: ____________________________

TELEPHONE: ____________________________

EMAIL ADDRESS: ____________________________

ON BEHALF OF: ____________________________

NAME: Steve Drutz

TITLE: Chief Financial Analyst

AFFILIATION: WA Office of the Insurance Commissioner

ADDRESS: ____________________________

FOR NAIC USE ONLY

Agenda Item # 2021-17BWG MOD

Year 2022

Changes to Existing Reporting [ X ]

New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

No Impact [ X ]

Modifies Required Disclosure [ ]

DISPOSITION

[ ] Rejected For Public Comment

[ ] Referred To Another NAIC Group

[ X ] Received For Public Comment

[ ] Adopted Date ________________

[ ] Rejected Date ________________

[ ] Deferred Date ________________

[ ] Other (Specify) ________________

BLANK(S) TO WHICH PROPOSAL APPLIES

[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ X ] INSTRUCTIONS
[ X ] CROSSCHECKS

[ X ] Life, Accident & Health/Fraternal
[ ] Property/Casualty
[ X ] Health

[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2023

IDENTIFICATION OF ITEM(S) TO CHANGE

Modify the Analysis of Operations by Lines of Business in the Health Blank to include all of health lines of business included in the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health. Add instructions for the new columns and adjust the column references. Add the Health Blank Analysis of Operations by Lines of Business as a supplement to the Life/Fraternal Blank with the appropriate instructions and crosschecks. Add crosscheck to the Health Blank Analysis of Operations by Lines of Business to the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health instructions

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to add the Health Blank Analysis of Operations by Lines of Business as a supplement to the Life/Fraternal Statement to capture data points Health Blank Analysis of Operations by Lines of Business. This will allow regulators to look at revenue and expenses in the same detail as reported on the Heath Analysis of Operations by Lines of Business.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

** This section must be completed on all forms.

Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – HEALTH

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

Please refer to the instructions in Statement of Revenues and Expenses for instructions and line descriptions for this Exhibit.

Riders/Endorsements/Floaters:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same line of business as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same line of business as the base policy.

Column 1 – Total

The amounts in this column are to agree with the corresponding amounts reported on Page 4, Column 2.

Column 2 – Comprehensive (Hospital & Medical) – Individual
Column 3 – Comprehensive (Hospital & Medical) – Group

Include: Business that provides for medical coverages including hospital, surgical and major medical. Include State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI), risk contracts.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business.

Column 4 – Medicare Supplement

Include: Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Vision only and Dental only business.

Column 45 – Dental Only

Include: Policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement and Vision only business.
<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Include</th>
<th>Exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Vision Only</td>
<td>Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits.</td>
<td>Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contract, Medicare Supplement, and Dental only business.</td>
</tr>
<tr>
<td>67</td>
<td>Federal Employees Health Benefits Plans (FEHBP)</td>
<td>Business allocable to the Federal Employees Health Benefits Plan (FEHBP) premium that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code.</td>
<td>Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business.</td>
</tr>
<tr>
<td>28</td>
<td>Title XVIII - Medicare</td>
<td>Business where the reporting entity charges a premium and agrees to cover the full medical costs of Medicare subscribers. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.</td>
<td>Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefits plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business. Policies providing stand alone Medicare Part D Prescription Drug Coverage.</td>
</tr>
<tr>
<td>89</td>
<td>Title XIX - Medicaid</td>
<td>Business where the reporting entity charges a premium and agrees to cover the full medical costs of Medicaid subscribers.</td>
<td>Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefits plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) risk contracts, Medicare Supplement, Vision only and Dental only business.</td>
</tr>
<tr>
<td>10</td>
<td>Credit A&amp;H</td>
<td>Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration (Group and Individual).</td>
<td></td>
</tr>
</tbody>
</table>
Column 11 – Disability Income

Include: The term ‘disability income’ includes contracts providing disability income coverage, both short-term and long-term.

Column 12 – Long-Term Care

Include: Any insurance policy or rider that provides coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Column 13 – Other Health

Include: Other health coverages such as stop loss, disability income, long-term care and prescription drug plans and coverages not specifically addressed in any other columns. Policies providing stand alone Medicare Part D Prescription Drug Coverage.

On Line 20, expenses and reimbursements from administrative services only (ASO), other non-underwritten business and administrative services contracts (ASC).

Exclude: Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.

Column 14 – Other Non-health

Include: Life and property/casualty coverages.
ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL

HEALTH SUPPLEMENT

HEALTH ANALYSIS OF OPERATIONS BY LINES OF BUSINESS SUPPLEMENT

Please refer to the instructions in Statement of Revenues and Expenses for instructions and line descriptions for this Exhibit.

Complete the supplement if the reporting entity has health lines of business to be reported in Columns 2 through 13. Reporting entities that only have non-health lines of business should not complete the supplement.

Riders/Endorsements/Floaters:

If a rider, endorsement or floater acts like a separate policy with separate premium, deductible and limit, then it is to be recorded on the same line of business as if it were a stand-alone policy regardless of whether it is referred to as a rider, endorsement or floater. If there is no additional premium, separate deductible or limit, the rider, endorsement or floater should be reported on the same line of business as the base policy.

Column 1 – Total

Column 1 (Line 19 plus Line 20) minus Column 14 (Line 19 plus Line 20) should equal Analysis of Operations by Lines of Business – Accident and Health Column 1, sum of Lines 21 through 24.

Column 2 – Comprehensive (Hospital & Medical) – Individual

Column 3 – Comprehensive (Hospital & Medical) – Group

Include: Business that provides for medical coverages including hospital, surgical and major medical. Include State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI), risk contracts.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business.

Column 4 – Medicare Supplement

Include: Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Vision only and Dental only business.

Column 5 – Dental Only

Include: Policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement and Vision only business.
Column 6 – Vision Only

Include: Policies providing for vision only coverage issued as stand-alone vision or as a rider to a medical policy that is not related to the medical policy through premiums, deductibles or out-of-pocket limits.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contract, Medicare Supplement, and Dental only business.

Column 7 – Federal Employees Health Benefits Plans (FEHBP)

Include: Business allocable to the Federal Employees Health Benefits Plan (FEHBP) premium that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), comprehensive hospital and medical policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business.

Column 8 – Title XVIII - Medicare

Include: Business where the reporting entity charges a premium and agrees to cover the full medical costs of Medicare subscribers. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business. Policies providing stand alone Medicare Part D Prescription Drug Coverage.

Column 9 – Title XIX - Medicaid

Include: Business where the reporting entity charges a premium and agrees to cover the full medical costs of Medicaid subscribers.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, comprehensive hospital and medical policies, Medicare (Title XVIII) risk contracts, Medicare Supplement, Vision only and Dental only business.

Column 10 – Credit A&H

Include: Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration (Group and Individual).
<table>
<thead>
<tr>
<th>Column 11</th>
<th>Disability Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>The term ‘disability income’ includes contracts providing disability income coverage, both short-term and long-term.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 12</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>Any insurance policy or rider that provides coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 13</th>
<th>Other Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>Other health coverages such as stop loss and prescription drug plans and coverages not specifically addressed in any other columns. Policies providing stand alone Medicare Part D Prescription Drug Coverage. On Line 20, expenses and reimbursements from administrative services only (ASO), other non-underwritten business and administrative services contracts (ASC).</td>
</tr>
<tr>
<td>Exclude:</td>
<td>Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 14</th>
<th>Other Non-health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>Life and property/casualty coverages.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 1</th>
<th>Net Premium Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include:</td>
<td>Accrued return premium adjustments for contracts subject to redetermination.</td>
</tr>
</tbody>
</table>
Line 2 – Change in Unearned Premium Reserves and Reserve for Rate Credits

Exclude: Reserves relating to uninsured plans and the uninsured portion of partially insured plans.

Line 3 – Fee-for-Service (Net of $____ Medical Expenses)

Include: Revenue recognized by the reporting entity for provision of health services to non-members by reporting entity providers and to members through provision of health services excluded from their prepaid benefit packages. Include in the inside amount, the medical expenses associated with fee-for-service business.

Line 4 – Risk Revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g., full professional, dental, radiology, etc.) provided to the policyholders or members of another insurer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting entity in exchange for services to be provided or offered by such organization.

Line 5 – Aggregate Write-ins for Other Health Care Related Revenues

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 5 for Other Health Care Related Revenues.

Line 6 – Aggregate Write-ins for Other Non-health Revenues

Enter the total of the write-ins in schedule Details of Write-ins Aggregate at Line 6 for Other Non-health Revenues.

Line 8 – Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.

Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.

Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.

Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals below.)

The cost of utilizing skilled nursing and intermediate care facilities.
Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.

Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.

Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.

Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing-care facility provides, but that do require care and services above the level of room and board.


Exclude: Expenses for medical personnel time devoted to administrative tasks.

Emergency room and out-of-area hospitalization.

All items meeting the definition of Cost Containment Expenses found in SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses.

Line 9 — Other Professional Services

Include: Expenses for other professional providers under contractual arrangement to the reporting entity.

Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified health services, consistent with state law, engaged in the delivery of medical services.

Compensation to personnel engaged in activities in direct support of the provision of medical services. For example, include compensation to pharmacists, dentists, psychologists, optometrists, podiatrists, extenders, nurses, clinical personnel such as ambulance drivers and technicians.

Exclude: Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.

Prescription drugs.

All items meeting the definition of Cost Containment Expenses found in SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses.
Line 10 — Outside Referrals

Include: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.

Line 11 — Emergency Room and Out-of-Area

Include: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.

In the event a member is admitted to the health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.

Line 12 — Prescription Drugs

Include: Expenses for Prescription Drugs and other pharmacy benefits covered by the reporting entity.

Deduct: Pharmaceutical rebates relating to insured plans.

Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits on Line 8.

Line 13 — Aggregate Write-ins for Other Hospital and Medical

Include: Other hospital and medical expenses not covered in the other claims accounts.

Line 14 — Incentive Pool, Withhold Adjustments and Bonus Amounts

This category is for adjusting the full medical expenses reported by means of both debit and credit entries. For example, report physician withholds forfeited to the reporting entity as a credit entry. Report amounts incurred due to an arrangement whereby the reporting entity agrees to utilization savings with a provider as a debit entry.

Line 16 — Net Reinsurance Recoveries

Amounts recovered and recoverable from reinsurers on paid losses

Include: Amounts related to assumed and ceded business.

Line 18 — Non-Health Claims (net)

Include: Claims for life or property/casualty insurance, net of reinsurance.

Line 19 — Claims Adjustment Expenses, Including $ Cost Containment Expenses

All expenses incurred in connection with the recording, adjustment and settlement of claims. This includes the total of the expense classification “Other Claim Adjustment Expenses” and all “Cost Containment Expenses” in the Underwriting and Investment Exhibit, Part 3, Analysis of Expenses.

Cost Containment Expenses and Other Claim Adjustment Expenses have been defined in SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses. Refer to SSAP No. 55 for accounting guidance.
Line 20 — General Administrative Expenses

Refer to SSAP No. 70—Allocation of Expenses, for accounting guidance.

Exclude: All expenses related to cost containment activities in accordance with SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses.


Line 21 — Increase in Reserves for Accident and Health Contracts

Include: Increase in policy reserves.

Change in premium deficiency reserve.

Line 22 — Increase in Reserves for Life Contracts

Include: Increase in policy reserves.

Change in premium deficiency reserve.

Line 24 — Net Underwriting Gain or (Loss)

Column 1 minus Column 14 should equal Analysis of Operations by Lines of Business—Summary Column 6, Line 29

Detail of Write-ins Aggregated at Line 5 for Other Health Care Related Revenues

Include: Revenue from sources not covered in the other revenue accounts.

Detail of Write-ins at Line 6 for Other Non-Health Revenues

Include: Revenue from life and property/casualty business (non-premium amounts).

Gains losses on fixed assets.

Details of Write-ins Aggregated at Line 13 for Other Hospital and Medical

Include: Other hospital and medical expenses not covered in the other claims accounts.
### ANALYSIS OF OPERATIONS BY LINES OF BUSINESS – ACCIDENT AND HEALTH

**Column 1 — Total**

Sum of Lines 21 through 24 should equal Health Analysis of Operations by Lines of Business Supplement Line 19 plus 20 (Column 1 minus Column 14).

**Line 1 — Premiums for Accident and Health Contracts**

Should equal Health Analysis of Operations by Lines of Business Supplement, Line 7 minus Line 6 (Column 1 minus Column 14).

**Line 8.3 — Aggregate Write-Ins for Miscellaneous Income**

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 8.3 for Miscellaneous Income.

**Line 13 — Disability Benefits and Benefits Under Accident and Health Contracts**

Should equal

- Health Supplement — Analysis of Operations by Lines of Business Supplement, Line 17, Column 1 minus Column 14,
- Plus Exhibit 6, Line 16, Column 1 CY,
- Minus Exhibit 6, Line 16, Column 1 PY.

**Line 16 — Group Conversions**

Include: The customary charges, in the appropriate columns, to cover the excess cost arising from group conversions.

*This line is not applicable to Fraternal Benefit Societies.*

**Line 19 — Increase in Aggregate Reserves for Life and Accident and Health Contracts**

Should equal the Health Supplement – Analysis of Operations by Lines of Business Supplement, Column 1 minus Column 14, Line 21 plus Line 22

Include: Increase in policy reserves reported in Exhibit 6

Change in premium deficiency reserve reported in Exhibit 6.
# Annual Statement Blank – Health

## Analysis of Operations by Lines of Business

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Individual</th>
<th>Group</th>
<th>Medicare Supplement</th>
<th>Dental Only</th>
<th>Vision Only</th>
<th>Title XVIII</th>
<th>Title XIX</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Creditable</th>
<th>Disability</th>
<th>Large Group</th>
<th>Other Health</th>
<th>Other Non-Health</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Net premium revenue</td>
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<td>Hospital and medical benefits</td>
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<td>Other professional services</td>
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<td>Emergency room and outpatient services</td>
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<td>Prescription drugs</td>
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<tr>
<td>13</td>
<td>Aggregate write-ins for other hospital and medical benefits</td>
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<td>Incentive pool, fee-for-service adjustments and bonus amounts</td>
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<td>Subtotal lines 7 to 14</td>
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<tr>
<td>17</td>
<td>Total hospital and medical benefits (Lines 15 minus 16)</td>
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<td>18</td>
<td>Non-health claims (net)</td>
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<td>Total underwriting deductions (Lines 17 to 22)</td>
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<td>Net underwriting gain (loss)</td>
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## Details of Write-Ins

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Individual</th>
<th>Group</th>
<th>Medicare Supplement</th>
<th>Dental Only</th>
<th>Vision Only</th>
<th>Title XVIII</th>
<th>Title XIX</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Creditable</th>
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## Title XVIII

### Long-Term Individual Dental Only

- **V127**
- **V128**

### Vision Only

- **V135**
- **V136**

### Income Health

- **V143**
- **V144**

---

### Emergency Room and Outpatient

- **V147**
- **V148**

### General Administration

- **V151**
- **V152**

### Details of Write-Ins

- **V161**
- **V162**

---

### Total Revenues (Lines 1 to 6)

- **V168**
- **V169**

---

### Total (Line 7 minus Line 23)

- **V193**
- **V194**

---

### Summary of Remaining Write-Ins for Line 5 from Line 6 Above

- **V198**
- **V199**

---

### Totals (Lines 1301 through 1303 Plus 1398)

- **V201**
- **V202**
The following supplemental reports are required to be filed as part of your annual statement filing if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

### MARCH FILING

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?</td>
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<tr>
<td>10. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1? (Not applicable to fraternal benefit societies)</td>
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<tr>
<td>35. Will the Health Care Receivables Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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<tr>
<td>36. Will the Health Analysis of Operations by Lines of Business Supplement be filed with the state of domicile and the NAIC by March 1?</td>
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### APRIL FILING

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<tr>
<th>Question</th>
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<tbody>
<tr>
<td>26. Will the confidential Regulatory Asset Adequacy Issues Summary (RAAIS) required by the Valuation Manual be filed with the state of domicile by April 1?</td>
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<tr>
<td>27. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>28. Will the Credit Insurance Experience Exhibit be filed with the state of domicile and the NAIC by April 1? (Not applicable to fraternal benefit societies)</td>
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<tr>
<td>29. Will the Accident and Health Policy Experience Exhibit be filed by April 1?</td>
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<td>30. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>31. Will the regulator only (non-public) Supplemental Health Care Exhibit’s Allocation Report be filed with the state of domicile and the NAIC by April 1?</td>
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<td>32. Will the confidential Actuarial Memorandum required by Actuarial Guideline XXXVIII 8D be filed with the state of domicile by April 30?</td>
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<tr>
<td>33. Will the Supplemental Term and Universal Life Insurance Reinsurance Exhibit be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>34. Will the Variable Annuities Supplement be filed with the state of domicile and the NAIC by April 1?</td>
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<tr>
<td>35. Will the confidential Executive Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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<tr>
<td>36. Will the confidential Life Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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<tr>
<td>37. Will the confidential Variable Annuities Summary of the PBR Actuarial Report be filed with the state of domicile by April 1?</td>
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### AUGUST FILING

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<td>38. Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?</td>
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**Explanation:**

**Bar code:**

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/BWG/Att2C_2021-17BWG_Modified.doc

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<td>ON BEHALF OF:</td>
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<tr>
<td>NAME: Steve Drutz</td>
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<td>TITLE: Chief Financial Analyst</td>
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<td>AFFILIATION: WA Office of the Insurance Commissioner</td>
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FOR NAIC USE ONLY

Agenda Item # 2021-19BWG MOD
Year 2022
Changes to Existing Reporting [X]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [X]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[X] Adopted Date 03/29/2022
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[X] ANNUAL STATEMENT
[X] QUARTERLY STATEMENT
[X] INSTRUCTIONS
[X] CROSSCHECKS

[ ] Life, Accident & Health/Fraternal
[ ] Property/Casualty
[ ] Health

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE

Add columns and lines to U&I (Parts 1, 2, 2A, 2B and 2D) and the Exhibit of Premiums, Enrollment and Utilization in the annual statement bring the lines of business reporting in line with Life/Fraternal and Property. Add columns and lines to the Exhibit of Premiums, Enrollment and Utilization and U&I Analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to bring consistency in lines of business reporting across all statement types that report health business. This proposal brings the Health Statement in line with Life/Fraternal and Property Statements.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.

Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – HEALTH

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 – PREMIUMS

Written premium is defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract. For health contracts without fixed contract periods, premiums written will be equal to the amount collected during the reporting period plus uncollected premiums at the end of the period less uncollected premiums at the beginning of the period.

Column 1 – Direct Business

Include: Experience rating refunds and return retrospective premiums. Deduct any experience rating refunds and return retrospective premiums paid. Refer to SSAP No. 66—Retrospectively Rated Contracts for accounting guidance.

Accrued return premium adjustments for contracts subject to redetermination.

Column 4 – Net Premium Income

For companies that record premium on a cash basis, make adjustments for uncollected premiums at the beginning and end of the year to reflect premiums on a written basis.

Line 1 – Comprehensive (Hospital & Medical) – Individual

Include: Policies providing for medical coverages including hospital, surgical and major medical. Include State Children’s Health Insurance Program (SCHIP) Medicaid Program (Title XXI), risk contracts.

Exclude: Administrative services only (ASO), other non-underwritten business, administrative services contracts (ASC), federal employees health benefit plan (FEHBP) premiums, medical only policies, Medicare (Title XVIII) and Medicaid (Title XIX) risk contracts, Medicare Supplement, Vision only and Dental only business.

Line 23 – Medicare Supplement

Include: Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement.

Exclude: Revenue as a result of an arrangement between the reporting entity and the Centers for Medicare & Medicaid Services (CMS), on a cost or risk basis, for services to a Medicare beneficiary.

Line 44 – Dental Only

Include: Premiums for policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Line 45 – Vision Only

Include: Premiums for policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Line 56 – Federal Employees Health Benefits Plan (FEHBP)
Include: Net premiums written attributable to the FEHBP.

Line 6
Title XVIII - Medicare

Include: Revenue as a result of a risk arrangement between the reporting entity and the Centers for Medicare & Medicaid Services (CMS), for services to a Medicare beneficiary. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.


Line 7
Title XIX - Medicaid

Include: Revenue resulting from an arrangement between the reporting entity and a Medicaid state agency for services to a Medicaid beneficiary.

Line 8
Credit A&H

Include: Coverage provided to, or offered to, borrowers in connection with a consumer credit transaction where the proceeds are used to repay a debt or an installment loan in the event the consumer is disabled as the result of an accident, including business not exceeding 120 months duration (Group and Individual).

Line 9
Disability Income

Include: The term ‘disability income’ includes contracts providing disability income coverage, both short-term and long-term.

Line 10
Long-Term Care

Include: Any insurance policy or rider that provides coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital.

A policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Line 11
Other Health

Include: Other health revenues not included in any other column, including stop loss, disability income and long-term care. Policies providing stand alone Medicare Part D Prescription Drug Coverage.

Exclude: ASO (administrative services only) contracts and ASC (administrative service contracts). Refer to SSAP No. 47—Uninsured Plans for accounting guidance. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.

Line 12
Health Subtotal

Column 1 should equal Schedule T, Line 61 sum of Columns 2, 3, 5 and 6.
Line 4014  —  Life

Include: Revenue for life insurance.

Column 1 should equal Schedule T, Line 61, Column 7.

Line 4015  —  Property/Casualty

Include: Revenue for property/casualty insurance.

Column 1 should equal Schedule T, Line 61, Column 8.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 – CLAIMS INCURRED DURING THE YEAR

Column 913 – Other Health

Include: Claims incurred for other health lines of business not included in any other column, including stop loss, disability income and long-term care.

Column 1014 – Other Non-health

Include: Claims incurred for life and property/casualty lines of business.

Line 1 – Payments During the Year

Report payments net of pharmaceutical rebates collected and risk share amount collected. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Line 1.3 should include only those reinsurance recoveries received during the year.

Exclude: Medical incentive pools and bonuses.

Line 2 – Paid Medical Incentive Pools and Bonuses

Equals Underwriting and Investment, Part 2B, Columns 1 and 2, Line 1216.

Detail Eliminated to Conserve Space

Line 12 – Incurred Benefits

Line 12.1 = Line 1.1 + Line 3.1 + Line 4.1 – Line 6 – Line 8.1 – Line 9.1

Line 12.2 = Line 1.2 + Line 3.2 + Line 4.2 – Line 8.2 – Line 9.2

Line 12.3 = Line 1.3 + Line 3.3 + Line 4.3 + Line 7 – Line 8.3 – Line 9.3 – Line 11

Line 12.4 = Line 1.4 + Line 3.4 + Line 4.4 – Line 6 – Line 7 – Line 8.4 – Line 9.4 + Line 11

Line 12.1 – Incurred Benefits: Direct

Column 1 minus Column 1014, Line 12.1 should agree with the sum of Lines 9 through 14 on the Statement of Revenue and Expenses.

Line 13 – Incurred Medical Incentive Pools and Bonuses

This should agree with Line 2 + Line 5 – Line 10.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 2A – CLAIMS LIABILITY END OF CURRENT YEAR

Refer to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses for accounting guidance. Include recoverables for anticipated coordination of benefits and subrogation as a reduction to unpaid claims.

Column 913 – Other Health

Include: Claims liability for other health lines of business not included in any other column, including stop loss, disability income and long-term care.

Column 1014 – Other Non-health

Include: Claims liability for life and property/casualty lines of business.

Line 1 – Reported in Process of Adjustment

Include: Liability for all claims that have been reported to the company on or before December 31 of the current year. Provision for claims of the current year or prior years, if any, reported after that date would be made in Line 2 as Incurred but Unreported. Portions of reported claims for which payments are due after December 31 of the current year are reported in Underwriting and Investment Exhibit, Part 2D, Line 9.

Line 2 – Incurred but Unreported

Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure, claim frequency or severity.

Line 3 – Amounts Withheld from Paid Claims and Capitations

Report the amounts withheld from paid claims and capitations that have not been distributed and the anticipated withholds from estimated incurred but not reported losses.

Line 4.4 – Net Total Claim Liability

This amount should agree to Page 3, Line 1, Column 3.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B – ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR – NET OF REINSURANCE

Claims are to include amounts paid or accrued for capitation, and any other means of payment, for medical or other health care services including, under other medical costs, amounts for occupancy, depreciation and amortization as it relates to medical and hospital expenses.

Incentive pool, withhold, and bonus amounts are defined as: amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim, and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim, and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

For arrangements involving amounts withheld, the claim payments should be recorded net of the withhold, and the unpaid withholds should be held as an additional liability until paid or formally retained. The amount due should be supported by signed agreements and the basis for establishing the liability should be documented when determining the amount of this liability.

Columns 1 and 2

Enter in Columns 1 and 2, Lines 1 through 8, all payments made during the year. Record actual payments only, net of applicable Coordination of Benefits, deductibles, copayments, pharmaceutical rebates collected, risk share amounts collected, reinsuranc, subrogation, and provider discounts. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Include in Columns 1 and 2, Line 10, the portion of current health care receivables balance relating to claims paid in the current year on insured plans. This would not include those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider as the claims have not been paid as of the statement date. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Include on Line 12 actual payments from provider incentive pools and bonus arrangements or supplemental facility settlements (distributions of utilization savings).

All claim payments made relating to service dates prior to the current reporting year should be reported in Column 1. Report in Column 2 all claim payments for service dates in the current reporting year.

Columns 3 and 4

Enter in Columns 3 and 4 all claims related liabilities and reserves held at the end of the current year. This includes liability for both reported and unreported claims and should be net of anticipated reductions for coordination of benefits, deductibles, copayments, provider discounts or reinsurance recoveries on unpaid claims.

Include in Columns 3 and 4, Line 10, the portion of current health care receivables of insured plans relating to claims in the process of adjustment, excluding those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider. Refer to SSAP No. 84—Health Care and Government Insured Plan Receivables for accounting guidance.

Report on Lines 1 through 8 the claims unpaid gross of the actual withholds on paid claims and net of settlement adjustments to prior withholds. Estimated incurred but unreported losses reported on Lines 1 through 8 should be calculated in accordance with SSAP No. 54R—Individual and Group Accident and Health Contracts and may include estimations as to return of withhold on claims incurred, but not yet paid. Liability for provider incentive pools and supplemental facility settlements should also be included on Line 12.


Line 13-17, Columns 1 through 4, less Column 6 should agree to Page 4, Line 18 plus Line 19, Column 2.

The sum of Columns 3 and 4, Line 13-17 plus 10-14 should agree to the sum of Lines 1, 2 and 7, Page 3, Column 3.

Line 8-12 – Other Health

Report the unpaid claims for other health business not included in any other line. This category includes all unspecified business written under the Company’s health line of business authority including stop loss as well as business that does not qualify for the Health Statement Test (e.g., disability income and long-term care).

Line 10-14 – Health Care Receivables

This line is based on the gross health care receivable, not just the admitted portion.

Columns 1 and 2 report the amounts of health care receivables associated with claims paid during the year, excluding those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Columns 3 and 4 report the health care receivable amount attributable to those claims remaining unpaid as of the reporting date. This will include those amounts of pharmaceutical rebates that are estimated in accordance with SSAP No. 84—Health Care and Government Insured Plan Receivables guidelines.

The sum of Columns 1 through 4 on the Underwriting and Investment Exhibit, Part 2B, Line 10-14 should equal the health care receivables on Exhibit 3, Column 6 plus Column 7, excluding those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider. If health care receivables reported on Underwriting and Investment Exhibit, Part 2B are affected by reinsurance, then the sum of Column 1 through Column 4 may be different from the amounts of health care receivables reported on Exhibit 3, which are gross of reinsurance.

If health care receivables are not affected by reinsurance, then Line 10-14, Column 1 through Column 4 should be no more than Exhibit 3, Line 0799999, Column 6 plus Column 7 and be no less than to Exhibit 3, Line 0799999, Column 6 plus Column 7 minus Exhibit 3, Line 0399999, Column 6 plus Column 7. If health care receivables are affected by reinsurance, then Line 10-14, Column 1 through Column 4 should be more/less than Exhibit 3, Line 0799999, Columns 6 plus 7 minus Exhibit 3, Line 0399999, Column 6 and Column 7.

Column 6 reports the amounts of prior year health care receivables, excluding those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Footnote (a) Line 10-14 reports those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

Line 14-15 – Other Non-health

Report the unpaid claims for life and property/casualty business.

Line 14-16 – Medical Incentive Pools and Bonus Amounts

Include disbursements for incentive pool and bonus amounts in Column 1 and 2. Include liability for incentive pool and bonus amounts in Column 3 and 4.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

Exclude reserves or other amounts relating to uninsured accident and health plans and the uninsured portion of partially insured accident and health plans from this exhibit.

Column 913 – Other

Include: Stop loss, disability income and long-term care.

Line 1 – Unearned Premium Reserves

Refer to SSAP No. 54R—Individual and Group Accident and Health Contracts for accounting guidance.

Detail Eliminated to Conserve Space

Details of Write-ins Aggregated on Line 5 for Other Policy Reserves

List separately all policy reserves for which there is no pre-printed line.

Include: Accrued return premium adjustments for contracts subject to redetermination.

Details of Write-ins Aggregated on Line 11 for Other Claim Reserves

List separately all claim reserves for which there is no pre-printed line.
### EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

A schedule must be prepared and submitted to the state of domicile for each jurisdiction in which the company has written direct business, or has direct amounts paid, incurred or unpaid for provisions of health care services. In addition, a schedule must be prepared and submitted that contains the grand total (GT) for the company. To other states in which the company is licensed it should submit a schedule for that state.

Written premium is defined as the contractually determined amount charged by the reporting entity to the policyholder for the effective period of the contract based on the expectation of risk, policy benefits, and expenses associated with the coverage provided by the terms of the insurance contract. For health contracts without fixed contract periods, premiums written will be equal to the amount collected during the reporting period plus uncollected premiums at the end of the period less uncollected premiums at the beginning of the period.

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
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<tbody>
<tr>
<td>Column 1</td>
<td>Total Members at End of Prior Year</td>
</tr>
<tr>
<td>Include:</td>
<td>All members.</td>
</tr>
<tr>
<td>Columns 2 through 1013</td>
<td>Lines of Business</td>
</tr>
<tr>
<td>See Appendix – Definitions of Lines of Business in determining with which source information is associated. Stop loss, disability income and long-term care are to be included in the Other column.</td>
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</tr>
<tr>
<td>Column 4</td>
<td>Medicare Supplement</td>
</tr>
<tr>
<td>Include:</td>
<td>Medicare Supplement contracts as defined by the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#650) and Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651). Contracts sold primarily to Medicare eligible persons and designed to coordinate with Medicare but that are exempt from the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#650) and Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651).</td>
</tr>
<tr>
<td>Column 8</td>
<td>Title XVIII Medicare</td>
</tr>
<tr>
<td>Include:</td>
<td>Only amounts collected from the Federal Government for Medicare benefits and the amounts collected from enrollees over and above that collected from the Federal Government as authorized under Title XVIII.</td>
</tr>
<tr>
<td>Column 14</td>
<td>Other Non-health</td>
</tr>
<tr>
<td>Include:</td>
<td>Claims incurred for life and property/casualty lines of business.</td>
</tr>
</tbody>
</table>

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Line 12 – Health Premiums Written
Include: Direct premiums written.
Column 1 should equal Underwriting and Investment Exhibit, Part 1, Column 1, Line 413.

Line 13 – Life Premiums Direct
Include: Direct premiums and annuity considerations for life contracts excluding reinsurance assumed and without deduction of reinsurance ceded.
Column 1 should equal Underwriting and Investment Exhibit, Part 1, Column 1, Line 4014.

Line 14 – Property/Casualty Premiums Written
Include: Direct premiums for property and casualty lines of business excluding reinsurance assumed and without deduction of reinsurance ceded.
Column 1 should equal Underwriting and Investment Exhibit, Part 1, Column 1, Line 4415.

Line 15 – Health Premiums Earned
Include: Direct written premium plus the change in unearned premium reserves and reserve for rate credits.
Sum of General Interrogatories Part 2, Lines 1.61, 1.64, 1.71 and 1.74 should equal Column 4, Grand Total Exhibit of Premiums, Enrollment and Utilization page.

Footnote (a) – Complete the information regarding number of persons covered under PPO managed care products and number of persons covered under indemnity only products. Include in PPO business health insurance products that provide access to higher level of benefits whenever participating provider networks are used. This will include all blended products whereby an indemnity product is sold and issued in conjunction with an HMO product. Health business includes all business equivalent to that included in the health blank.

Footnote (b) – Report Medicare Title XVIII premiums that are exempted from state taxes or other fees by Section 1854(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This includes but is not limited to premiums written under a Medicare Advantage product, a Medicare PPO product, or a stand-alone Medicare part D product.
QUARTERLY STATEMENT INSTRUCTIONS – HEALTH

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

Column 1 – Total
Include: All members.

Columns 2 through 1013 – Lines of Business
See Annual Statement Appendix – Definitions of Lines of Business and Product Lines in determining with which source information is associated. Stop loss, disability income and long-term care are to be included in the Other column.

Column 4 – Medicare Supplement
Include: Medicare Supplement contracts as defined by the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#650) and Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651).

Column 8 – Title XVIII Medicare
Include only amounts collected from the Federal Government for Medicare benefits and the amounts collected from enrollees over and above that collected from the Federal Government as authorized under Title XVIII. Policies providing Medicare Part D Prescription Drug Coverage through a Medicare Advantage product.

Column 14 – Other Non-health
Include: Claims incurred for life and property/casualty lines of business.

Line 1 – Total Members at End of Prior Year
A member is a person who has been enrolled as a subscriber, or an eligible dependent of a subscriber, and for whom the reporting entity has accepted the responsibility for the provision of basic health services as provided by contract.

Line 2 – Total Members at End of First Quarter
Show total members (cumulative) at the end of the quarter.
UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR NET OF REINSURANCE

Information should be reported for current year-to-date.

Refer to SSAP No. 54R—Individual and Group Accident and Health Contracts, and SSAP No. 66—Retrospectively Rated Contracts, for accounting guidance.

Exclude: From the appropriate lines and columns, those amounts attributable to the Federal Employees Health Benefit Plan (FEHBP) that are exempted from state taxes or other fees by Section 8909(f)(1) of Title 5 of the United States Code.

Amounts attributable to uninsured plans and the uninsured portion of partially insured plans.

Claims are to include amounts paid or accrued for capitation, and any other means of payment, for medical or other health care services including, under other medical costs, amounts for occupancy, depreciation and amortization as it relates to medical and hospital expenses.

Incentive pool, withhold and bonus amounts are defined as amounts to be paid to providers by the Health entity as an incentive to achieve goals such as effective management of care. Some arrangements involve paying an agreed-on amount for each claim and then paying a bonus at the end of the contract period. Other arrangements involve a set amount to be withheld from each claim and then paying a portion (which could be none or all) of the withheld amount at the end of the contract period.

For arrangements involving amounts withheld, the claim payments should be recorded net of the withhold, and the unpaid withhold should be held as an additional liability until paid or formally retained. The amount due should be supported by signed agreements and the basis for establishing the liability should be documented when determining the amount of this liability.

Columns 1 and 2:

Enter in Columns 1 and 2, Lines 1 through 8, 12 and 115, all payments made year-to-date. Record actual payments only, net of applicable Coordination of Benefits, deductibles, copayments, pharmaceutical rebates collected, risk share amounts collected, reinsurance, subrogation and provider discounts. Refer to SSAP No. 84—Health Care and Government Insured Plans Receivables, for accounting guidance.

Include in Columns 1 and 2, Line 1014, the current health care receivables balance relating to claims paid year-to-date on insured plans. Refer to SSAP No. 84—Health Care and Government Insured Plans Receivables, for accounting guidance.

Include on Line 12 16 actual payments from provider incentive pools and bonus arrangements or supplemental facility settlements (distributions of utilization savings).

All claim payments made relating to service dates prior to the current reporting year should be reported in Column 1. Report in Column 2 all claim payments for service dates in the current reporting year.

Columns 3 and 4:

Enter in Columns 3 and 4 all claims related liabilities and reserves held at the end of the current quarter. This includes liability for both reported and unreported claims and should be net of anticipated reductions for coordination of benefits, deductibles, copayments, provider discounts or reinsurance recoveries.

Included in Columns 3 and 4, Line 10 14 current health care receivables of insured plans relating to claims in the process of adjustment. Refer to SSAP No. 84—Health Care and Government Insured Plans Receivables, for accounting guidance.
Report on Line 1 through 8-12 and 14-15, the claims unpaid gross of the actual withholds on paid claims and net of settlement adjustments to prior withholds. Estimated incurred but unreported losses reported on Lines 1 through 8-12 should be calculated in accordance with SSAP No. 54R—Individual and Group Accident and Health Contracts and may include estimations as to return of withhold on claims incurred, but not yet paid. Liability for provider incentive pools and supplemental facility settlements should also be included on Line 14-16.


Line 13-17, Columns 1 through 4, less Column 6 should agree to Page 4, Line 18 plus Line 19, Column 2.

The sum of Columns 3 and 4, Line 13-17 plus 10-14 should agree to the sum of Lines 1, 2 and 7, Page 3, Column 3.

Line 8-12 – Other Health

Report the unpaid claims for other health business not included in any other line. This category includes all unspecified business written under the Company’s health line of business authority, including stop loss as well as business that does not qualify for the Health Statement Test (e.g., disability income and long-term care).

Line 10-14 – Health Care Receivables

This line is based on the gross health care receivable, not just the admitted portion.

Columns 1 and 2 report the amounts of health care receivables associated with claims paid year-to-date.

Columns 3 and 4 report the health care receivable amount attributable to those claims remaining unpaid as of the end of the current quarter. This will include those amounts of pharmaceutical rebates that are estimated in accordance with SSAP No. 84—Health Care and Government Insured Plans Receivables, guidelines.

Line 11-14 – Other Non-health

Report the unpaid claims for life and property/casualty business.

Line 12-16 – Medical Incentive Pools and Bonus Amounts

Include disbursements for incentive pool and bonus amounts in Column 1 and 2. Include liability for incentive pool and bonus amounts in Column 3 and 4.
### UNDERWRITING AND INVESTMENT EXHIBIT

#### PART 1 – PREMIUMS

<table>
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<th>Line of Business</th>
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<td>Direct Business</td>
<td>Reinsurance Assumed</td>
<td>Reinsurance Ceded</td>
<td>Net Premium Income (Cols. 1+2-3)</td>
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<td>2. Comprehensive (hospital and medical) Group</td>
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<td>3. Medicare Supplement</td>
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<td>4. Dental only</td>
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<td>5. Vision only</td>
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<td>6. Federal Employees Health Benefits Plan</td>
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<td>7. Title XIX – Medicaid</td>
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<td>8. Title XIX – Medicaid</td>
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<td>10. Disability Income</td>
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<td>13. Health subtotal (Lines 1 through 12)</td>
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<td>14. Life</td>
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<td>15. Property/casualty</td>
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<td>17. Health subtotal (Lines 1 through 16)</td>
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### UNDERWRITING AND INVESTMENT EXHIBIT

**PART 2 – CLAIMS INCURRED DURING THE YEAR**

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<td>Other Health</td>
<td>Other Non-Health</td>
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</table>

1. Payments during the year:
   1.1 Direct
   1.2 Reinsurance assumed
   1.3 Reinsurance ceded
   1.4 Net

2. Paid medical indemnity pool settlements:
   2.1 Direct
   2.2 Reinsurance assumed
   2.3 Reinsurance ceded
   2.4 Net

3. Claims liability December 31, current year from Part 2A:
   3.1 Direct
   3.2 Reinsurance assumed
   3.3 Reinsurance ceded
   3.4 Net

4. Claims reserve December 31, current year from Part 2D:
   4.1 Direct
   4.2 Reinsurance assumed
   4.3 Reinsurance ceded
   4.4 Net

5. Accrued medical indemnity pool settlements, current year:

6. Net health care receivables (a)

7. Amounts recoverable from insurers December 31, current year:
   7.1 Direct
   7.2 Reinsurance assumed
   7.3 Reinsurance ceded
   7.4 Net

8. Claims liability December 31, prior year from Part 2A:
   8.1 Direct
   8.2 Reinsurance assumed
   8.3 Reinsurance ceded
   8.4 Net

9. Claims reserve December 31, prior year from Part 2D:
   9.1 Direct
   9.2 Reinsurance assumed
   9.3 Reinsurance ceded
   9.4 Net

10. Accrued medical indemnity pool settlements and recoveries, prior year:

11. Amounts receivable from insurers December 31, prior year:
   11.1 Direct
   11.2 Reinsurance assumed
   11.3 Reinsurance ceded
   11.4 Net

12. Incurred benefits:
   12.1 Direct
   12.2 Reinsurance assumed
   12.3 Reinsurance ceded
   12.4 Net

(a) Excludes $………. loans or advances to providers not yet expensed.

---

**Note:**
- Table entries may be placeholders or require specific data that is not provided in the image.
- The table layout and cell contents are placeholders to illustrate the structure of the data presentation.
- Actual data would replace the placeholders and provide meaningful information for analysis.

---

**Footnotes:**
- (a) Excludes $………. loans or advances to providers not yet expensed.
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**UNDERWRITING AND INVESTMENT EXHIBIT**
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(a) Excludes $……… loans or advances to providers not yet expensed.
## UNDERWRITING AND INVESTMENT EXHIBIT

### PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

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### DETAILS OF WRITE-INS

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(a) Includes $……. premium deficiency reserve

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4/5/22
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION  __________________________________________________________________________________________

2. __________________________________________________________________________________________________________________________________________

NAIC Group Code ________ BUSINESS IN THE STATE OF _____________________________ DURING THE YEAR ________________

NAIC Company Code __________________________

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6. Current Year Member Months

7. Total Member Ambulatory Encounters

8. Year:

9. Total

10. Hospital Referral Days Incurred

11. Number of Hospital Admissions

12. Health Premiums Written (h)

13. Life Premiums Direct

14. Property/Casualty Premiums Written

15. Health Premiums Earned

16. Property/Casualty Premiums Earned

17. Amount Paid for Provision of Health Care Services

18. Amount Incurred for Provision of Health Care Services

(a) For health business: number of persons insured under PPO managed care products___ and number of persons insured under indemnity only products__.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $……………….

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Affix Bar Code Above

NAIC Proceedings – Spring 2022

Accounting Practices and Procedures (E) Task Force

Attachment Two-D

9-203
# QUARTERLY STATEMENT BLANK – HEALTH

## EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

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(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $………

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NAIC Proceedings – Spring 2022

Accounting Practices and Procedures (E) Task Force
4/5/22
## UNDERWRITING AND INVESTMENT EXHIBIT
### ANALYSIS OF CLAIMS UNPAID-PRIOR YEAR-NET OF REINSURANCE

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<th>6 Estimated Claim Reserve and Claim Liability Dec. 31 of Prior Year</th>
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<td>2. Comprehensive (hospital and medical) Group</td>
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<tr>
<td>3. Medicare Supplement</td>
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<td>4. Dental only</td>
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<td>5. Vision only</td>
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<td>6. Federal Employees Health Benefits Plan</td>
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<td>7. Title XVIII - Medicare</td>
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<td>8. Title XIX - Medicaid</td>
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<td>9. Credit A&amp;H</td>
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<td>10. Disability Income</td>
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<td>11. Long-Term Care</td>
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<td>12. Other health</td>
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<td>13. Health subtotal (Lines 1 to 12)</td>
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<td>14. Health care receivables (a)</td>
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<td>15. Other non-health</td>
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<td>16. Medical incentive pools and bonus amounts</td>
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<td>17. Totals (Lines 913-1014+1115+1216)</td>
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(a) Excludes $………. loans or advances to providers not yet expensed.
## NAIC BLANKS (E) WORKING GROUP

### Blanks Agenda Item Submission Form

<table>
<thead>
<tr>
<th>CONTACT PERSON:</th>
<th>Jacob W. Garn</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE:</td>
<td>Chair, Blanks Working Group</td>
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<td>AFFILIATION:</td>
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### FOR NAIC USE ONLY

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<tr>
<td>Year: 2023</td>
</tr>
<tr>
<td>Changes to Existing Reporting: [ X ]</td>
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<tr>
<td>New Reporting Requirement: [ ]</td>
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</table>

### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact: [ X ] |
| Modifies Required Disclosure: [ ] |

### DISPOSITION

| Rejected For Public Comment: [ ] |
| Referred To Another NAIC Group: [ ] |
| Received For Public Comment: [ ] |
| Adopted Date: 03/29/2022 |
| Rejected Date: [ ] |
| Deferred Date: [ ] |
| Other (Specify): [ ] |

### BLANK(S) TO WHICH PROPOSAL APPLIES

- Annual Statement: [ X ]
- Quarterly Statement: [ ]
- Instructions: [ X ]
- Crosschecks: [ X ]
- Life, Accident & Health/Fraternity: [ X ]
- Property/Casualty: [ ]
- Health: [ ]
- Separate Accounts: [ ]
- Protected Cell: [ ]
- Health (Life Supplement): [ ]

Anticipated Effective Date: Annual 2023

### IDENTIFICATION OF ITEM(S) TO CHANGE

Starting at Line 72 of the Life/Fraternity Five-Year Historical add or delete lines that don’t pull in the specific lines of business reported on the Life/Fraternity Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and A&H for Line 33 of those pages.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to bring back the line of business detail reporting of Net Gains from Operations After Dividends to Policyholders/Refunds to Members and Federal Income Taxes by Lines of Business as was done before the Life/Fraternity Analysis of Operations by Lines of Business page was expanded for the new lines of business categories.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** This section must be completed on all forms.
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

FIVE-YEAR HISTORICAL DATA

Detail Eliminated to Conserve Space

Net Gains From Operations After Dividends to Policyholders, Refunds to Members and Federal Income Taxes and Before Realized Capital Gains or (Losses) by Lines of Business

Line 72 – Individual Industrial Life
All years .................................. Page 6.1, Line 33, Column 2

Line 73 – Individual Whole Life
All years .................................. Page 6.1, Line 33, Column 3

Line 74 – Individual Term Life
All years .................................. Page 6.1, Line 33, Column 4

Line 75 – Individual Indexed Life
All years .................................. Page 6.1, Line 33, Column 5

Line 76 – Individual Universal Life
All years .................................. Page 6.1, Line 33, Column 6

Line 77 – Individual Universal Life With Secondary Guarantees
All years .................................. Page 6.1, Line 33, Column 7

Line 78 – Individual Variable Life
All years .................................. Page 6.1, Line 33, Column 8

Line 79 – Individual Variable Universal Life
All years .................................. Page 6.1, Line 33, Column 9

Line 80 – Individual Credit Life
All years .................................. Page 6.1, Line 33, Column 10

Line 81 – Individual Other Life
All years .................................. Page 6.1, Line 33, Column 11

Line 82 – Individual YRT Mortality Risk Only
All years .................................. Page 6.1, Line 33, Column 12
Line 83 – Group Whole Life
   All years ......................... Page 6.2, Line 33, Column 2
Line 84 – Group Term Life
   All years ......................... Page 6.21, Line 33, Column 3
Line 85 – Group Universal Life
   All years ......................... Page 6.2, Line 33, Column 4
Line 86 – Group Variable Life
   All years ......................... Page 6.2, Line 33, Column 5
Line 87 – Group Variable Universal Life
   All years ......................... Page 6.24, Line 33, Column 6
Line 88 – Group Credit Life
   All years ......................... Page 6.2, Line 33, Column 7
Line 89 – Group Other Life
   All years ......................... Page 6.2, Line 33, Column 8
Line 90 – Group YRT Mortality Risk Only
   All years ......................... Page 6.2, Line 33, Column 9
Line 73 – Ordinary – Life
   All years ......................... Page 6.1, Line 33, Column 1 less Columns 2, 10 and 12
Line 2491 – Ordinary – Individual Deferred Fixed Annuities
   All years ......................... Page 6.3, Line 33, Column 42
Line 92 – Individual Deferred Indexed Annuities
   All years ......................... Page 6.3, Line 33, Column 3
Line 93 – Individual Deferred Variable Annuities With Guarantees
   All years ......................... Page 6.3, Line 33, Column 4
Line 94 – Individual Deferred Variable Annuities Without Guarantees
   All years ......................... Page 6.3, Line 33, Column 5
Line 95 – Individual Contingent Payout (Immediate and Annuitization)
   All years ......................... Page 6.3, Line 33, Column 6
Line 96 – Individual Other Annuities

All years .................................... Page 6.3, Line 33, Column 7

Line 75 – Ordinary – Supplementary Contracts

All years ............................... No longer a separate column on the Analysis of Operations by Lines of Business pages. The amounts are included in the individual and group annuities amounts on Lines 74 and 78.

Line 76 – Credit Life

All years ................................... Line 33, Page 6.1, Column 10 plus Page 6.2, Column 7

Line 77 – Group Life

All years .................................... Page 6.2, Line 33, Column 1 less Columns 7 and 9

Line 78 – Group Deferred Fixed Annuities

All years ............................... Page 6.4, Line 33, Column 52

Line 79 – Group Deferred Indexed Annuities

All years ............................... Page 6.4, Line 33, Column 3

Line 97 – Group Deferred Variable Annuities With Guarantees

All years ............................... Page 6.4, Line 33, Column 4

Line 100 – Group Deferred Variable Annuities Without Guarantees

All years ............................... Page 6.4, Line 33, Column 5

Line 101 – Group Contingent Payout (Immediate and Annuitization)

All years ............................... Page 6.4, Line 33, Column 6

Line 102 – Group Other Annuities

All years ............................... Page 6.4, Line 33, Column 7

Line 103 – A & H – Comprehensive Group

All years ............................... Page 5.6, Line 33, Column 2

Line 104 – A & H – Comprehensive Group

All years ............................... Page 6.5, Line 33, Column 3
Line 105 – A & H – Medicate Supplement
All years ............................... Page 6.5, Line 33, Column 4

Line 106 – A & H – Vision Only
All years ............................... Page 6.5, Line 33, Column 5

Line 107 – A & H – Dental Only
All years ............................... Page 6.5, Line 33, Column 6

Line 108 – A & H – Federal Employees Health Benefits Plan
All years ............................... Page 6.5, Line 33, Column 7

Line 109 – A & H – Title XVII Medicare
All years ............................... Page 6.5, Line 33, Column 8

Line 110 – A & H – Title XIX Medicaid
All years ............................... Page 6.5, Line 33, Column 9

Line 80111 – A&H – Credit
All years ............................... Page 6.5, Line 33, Column 10

Line 112 – A & H – Disability Income
All years ............................... Page 6.5, Line 33, Column 11

Line 113 – A & H – Long-Term Care
All years ............................... Page 6.5, Line 33, Column 12

Line 84114 – A&H – Other Health
All years ............................... Page 6.5, Line 33, Column 12 less Columns 3 and 10

Line 82115 – Aggregate of All Other Lines of Business
All years ............................... Page 6, Line 33, Column 8

Line 83116 – Fraternal
All years ............................... Page 6, Line 33, Column 7
### ANNUAL STATEMENT BLANKS – LIFE/FRATERNAL

#### FIVE–YEAR HISTORICAL DATA

Show amounts in whole dollars only, no cents; show percentages to one decimal place, i.e., 17.6

$000 omitted for amounts of life insurance

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<th>3</th>
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**Detail Eliminated to Conserve Space**

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<tr>
<th>Net Income Taxes and Before Realized Capital Gains or (Losses) by Lines of Business (Page 6.x, Line 33)</th>
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<tr>
<td>71. Ordinary life (Page 6.1, Col. 1) ...............................................................................................................</td>
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<tr>
<td>72. Ordinary life (Page 6.1, Col. 2) ...............................................................................................................</td>
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<tr>
<td>73. Individual whole life (Page 6.1, Col. 3) ....................................................................................................</td>
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<tr>
<td>74. Individual term life (Page 6.1, Col. 4) .....................................................................................................</td>
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<tr>
<td>75. Individual index life (Page 6.1, Col. 5) .....................................................................................................</td>
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<tr>
<td>76. Individual universal life (Page 6.1, Col. 6) ............................................................................................</td>
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<td>77. Individual universal life with secondary guarantees (Page 6.1, Col. 7) ..............................................</td>
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<tr>
<td>78. Individual variable universal life (Page 6.1, Col. 8) ..............................................................................</td>
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<tr>
<td>79. Individual variable universal life (Page 6.1, Col. 9) ..............................................................................</td>
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<td>80. Individual credit life (Page 6.1, Col. 10) .................................................................................................</td>
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<td>81. Individual other life (Page 6.1, Col. 11) ...................................................................................................</td>
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<tr>
<td>82. Individual YRT mortality risk only (Page 6.1, Col. 12) ..........................................................................</td>
</tr>
<tr>
<td>83. Group whole life (Page 6.2, Col. 1) ............................................................................................................</td>
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<tr>
<td>84. Group term life (Page 6.2, Col. 2) .............................................................................................................</td>
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<tr>
<td>85. Group universal life (Page 6.2, Col. 3) .....................................................................................................</td>
</tr>
<tr>
<td>86. Group variable life (Page 6.2, Col. 4) .......................................................................................................</td>
</tr>
<tr>
<td>87. Group variable universal life (Page 6.2, Col. 5) ......................................................................................</td>
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<tr>
<td>88. Group credit life (Page 6.2, Col. 6) ..........................................................................................................</td>
</tr>
<tr>
<td>89. Group other life (Page 6.3, Col. 1) ............................................................................................................</td>
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<tr>
<td>90. Group YRT mortality risk only (Page 6.2, Col. 9) ....................................................................................</td>
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<tr>
<td>91. Ordinary life (Page 6.1, Col. 2) ...............................................................................................................</td>
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<tr>
<td>92. Individual deferred indexed annuities (Page 6.3, Col. 1) .......................................................................</td>
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<td>93. Individual deferred variable annuities with guarantees (Page 6.3, Col. 2) ..........................................</td>
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<td>94. Individual deferred variable annuities without guarantees (Page 6.3, Col. 3) ....................................</td>
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<td>95. Individual life contingent payout (Immediate and Annuity for a Specific Period) (Page 6.3, Col. 6)</td>
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<tr>
<td>96. Individual other annuities (Page 6.3, Col. 7) ........................................................................................</td>
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<td>97. Group deferred fixed annuities (Page 6.4, Col. 1) ...................................................................................</td>
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<td>98. Group deferred indexed annuities (Page 6.4, Col. 2) .............................................................................</td>
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<td>99. Group deferred variable annuities with guarantees (Page 6.4, Col. 3) ..............................................</td>
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<td>100. Group deferred variable annuities without guarantees (Page 6.4, Col. 4) .......................................</td>
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<td>102. Group other annuities (Page 6.4, Col. 6) .............................................................................................</td>
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<tr>
<td>103. A &amp; H-comprehensive individual (Page 6.5, Col. 1) ..........................................................................</td>
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<tr>
<td>104. A &amp; H-comprehensive group (Page 6.5, Col. 2) ..................................................................................</td>
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<tr>
<td>105. A &amp; H-medicare supplement (Page 6.5, Col. 3) ....................................................................................</td>
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<tr>
<td>106. A &amp; H-vision only (Page 6.5, Col. 4) .....................................................................................................</td>
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<tr>
<td>107. A &amp; H-dental only (Page 6.5, Col. 5) .....................................................................................................</td>
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<tr>
<td>108. A &amp; H-federal employees health benefits plan (Page 6.5, Col. 6) ......................................................</td>
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<tr>
<td>109. A &amp; H-Telie XVII Medicare (Page 6.5, Col. 7) .......................................................................................</td>
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<td>110. A &amp; H-GH-Plan II Medicare (Page 6.5, Col. 8) .......................................................................................</td>
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<td>111. A &amp; H-credit (Page 6.5, Col. 9) .............................................................................................................</td>
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<td>112. A &amp; H-disability income (Page 6.5, Col. 10) .........................................................................................</td>
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<td>113. A &amp; H-dental-med care (Page 6.5, Col. 11) ............................................................................................</td>
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<tr>
<td>114. A &amp; H-other (Page 6.5, Col. 12) .............................................................................................................</td>
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<td>115. Aggregate of all other lines of business (Page 6.8, Col. 1) ...................................................................</td>
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<td>116. Fraternal (Page 6.7, Col. 1) ....................................................................................................................</td>
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<td>117. Total (Page 6, Col. 1) ............................................................................................................................</td>
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https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/BWG/Att2E_2021-20BWG_Modified.doc

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NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

| CONTACT PERSON: | Dale Bruggeman |
| TELEPHONE: |  |
| EMAIL ADDRESS: |  |
| ON BEHALF OF: | Ohio Department of Insurance |
| ADDRESS: | 50W. Town St., 3rd Fl., Ste. 300 |

**FOR NAIC USE ONLY**

| Agenda Item # | 2021-21BWG MOD |
| Year | 2022 |
| Changes to Existing Reporting | [ X ] |
| New Reporting Requirement | [ ] |
| REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT |
| No Impact | [ X ] |
| Modifies Required Disclosure | [ ] |
| DISPOSITION |
| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ ] Adopted Date |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ ] Other (Specify) |

**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] Life, Accident & Health/Fraternal
- [ X ] Property/Casualty
- [ X ] Health

**INSTRUCTIONS**

- [ ] Separate Accounts
- [ ] Protected Cell
- [ X ] Title
- [ ] Other

**CROSSCHECKS**

- [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Add instruction to the Investment Schedules General Instructions to exclude residual tranches or interests from being reported as bonds on Schedule D, Part 1 and add lines to Schedule BA for the reporting of those investments.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to reflect changes being adopted by the Statutory Accounting Principles (E) Working Group SSAP No. 43R – Loan-Backed and Structured Securities (Ref #2021-15). The proposal excludes residual tranches or interests from being reported as bonds on Schedule D, Part 1 and requires them to be reported on Schedule BA.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE BA – PARTS 1, 2 AND 3

OTHER LONG-TERM INVESTED ASSETS – GENERAL INSTRUCTIONS

<table>
<thead>
<tr>
<th>Group or Category</th>
<th>Line Number</th>
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<tr>
<td>Oil and Gas Production</td>
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<td>Unaffiliated</td>
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<tr>
<td>Affiliated</td>
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<td>Residual Tranches or Interests with Underlying Assets Having Characteristics of:</td>
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<tr>
<td>Fixed Income Instruments</td>
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</tr>
<tr>
<td>Unaffiliated</td>
<td></td>
</tr>
<tr>
<td>Affiliated</td>
<td></td>
</tr>
<tr>
<td>Common Stock</td>
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<td>Any Other Class of Assets</td>
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<tr>
<td>TOTALS</td>
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The following listing is intended to give examples of investments to be included in each category; however, the list should not be considered all inclusive, and it should not be implied that any invested asset currently being reported in Schedules A, B or D is to be reclassified to Schedule BA:
Oil and Gas Production

Include: Offshore oil and gas leases.

**Residual Tranches or Interests with Underlying Assets Having Characteristics of:**

Investment in Residual Tranches or Interests should be assigned to the subcategory with the highest underlying asset concentration. There shouldn’t be any bifurcation of the underlying assets among the subcategories.

Include: Residual tranches or interests captures securitization tranches and beneficial interests as well as other structures captured in scope of SSAP No. 43R – Loan-Backed and Structured Securities, that reflect loss layers without any contractual payments, whether interest or principal, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. See SSAP No. 43R for accounting guidance.

**Fixed Income Instruments**

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 1 – Long-Term Bonds

**Common Stocks**

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 2 – Section 2 – Common Stocks

**Preferred Stocks**

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 2 – Section 1 – Preferred Stocks

**Real Estate**

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule A – Real Estate Owned

**Mortgage Loans**

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule B – Mortgage Loans

**Other**

Include: Items that do not qualify for inclusion in the above subcategories.

**Any Other Class of Assets**

Include: Investments that do not fit into one of the other categories. An example of items that may be included are reverse mortgages.

All structured settlement income streams acquired as investments where the reporting entity acquires the legal right to receive payments. (Valuation and admittance provisions are detailed in SSAP No. 21R — Other Admitted Assets.)
QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE BA – PARTS 2 AND 3

OTHER LONG-TERM INVESTED ASSETS ACQUIRED AND DISPOSED OF

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<td>Residual Tranches or Interests with Underlying Assets Having Characteristics of:</td>
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<tr>
<td>Fixed Income Instruments</td>
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<tr>
<td>TOTALS</td>
<td>5099999</td>
</tr>
</tbody>
</table>

The following listing is intended to give examples of investments to be included in each category; however, the list should not be considered all-inclusive and it should not be implied that any invested asset currently being reported in Schedules A, B or D is to be reclassified to Schedule BA.
## Oil and Gas Production

Include: Offshore oil and gas leases.

**Detail Eliminated to Conserve Space**

## Residual Tranches or Interests with Underlying Assets Having Characteristics of:

Investment in Residual Tranches or Interests should be assigned to the subcategory with the highest underlying asset concentration. There shouldn’t be any bifurcation of the underlying assets among the subcategories.

Include: Residual tranches or interests captures securitization tranches and beneficial interests as well as other structures captured in scope of SSAP No. 43R – Loan-Backed and Structured Securities, that reflect loss layers without any contractual payments, whether interest or principal, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. See SSAP No. 43R for accounting guidance.

## Fixed Income Instruments

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 1 – Long-Term Bonds

### Common Stocks
Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 2 – Section 2 – Common Stocks

### Preferred Stocks
Include: Investments with underlying collateral which, if held individually, would be reported on Schedule D – Part 2 – Section 1 – Preferred Stocks

## Real Estate

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule A – Real Estate Owned

## Mortgage Loans

Include: Investments with underlying collateral which, if held individually, would be reported on Schedule B – Mortgage Loans

## Other

Include: Items that do not qualify for inclusion in the above subcategories.

## Any Other Class of Assets

Include: Investments that do not fit into one of the other categories. An example of items that may be included are reverse mortgages.

All structured settlement income streams acquired as investments where the reporting entity acquires the legal right to receive payments. (Valuation and admittance provisions are detailed in SSAP No. 21R—Other Admitted Assets.)
ANNUAL AND QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

INVESTMENT SCHEDULES GENERAL INSTRUCTIONS
(Applies to all investment schedules)

Detail Eliminated to Conserve Space

The following is the description of the General and Specific Classifications used for reporting the detail lines for bonds and stocks.

**General Classifications Bonds Only:**

Exclude residual tranches or interests captured in scope of SSAP No. 43R – Loan-Backed and Structured Securities. See SSAP No. 43R for accounting guidance. These securities should be reported on Schedule BA.

Refer to SSAP No. 26R—Bonds, SSAP No. 43R—Loan-Backed and Structured Securities and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities for additional guidance.

**U.S. Government:**

U.S. Government shall be defined as U.S. Government Obligations as defined per the Purposes and Procedures Manual of the NAIC Investment Analysis Office.
### NAIC BLANKS (E) WORKING GROUP

#### Blanks Agenda Item Submission Form

<table>
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<th>12/16/2021</th>
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<tr>
<td>ON BEHALF OF:</td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Dale Bruggeman</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Chair SAPWG</td>
</tr>
<tr>
<td>AFFILIATION:</td>
<td>Ohio Department of Insurance</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>50W. Town St., 3rd Fl., Ste. 300 Columbus, OH 43215</td>
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#### FOR NAIC USE ONLY

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<td>2022</td>
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<td>[ X ]</td>
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<tr>
<td>New Reporting Requirement</td>
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</table>

#### REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

<table>
<thead>
<tr>
<th>No Impact</th>
<th>[ X ]</th>
</tr>
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<tbody>
<tr>
<td>Modifies Required Disclosure</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### DISPOSITION

| [ ] Rejected For Public Comment |
| [ ] Referred To Another NAIC Group |
| [ ] Received For Public Comment |
| [ ] Adopted Date |
| [ ] Rejected Date |
| [ ] Deferred Date |
| [ X ] Other (Specify) | Re-exposed 03/29/2022 |

#### BLANK(S) TO WHICH PROPOSAL APPLIES

- [ X ] ANNUAL STATEMENT
- [ X ] QUARTERLY STATEMENT
- [ X ] Life, Accident & Health/Fraternity
- [ X ] Property/Casualty
- [ X ] Health
- [ X ] Separate Accounts
- [ X ] Protected Cell
- [ X ] Health (Life Supplement)
- [ ] Title
- [ ] Other _______________________

Anticipated Effective Date: Annual 2022

#### IDENTIFICATION OF ITEM(S) TO CHANGE

This item proposes new reporting requirements for investment transactions with related parties. In addition to capturing direct loans in related parties, it will also capture information involving securitizations (or other similar investments) where the related party is a sponsor / originator along with whether the underlying investment is in a related party.

#### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

Pursuant to recent discussions, regulators desire additional information on investment transactions involving related parties, regardless of whether the related party is “affiliated” pursuant to Model #440. To preserve the affiliate definition and reporting categories for affiliated investments, these additional proposed reporting elements will be captured outside of the current affiliate reporting requirements. The new electronic columns will capture investments issued by a related party or acquired through a related party transaction or arrangement, regardless if the specific affiliate definition has been met or if there has been a disclaimer of affiliation / control.

#### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: _______________________

Other Comments:

---

** This section must be completed on all forms. Revised 7/18/2018

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**ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE**

**SCHEDULE BA – PART 1**

**OTHER LONG-TERM INVESTED ASSETS OWNED DECEMBER 31 OF CURRENT YEAR**

<table>
<thead>
<tr>
<th>Column 27 – Investments Involving Related Parties</th>
</tr>
</thead>
</table>

 Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

2. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.**

3. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.**

4. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.**

5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**

**NAIC Designation Category Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount in reported in Column 12.
### SCHEDULE BA – PART 2

**OTHER LONG-TERM INVESTED ASSETS ACQUIRED AND ADDITIONS MADE DURING THE YEAR**

<table>
<thead>
<tr>
<th>Column 15</th>
<th>Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use only for securities included in the following subtotal lines.</td>
<td></td>
</tr>
</tbody>
</table>

Non-Registered Private Funds with Underlying Assets Having Characteristics of:

- **Mortgage Loans**
  - Unaffiliated: 1199999
  - Affiliated: 1299999

State the date the mortgage loan matures.

<table>
<thead>
<tr>
<th>Column 16</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
<td></td>
</tr>
</tbody>
</table>

Enter one of the following codes to identify the role of the related party in the investment:

1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

2. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.**

3. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.**

4. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.**

5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**
# SCHEDULE BA – PART 3

OTHER LONG-TERM INVESTED ASSETS DISPOSED, TRANSFERRED OR REPAID DURING THE YEAR

** Columns 21 through 24-25 will be electronic only. **

** Detail Eliminated to Conserve Space **

<table>
<thead>
<tr>
<th>Column 24</th>
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<tbody>
<tr>
<td>Use only for securities included in the following subtotal lines.</td>
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Non-Registered Private Funds with Underlying Assets Having Characteristics of:

<table>
<thead>
<tr>
<th>Mortgage Loans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaffiliated ............................................................................................................. 1199999</td>
</tr>
<tr>
<td>Affiliated ................................................................................................................. 1299999</td>
</tr>
</tbody>
</table>

State the date the mortgage loan matures.

** Column 25 – Investments Involving Related Parties **

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE D – PART 1

LONG-TERM BONDS OWNED DECEMBER 31 OF CURRENT YEAR

** Columns 23 through 34-35 will be electronic only. **

Column 35 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.

NAIC Designation Category Footnote:

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 11.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal Line 2509999999.
** SCHEDULE D – PART 2 – SECTION 1 **

** PREFERRED STOCKS OWNED DECEMBER 31 OF CURRENT YEAR **

<table>
<thead>
<tr>
<th>Column 28</th>
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</thead>
</table>

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but that does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.

** NAIC Designation Category Footnote: **

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 8.

The sum of the amounts reported for each NAIC Designation Category in the footnote should equal the sum of Lines 4019999999 and 4029999999.
** SCHEDULE D – PART 2 – SECTION 2 **

**COMMON STOCKS OWNED DECEMBER 31 OF CURRENT YEAR**

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<th><strong>Column 25</strong></th>
<th>Investments Involving Related Parties</th>
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<td><strong>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Enter one of the following codes to identify the role of the related party in the investment:</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.</td>
</tr>
<tr>
<td>2.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>3.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>4.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.</td>
</tr>
<tr>
<td>5.</td>
<td>The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.</td>
</tr>
<tr>
<td>6.</td>
<td>The investment does not involve a related party.</td>
</tr>
</tbody>
</table>

**NAIC Designation Category Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 6.
SCHEDULE D – PART 3
LONG-TERM BONDS AND STOCKS ACQUIRED DURING CURRENT YEAR

** Columns 10 through 14 will be electronic only. **

Column 14 – ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

Column 15 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

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4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
## SCHEDULE D – PART 4

**LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING CURRENT YEAR**

**Detail Eliminated to Conserve Space**

**Columns 22 through 26 will be electronic only.**

**Detail Eliminated to Conserve Space**

<table>
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<th>Column 26</th>
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<td>The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 27</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation. Enter one of the following codes to identify the role of the related party in the investment.</td>
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1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

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5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**
** SCHEDULE D – PART 5 **

** LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE YEAR AND FULLY DISPOSED OF DURING CURRENT YEAR **

** Columns 22 through 26, 27 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 26</th>
<th>ISIN Identification</th>
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<tbody>
<tr>
<td><strong>NOTE</strong>: The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 27</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTE</strong>: Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation. Enter one of the following codes to identify the role of the related party in the investment.</td>
<td></td>
</tr>
</tbody>
</table>

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

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4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
### Schedule DA – Part 1

**Short-Term Investments Owned December 31 of Current Year**

<table>
<thead>
<tr>
<th>Column 23</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required</strong></td>
<td>for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
</tr>
</tbody>
</table>

Enter one of the following codes to identify the role of the related party in the investment.

1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

2. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.**

3. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.**

4. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.**

5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**

**NAIC Designation Category Equivalent Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 2509999999.
** SCHEDULE DL – PART 1 **

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

---

Detail Eliminated to Conserve Space

** Columns 8 through 11 will be electronic only. **

---

Detail Eliminated to Conserve Space

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Column 12 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
The code reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

- Lines 0019999999 through 2509999999 ........................................... Schedule D, Part 1, Column 35
- Lines 4019999999 through 4509999999 ........................................... Schedule D, Part 2, Section 1, Column 28
- Lines 5019999999 through 5989999999 ........................................... Schedule D, Part 2, Section 2, Column 25
- Line 9309999999 ........................................................................... Schedule B, Part 1, Column 20
- Line 9409999999 ........................................................................... Schedule BA, Part 1, Column 27
- Line 9509999999 ........................................................................... Schedule DA, Part 1, Column 23
- Line 9709999999 ........................................................................... Schedule E, Part 2, Column 12

The column should be left blank for the following lines:

- Real Estate (Schedule A type) ............................................................. 9209999999
- Cash (Schedule E, Part 1 type) ............................................................ 9609999999
- Other Assets ..................................................................................... 9809999999

**General Interrogatories:**

1. The total activity for the year represents the net increase (decrease) from the prior year-end to the current year-end.

2. The average balance for the year is the average daily balance.

   **Average daily balance:** Total of daily balances divided by the number of days. Always calculate based on a 365/366 day year. If data is missing for a given date (e.g., weekend, holiday), count the previous day’s value multiple times. The actual day count for the year (365/366) would serve as the denominator in the average calculation.

3. NAIC Designation Category:

   Provide the total book/adjusted carrying value amount by NAIC Designation Category that represents the amount reported in Column 6.
SCHEDULE DL – PART 2

SECURITIES LENDING COLLATERAL ASSETS
Reinvested Collateral Assets Owned December 31 Current Year
(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E
and not reported in aggregate on Line 10 of the asset page.)

** Columns 8 through 11 will be electronic only. **

Column 12 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
The code reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 2509999999 ................................................. Schedule D, Part 1, Column 35
- Lines 4019999999 through 4509999999 ................................................. Schedule D, Part 2, Section 1, Column 28
- Lines 5019999999 through 5989999999 ................................................. Schedule D, Part 2, Section 2, Column 25
- Line 9309999999 .................................................................................. Schedule B, Part 1, Column 20
- Line 9409999999 .................................................................................. Schedule BA, Part 1, Column 27
- Line 9509999999 .................................................................................. Schedule DA, Part 1, Column 23
- Line 9709999999 .................................................................................. Schedule E, Part 2, Column 12

The column should be left blank for the following lines:

- Real Estate (Schedule A) ........................................................................... 9209999999
- Cash (Schedule E, Part 1) ....................................................................... 9609999999
- Other Assets ............................................................................................ 9809999999

General Interrogatories:

1. The total activity for the year represents the net increase (decrease) from the prior year-end to the current year-end.

2. The average balance for the year is the average daily balance.

   **Average daily balance:** Total of daily balances divided by the number of days. Always calculate based on a 365/366 day year. If data is missing for a given date (e.g., weekend, holiday), count the previous day’s value multiple times. The actual day count for the year (365/366) would serve as the denominator in the average calculation.
**SCHEDULE E – PART 2 – CASH EQUIVALENTS**

**Columns 10 and through 11-12 will be electronic only.**

**Detail Eliminated to Conserve Space**

**Detail Eliminated to Conserve Space**

**Column 12** — Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.

**NAIC Designation Category Equivalent Footnote:**

Provide the total book/adjusted carrying value amount by NAIC Designation Category Equivalent that represents the amount reported in Column 7.

The sum of the amounts reported for each NAIC Designation Category Equivalent in the footnote should equal Line 2509999999.
SCHEDULE B – PART 1

MORTGAGE LOANS OWNED DECEMBER 31 OF CURRENT YEAR

Column 5 – Loan Type

If the loan was made to an officer or director of the reporting entity/subsidiary/affiliate, enter “E”. If the loan was made directly to a subsidiary or affiliate enter “S.” If the loan was made directly to a related party that doesn't meet the affiliate definition or the reporting entity has received domiciliary state approval to disclaim control/affiliation, enter “R.” Otherwise, leave the column blank.

** Columns 16 through 20 will be electronic only. **

Column 19 – Maturity Date

State the date the mortgage loan matures.

Column 20 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE B – PART 2

MORTGAGE LOANS ACQUIRED AND ADDITIONS MADE DURING YEAR

<table>
<thead>
<tr>
<th>Column 4 – Loan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the loan was made to an officer or director of the reporting entity/subsidiary/affiliate, enter “E”. If the loan was made directly to a subsidiary or affiliate, enter “S.” If the loan was made directly to a related party that doesn’t meet the affiliate definition or the reporting entity has received domiciliary state approval to disclaim control/affiliation, enter “R.” Otherwise, leave the column blank.</td>
</tr>
</tbody>
</table>

** Columns 10 through 13 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 13 – Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>State the date the mortgage loan matures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 14 – Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
</tr>
<tr>
<td>Enter one of the following codes to identify the role of the related party in the investment.</td>
</tr>
<tr>
<td>1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.</td>
</tr>
<tr>
<td>2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
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<tr>
<td>3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.</td>
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<tr>
<td>5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.</td>
</tr>
<tr>
<td>6. The investment does not involve a related party.</td>
</tr>
</tbody>
</table>
## SCHEDULE B – PART 3

### MORTGAGE LOANS DISPOSED, TRANSFERRED OR REPAID DURING THE YEAR

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Loan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>If the loan was made to an officer or director of the reporting entity/subsidiary/affiliate, enter “E.”</strong> If the loan was made directly to a subsidiary or affiliate enter “S.” If the loan was made directly to a related party that doesn’t meet the affiliate definition or the reporting entity has received domiciliary state approval to disclaim control/affiliation, enter “R.” Otherwise, leave the column blank.**</td>
</tr>
</tbody>
</table>

**Columns 19 through 22 will be electronic only.**

<table>
<thead>
<tr>
<th>Column 22</th>
<th>Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State the date the mortgage loan matures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 23</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
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Enter one of the following codes to identify the role of the related party in the investment.

1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

2. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.**

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5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**
## SCHEDULE DB – PART A – SECTION 1

**OPTIONS, CAPS, FLOORS, COLLARS, SWAPS AND FORWARDS OPEN DECEMBER 31 OF CURRENT YEAR**

**Detail Eliminated to Conserve Space**

**Columns 24 through 32 will be electronic only.**

**Detail Eliminated to Conserve Space**

### Column 32 – CDHS Identifier

Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) applying the provisions of SSAP No. 108 reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.

This column should only be used for the following line numbers:

- **Purchased Options** Lines 0089999999 through 0139999999
- **Written Options** Lines 0579999999 through 0629999999
- **Swaps** Lines 1059999999 through 1099999999
- **Forwards** Line 1429999999

### Column 33 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment:

1. **Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.**

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3. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.**

4. **Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.**

5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**
SCHEDULE DB – PART A – SECTION 2
OPTIONS, CAPS, FLOORS, COLLARS, SWAPS AND FORWARDS TERMINATED
DURING CURRENT YEAR

** Column 26 through 31 will be electronic only. **

Column 31 – CDHS Identifier

Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) applying the provisions of SSAP No. 108 reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.

This column should only be used for the following line numbers:

- Purchased Options Lines 0089999999 through 0139999999
- Written Options Lines 0579999999 through 0629999999
- Swaps Lines 1059999999 through 1099999999
- Forwards Line 1429999999

Column 32 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.
2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.
3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.
4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.
5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.
6. The investment does not involve a related party.
**SCHEDULE DB – PART B – SECTION 1**

**FUTURES CONTRACTS OPEN**
**DECEMBER 31 OF CURRENT YEAR**

**Detail Eliminated to Conserve Space**

**Columns 23 through 30-31 will be electronic only. **

**Detail Eliminated to Conserve Space**

Column 30 – **CDHS Identifier**

Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) applying the provisions of SSAP No. 108 reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.

This column should only be used for the following line numbers:

- Long Futures Line 1529999999
- Short Futures Line 1599999999

Column 31 – **Investments Involving Related Parties**

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. **The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.**

6. **The investment does not involve a related party.**
** SCHEDULE DB – PART B – SECTION 2 **

** FUTURES CONTRACTS TERMINATED **

** detail eliminated to conserve space **

** column 21 through 26 will be electronic only. **

<table>
<thead>
<tr>
<th><strong>Column 26</strong></th>
<th><strong>CDHS Identifier</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) applying the provisions of SSAP No. 108 reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.</td>
</tr>
<tr>
<td></td>
<td>This column should only be used for the following line numbers:</td>
</tr>
<tr>
<td></td>
<td>Long Futures Line 1529999999</td>
</tr>
<tr>
<td></td>
<td>Short Futures Line 1599999999</td>
</tr>
</tbody>
</table>

** Column 27 **

** Investments Involving Related Parties **

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DB – PART D – SECTION 1

COUNTERPARTY EXPOSURE FOR DERIVATIVE INSTRUMENTS OPEN
DECEMBER 31 OF CURRENT YEAR

** Columns 14 and 15 will be electronic only. **

Column 14 – Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for any counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

Column 15 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
** SCHEDULE DB – PART D – SECTION 2 **

COLLATERAL FOR DERIVATIVE INSTRUMENTS OPEN DECEMBER 31 OF CURRENT YEAR

** Columns 10 and 11 will be electronic only. **

Column 10 – Legal Entity Identifier (LEI)

Provide the 20-character Legal Entity Identifier (LEI) for counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

Column 11 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

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2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DB – PART E

DERIVATIVES HEDGING VARIABLE ANNUITY GUARANTEES AS OF DECEMBER 31 OF CURRENT YEAR

(This schedule is specific for the derivatives and the hedging programs captured in SSAP No. 108.)


---

Column 19 – Ending Deferred Balance

Specific CDHS Deferred Liability (Asset) balance at end of current reporting period.

** Column 20 will be electronic only. **

Column 20 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DB – PART C – SECTION 1

REPLICATION (SYNTHETIC ASSET) TRANSACTIONS (RSATs) OPEN ON DECEMBER 31 OF CURRENT YEAR

Detail Eliminated to Conserve Space

Column 16 – Fair Value of Cash Instrument(s) Held

Enter the fair value of cash instrument(s) used in the RSAT.

** Column 17 will be electronic only. **

Column 17 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
QUARTERLY STATEMENT INSTRUCTIONS – LIFE/FRATERNAL, HEALTH, PROPERTY AND TITLE

SCHEDULE BA – PART 2

OTHER LONG-TERM INVESTED ASSETS ACQUIRED
AND ADDITIONS MADE DURING THE CURRENT QUARTER

** Columns 14 through 17-18 will be electronic only. **

Column 17 – Maturity Date

Use only for securities included in the following subtotal lines.

Non-Registered Private Funds with Underlying Assets Having Characteristics of:

Mortgage Loans

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaffiliated</td>
<td>1199999</td>
</tr>
<tr>
<td>Affiliated</td>
<td>1299999</td>
</tr>
</tbody>
</table>

State the date the mortgage loan matures.

Column 18 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
### SCHEDULE BA – PART 3

**OTHER LONG-TERM INVESTED ASSETS DISPOSED, TRANSFERRED OR REPAID DURING THE CURRENT QUARTER**

<table>
<thead>
<tr>
<th>Column 24 – Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use only for securities included in the following subtotal lines.</td>
</tr>
<tr>
<td><strong>Non-Registered Private Funds with Underlying Assets Having Characteristics of:</strong></td>
</tr>
<tr>
<td><strong>Mortgage Loans</strong></td>
</tr>
<tr>
<td>Unaffiliated: 1199999</td>
</tr>
<tr>
<td>Affiliated: 1299999</td>
</tr>
<tr>
<td>State the date the mortgage loan matures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 25 – Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
</tr>
<tr>
<td>Enter one of the following codes to identify the role of the related party in the investment.</td>
</tr>
<tr>
<td>1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.</td>
</tr>
<tr>
<td>2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.</td>
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<tr>
<td>5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.</td>
</tr>
<tr>
<td>6. The investment does not involve a related party.</td>
</tr>
</tbody>
</table>
SCHEDULE D – PART 3

LONG-TERM BONDS AND STOCKS ACQUIRED DURING THE CURRENT QUARTER

** Columns 11 through 16 will be electronic only. **

Column 15 – ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

Column 16 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE D – PART 4

LONG-TERM BONDS AND STOCKS SOLD, REDEEMED OR OTHERWISE DISPOSED OF DURING THE CURRENT QUARTER

**  Columns 23 through 27 28 will be electronic only.  **

Column 27 – ISIN Identification

The International Securities Identification Numbering (ISIN) system is an international standard set up by the International Organization for Standardization (ISO). It is used for numbering specific securities, such as stocks, bonds, options and futures. ISIN numbers are administered by a National Numbering Agency (NNA) in each of their respective countries, and they work just like serial numbers for those securities. Record the ISIN number only if no valid CUSIP, CINS or PPN exists to report in Column 1.

Column 28 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DL – PART 1

SECURITIES LENDING COLLATERAL ASSETS

Reinvested Collateral Assets Owned Current Statement Date

(Securities lending collateral assets reported in aggregate on Line 10 of the asset page and not included on Schedules A, B, BA, D, DB and E.)

** Columns 8 and through 10 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 10</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.</td>
</tr>
<tr>
<td>2.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
</tr>
<tr>
<td>3.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
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<tr>
<td>4.</td>
<td>Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.</td>
</tr>
<tr>
<td>5.</td>
<td>The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.</td>
</tr>
<tr>
<td>6.</td>
<td>The investment does not involve a related party.</td>
</tr>
</tbody>
</table>
The code reported for this column should be determined in a manner consistent with the instructions of other schedules for the lines shown below:

Lines 0019999999 through 2509999999 ......................... Schedule D, Part 1, Column 35  
Lines 4019999999 through 4509999999 ......................... Schedule D, Part 2, Section 1, Column 28  
Lines 5019999999 through 5989999999 ......................... Schedule D, Part 2, Section 2, Column 25  
Line 9309999999 .................................................. Schedule B, Part 1, Column 20  
Line 9409999999 .................................................. Schedule BA, Part 1, Column 27  
Line 9509999999 .................................................. Schedule DA, Part 1, Column 23  
Line 9709999999 .................................................. Schedule E, Part 2, Column 12

The column should be left blank for the following lines:

Real Estate (Schedule A type) .......................................................... 9209999999  
Cash (Schedule E, Part 1 type) .......................................................... 9609999999  
Other Assets .................................................................................. 9809999999

General Interrogatories:

1. The total activity for the year to date represents the net increase (decrease) from the prior year-end to the current statement date.

2. The average balance for the year to date is the average daily balance.

Average daily balance: Total of daily balances divided by the number of days that have passed in the year as of the reporting date. If data is missing for a given date (e.g., weekend, holiday), count the previous day’s value multiple times. The actual day count for the year to date would serve as the denominator in the average calculation.
**SCHEDULE DL – PART 2**

**SECURITIES LENDING COLLATERAL ASSETS**

Reinvested Collateral Assets Owned Current Statement Date

(Securities lending collateral assets included on Schedules A, B, BA, D, DB and E
and not reported in aggregate on Line 10 of the asset page.)

---

**Detail Eliminated to Conserve Space**

**Columns 8 and through 10** will be electronic only. **

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**Detail Eliminated to Conserve Space**

---

**Column 10 – Investments Involving Related Parties**

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
The code reported for this column should be same for the security as reported in other schedules for the lines shown below:

- Lines 0019999999 through 2509999999 ................. Schedule D, Part 1, Column 35
- Lines 4019999999 through 4509999999 .................. Schedule D, Part 2, Section 1, Column 28
- Lines 5019999999 through 5989999999 ................. Schedule D, Part 2, Section 2, Column 25
- Line 9309999999 .................................................. Schedule B, Part 1, Column 20
- Line 9409999999 .................................................. Schedule BA, Part 1, Column 27
- Line 9509999999 .................................................. Schedule DA, Part 1, Column 23
- Line 9709999999 .................................................. Schedule E, Part 2, Column 12

The column should be left blank for the following lines:

- Real Estate (Schedule A) ............................................................ 9209999999
- Cash (Schedule E, Part 1) .......................................................... 9609999999
- Other Assets ................................................................................... 9809999999

General Interrogatories:

1. The total activity for the year to date represents the net increase (decrease) from the prior year-end to the current statement date.

2. The average balance for the year to date is the average daily balance.

   Average daily balance: Total of daily balances divided by the number of days that have passed in the year as of the reporting date. If data is missing for a given date (e.g., weekend, holiday), count the previous day’s value multiple times. The actual day count for the year to date would serve as the denominator in the average calculation.
** SCHEDULE E – PART 2 – CASH EQUIVALENTS **

** INVESTMENTS OWNED END OF CURRENT QUARTER **

** Columns 10 and 11 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 10</th>
<th>Legal Entity Identifier (LEI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide the 20-character Legal Entity Identifier (LEI) for any issuer as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 11</th>
<th>Investments Involving Related Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Enter one of the following codes to identify the role of the related party in the investment.</strong></td>
<td></td>
</tr>
<tr>
<td>1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.</td>
<td></td>
</tr>
<tr>
<td>2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
<td></td>
</tr>
<tr>
<td>3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.</td>
<td></td>
</tr>
<tr>
<td>4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.</td>
<td></td>
</tr>
<tr>
<td>5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.</td>
<td></td>
</tr>
<tr>
<td>6. The investment does not involve a related party.</td>
<td></td>
</tr>
</tbody>
</table>
** SCHEDULE B – PART 2 **

** MORTGAGE LOANS ACQUIRED AND ADDITIONS MADE DURING THE CURRENT QUARTER **

<table>
<thead>
<tr>
<th>Column 4</th>
<th>Loan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the loan was made to an officer or director of the reporting entity/subsidiary/affiliate, enter “E.” If the loan was made directly to a subsidiary or affiliate, enter “S.” If the loan was made directly to a related party that doesn’t meet the affiliate definition or the reporting entity has received domiciliary state approval to disclaim control/affiliation, enter “R.” Otherwise, leave the column blank.</td>
<td></td>
</tr>
</tbody>
</table>

** Columns 10 through 13 will be electronic only. **

** Column 13 | Maturity Date |
| State the date the mortgage loan matures. |

** Column 14 | Investments Involving Related Parties |
| Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation. |

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6. The investment does not involve a related party.
SCHEDULE B – PART 3

MORTGAGE LOANS DISPOSED, TRANSFERRED OR REPAID DURING THE CURRENT QUARTER

Column 4 – Loan Type

If the loan was made to an officer or director of the reporting entity/subsidiary/affiliate, enter “E.” If the loan was made directly to a subsidiary or affiliate, enter “S.” If the loan was made directly to a related party that doesn’t meet the affiliate definition or the reporting entity has received domiciliary state approval to disclaim control/affiliation, enter “R.” Otherwise, leave the column blank.

** Columns 19 through 22 will be electronic only. **

Column 22 – Maturity Date

State the date the mortgage loan matures.

Column 23 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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6. The investment does not involve a related party.
**SCHEDULE DB – PART A – SECTION 1**

**Options, Caps, Floors, Collars, Swaps and Forwards Open**

**Columns 24 through 32-33 will be electronic only.**

**Detail Eliminated to Conserve Space**

**Column 32 – CDHS Identifier**

Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.

This column should only be used for the following line numbers:

- **Purchased Options** Lines 0089999999 through 0139999999
- **Written Options** Lines 0579999999 through 0629999999
- **Swaps** Lines 1059999999 through 1099999999
- **Forwards** Lines 1429999999

**Column 33 – Investments Involving Related Parties**

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3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DB – PART B – SECTION 1

FUTURES CONTRACTS OPEN

** Column 23 through 28 will be electronic only. **

Column 28 – CDHS Identifier

Provide a unique identifier for each Clearly Defined Hedging Strategy (CDHS) reported on this schedule (e.g., 001, 002, etc.). This identifier will also be used for reporting of the CDHS in Column 1 of Schedule DB, Part E.

This column should only be used for the following line numbers:

<table>
<thead>
<tr>
<th>Line Number</th>
<th>CDHS Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Futures</td>
<td>1529999999</td>
</tr>
<tr>
<td>Short Futures</td>
<td>1599999999</td>
</tr>
</tbody>
</table>

Column 29 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
** SCHEDULE DB – PART D – SECTION 1 **  
** COUNTERPARTY EXPOSURE FOR DERIVATIVE INSTRUMENTS OPEN **  
** AS OF CURRENT STATEMENT DATE **

** Detail Eliminated to Conserve Space **

** Columns 14 and 15 will be electronic only. **

<table>
<thead>
<tr>
<th>Column 14</th>
<th>Legal Entity Identifier (LEI)</th>
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<tbody>
<tr>
<td>Provide the 20-character Legal Entity Identifier (LEI) for counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.</td>
<td></td>
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<table>
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<tr>
<th>Column 15</th>
<th>Investments Involving Related Parties</th>
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<tr>
<td>Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.</td>
<td></td>
</tr>
</tbody>
</table>

Enter one of the following codes to identify the role of the related party in the investment.

1. Direct loan or direct investment (excluding securitizations) in a related party, for which the related party represents a direct credit exposure.

2. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer, or other similar influential role and for which 50% or more of the underlying collateral represents investments in or direct credit exposure to related parties.

3. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies involving a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role and for which less than 50% (including 0%) of the underlying collateral represents investments in or direct credit exposure to related parties.

4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
SCHEDULE DB – PART D – SECTION 2
COLLATERAL FOR DERIVATIVE INSTRUMENTS OPEN
AS OF CURRENT STATEMENT DATE

** Columns 10 and 11 will be electronic only.**

Column 10  –  Legal Entity Identifier (LEI)
Provide the 20-character Legal Entity Identifier (LEI) for counterparty as assigned by a designated Local Operating Unit. If no LEI number has been assigned, leave blank.

Column 11  –  Investments Involving Related Parties
Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

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SCHEDULE DB – PART E

DERIVATIVES HEDGING VARIABLE ANNUITY GUARANTEES AS OF CURRENT QUARTER

This schedule is specific for the derivatives and the hedging programs captured in SSAP No. 108. See SSAP No. 108—Derivatives Hedging Variable Annuities Guarantees for additional accounting guidance.

Column 19 — Ending Deferred Balance

Specific CDHS Deferred Liability (Asset) balance at end of current reporting period.

** Column 20 will be electronic only.**

Column 20 — Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

Enter one of the following codes to identify the role of the related party in the investment.

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4. Securitization or similar investment vehicles such as mutual funds, limited partnerships and limited liability companies in which the structure reflects an in-substance related party transaction but does not involve a relationship with a related party as sponsor, originator, manager, servicer or other similar influential role.

5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
Column 16 – Fair Value of Cash Instrument(s) Held

Enter the fair value of cash instrument(s) used in the RSAT.

** Column 17 will be electronic only.**

Column 17 – Investments Involving Related Parties

Required for all investments involving related parties including, but not limited to, those captured as affiliate investments. This disclosure intends to capture information on investments held that reflect interactions involving related parties, regardless of whether the related party meets the affiliate definition, or the reporting entity has received domiciliary state approval to disclaim control/affiliation.

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5. The investment is identified as related party, but the role of the related party represents a different arrangement than the options provided in choices 1-4.

6. The investment does not involve a related party.
NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

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<tr>
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<tr>
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<td>Chair / Vice Chair SAPWG</td>
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<tr>
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<td>OH and IA Dept of Insurance</td>
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<tbody>
<tr>
<td>Added a group of lines for Residual Tranches or Interests in the Asset Valuation Reserve Equity and Other Invested Asset Component blank and renumber lines below them. Modify instructions as appropriate for the added lines.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>With the new reporting lines proposed for residuals in Schedule BA, additional revisions are needed to map those reporting lines to the AVR schedule. The proposed revisions will separately capture these items in a new category within AVR as they are items that are not comparable to other investments. As defined in the AP&amp;P Manual, residuals reflect loss layers without contractual interest or principal payments. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.</td>
</tr>
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<table>
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<tr>
<th>NAIC STAFF COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment on Effective Reporting Date: The 2022 effective date will match the Schedule BA changes and the effective date for reporting on Schedule BA in the AP&amp;P Manual.</td>
</tr>
</tbody>
</table>

Other Comments: This proposal assumes adoption of 2021-21BWG

** This section must be completed on all forms. Revised 7/18/2018
ANNUAL STATEMENT INSTRUCTIONS – LIFE/FRATERNAL

EQUITY AND OTHER INVESTED ASSET COMPONENT – BASIC CONTRIBUTION, RESERVE OBJECTIVE AND MAXIMUM RESERVE CALCULATIONS

Detail Eliminated to Conserve Space

Lines 75 through 80 – Low-Income Housing Tax Credit Investments

Report Column 1 in accordance with SSAP No. 93—Low-Income Housing Tax Credit Property Investments.

For Line 75, report guaranteed low-income housing tax credit (LIHTC) investments. There must be an all-inclusive guarantee from a CRP-rated entity that guarantees the yield on the investment. Line 75 should equal Schedule BA, Part 1, Column 12, Line 3599999 + Line 3699999.

For Line 76, report non-guaranteed LIHTC investments with the following risk mitigation factors:

I. A level of leverage below 50%. For LIHTC Fund, the level of leverage is measured at the fund level.

II. There is a Tax Credit Guarantee Agreement from General Partner or managing member. This agreement requires the General Partner or managing member to reimburse investors for any shortfalls in tax credits due to errors of compliance, for the life of the partnership. For an LIHTC Fund, a Tax Credit Guarantee is required from the developers of the lower tier LIHTC properties to the upper tier partnership.

III. There are sufficient operating reserves, capital replacement reserves and/or operating deficit guarantees present to mitigate foreseeable foreclosure risk at the time of the investment.

Line 76 should equal Schedule BA, Part 1, Column 12, Line 3799999 + Line 3899999.

Only federal low-income housing tax credit investments can be reported on Lines 75 and 76. State low-income housing tax credit investments that meet the requirements of SSAP No. 93 and that, at a minimum, meet the requirements for federal guaranteed programs should be reported on Line 77. Line 77 should equal Schedule BA, Part 1, Column 12, Line 3999999 + Line 4099999.

State low-income housing tax credit investments that do not meet the requirements of SSAP No. 93 and that do not, at a minimum, meet the requirements for federal non-guaranteed programs should be reported on Line 78. Line 78 should equal Schedule BA, Part 1, Column 12, Line 4199999 + Line 4299999.

Any other low-income housing tax credit investments that meet the requirements of SSAP No. 93 and cannot be reported on Lines 75 through 78 should be reported on Line 79. Line 79 should equal Schedule BA, Part 1, Column 12, Line 4399999 + Line 4499999.

Multiply the amount in Column 4 for each category by the reserve factors for Page 34, Columns 5, 7 and 9, Lines 75 through 79. Report the products by category in Columns 6, 8 and 10, respectively.

Lines 81 through 91 – Residual Tranches or Interests

Line 81 – Fixed Income Instruments – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 4699999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report
the products in Columns 6, 8 and 10, respectively. For Lines 66 through 69, multiply the amounts in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 82 – Fixed Income Instruments – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 4799999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively. For Lines 66 through 69, multiply the amounts in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 83 – Common Stock – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 4899999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively. For Lines 66 through 69, multiply the amounts in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 84 – Common Stock – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 4999999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively. For Lines 66 through 69, multiply the amounts in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 85 – Preferred Stock – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 5099999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 86 – Preferred Stock – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 5199999 in Columns 1 and 4. Multiply the amount in Column 4 by the calculated reserve factors in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 8587 – Real Estate – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 505299999 in Column 1, any related encumbrances on these assets in Column 2, and any third-party encumbrances on these assets in Column 3. Report the sum of Columns 1, 2, and 3 in Column 4. Column 4 may not be less than zero. Multiply the amount in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 8688 – Real Estate – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 515399999 in Column 1, any related encumbrances on these assets in Column 2, and any third-party encumbrances on these assets in Column 3. Report the sum of Columns 1, 2, and 3 in Column 4. Column 4 may not be less than zero. Multiply the amount in Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.
Line 8789  –  Mortgage Loans – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 525999999 in Columns 1 and 4. Multiply the amount in Column 4 by the reserve factors in Columns 5, 7 and 9. Report the products in Columns 6, 8 and 10, respectively.

Line 8890  –  Mortgage Loans – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 535999999 in Columns 1 and 4. Multiply the amount in Column 4 by the reserve factors in Columns 5, 7 and 9. Report the products in Columns 6, 8 and 10, respectively.

Line 8991  –  Other – Unaffiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 545999999 in Columns 1 and 4. Multiply the amount in Column 4 by the reserve factors in Columns 5, 7 and 9. Report the products in Columns 6, 8 and 10, respectively.

Line 9092  –  Other – Affiliated

Report the book/adjusted carrying value of all Schedule BA assets in Line 555999999 in Columns 1 and 4. Multiply the amount in Column 4 by the reserve factors in Columns 5, 7 and 9. Report the products in Columns 6, 8 and 10, respectively.

Line 819294 & 829395  –  Working Capital Finance Investments

Report the book/adjusted carrying value of all working capital finance investments owned (Schedule BA, Part 1, Line 4599999) in Columns 1 and 4. Categorize the working capital finance investments into NAIC designations 1 or 2 as directed by the Purposes and Procedures Manual of the NAIC Investment Analysis Office. Multiply the amount in Column 4 for each designation by the reserve factors provided in Columns 5, 7 and 9, and report the products by designation in Columns 6, 8 and 10, respectively.

Line 839496  –  Other Invested Assets – Schedule BA

Report the book/adjusted carrying value of all other Schedule BA investments owned that cannot be classified into one of the above categories (Lines 0199999, 0299999, 0399999, 0499999, 0599999, 0699999, 0999999, 1099999, 1799999, 1899999, 2599999, 2699999, 2799999, 2899999, 3399999, 3499999, 4699999, 5599999, and 4799999) in Column 1 and any encumbrances on these assets in Column 3. Schedule DL, Part 1 investments reported on Line 940999999 would be included in this total if not classified in one of the above categories. Collateral loans (Lines 2999999 and 3099999) have been intentionally excluded from this total. For surplus debentures and capital notes, the amount to report in Column 1 is to be calculated based upon the accounting prescribed in SSAP No. 41—Surplus Notes. Report the sum of Columns 1 and 3 in Column 4. Column 4 may not be less than zero. Note that ALL surplus debentures and capital notes should be included here in Line 839496, EXCEPT those with a CRP rating equivalent to an NAIC 1 or NAIC 2 designation (which are reported in Lines 30 and 31 of this schedule). Multiply the amount in Column 4 by the reserve factors provided in Columns 5, 7 and 9, and report the products in Columns 6, 8 and 10, respectively.

Exclude: All surplus debentures and capital notes that possess a CRP rating equivalent to an NAIC 1 or NAIC 2 designation. These surplus debentures are to be reported in Line 30 and 31 (Other Invested Assets with Underlying Characteristics of Preferred Stocks) of this schedule.
Line 849597 – Other Short-Term Invested Assets – Schedule DA

Report the book/adjusted carrying value of all other Schedule DA (Lines 7029999999 and 7509999999) and Schedule DL, Part 1 (Line 9509999999) assets owned that cannot be classified into one of the above categories in Column 1 and any encumbrances on these assets in Column 3. Report the sum of Columns 1 and 3 in Column 4. Multiply the amount on Column 4 by the reserve factors provided in Columns 5, 7 and 9 and report the products in Columns 6, 8 and 10, respectively.

Line 869708 – Total Other Invested Assets – Schedules BA & DA

The Columns 6, 8 and 10 amounts must be combined with Columns 6, 8 and 10, Line 21 amounts and reported on the Asset Valuation Reserve Page, Column 5, Lines 7, 10 and 9, respectively.

NOTE: Other invested asset reserves will be calculated based on the nature of the underlying investments related to the Schedule BA and Schedule DA assets. Assets should be categorized as if the company owned the underlying investment. For example:

- Mortgage participation certificates and similar holdings should be classified as fixed income assets.
- Gas and oil production and mineral rights have potential variability of return and should be categorized as equity investments.
- Partnership investments should be classified as fixed or equity investments or as equity real estate, depending on the purpose of the partnership. The maximum AVR factor would be that appropriate for the asset classification.
- A “look through” approach should be taken for any Schedule BA and Schedule DA assets not specifically listed, so as to reflect in the AVR calculation the essential nature of the investments.
### Basic Contribution:

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### Reserve Objective:

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<td>P18, L60, C10</td>
<td>P18, L17, C10</td>
<td>P18, L21, C10 + P19, L978699, C10</td>
<td>P18, L21, C10 + P19, L978699, C10</td>
</tr>
<tr>
<td>Line 7</td>
<td>Basic Contribution (includes separate accounts assets, if applicable)</td>
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<tr>
<td></td>
<td>Report the basic contribution amount for each asset category as calculated on Pages 30 through 35 (General Account) and Pages 15 through 20 (Separate Accounts).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Column 1: Report the total bonds, preferred stock, short–term investments and derivative instruments from Page 30, Line 34, Column 6 (General Account) and Page 15, Line 34, Col. 6 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0199999, Column 7 (General Account) and Page 20, Line 0199999, Column 7 (Separate Accounts).</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Column 2: Report the total mortgage loans from Page 31, Line 60, Column 6 (General Account) and Page 16, Line 60, Col. 6 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0299999, Column 7 (General Account) and Page 20, Line 0299999, Column 7 (Separate Accounts).</td>
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</tr>
<tr>
<td></td>
<td>Column 4: Report the total common stock from Page 32, Line 17, Column 6 (General Account) and Page 17, Line 17, Col. 6 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0399999, Column 7 (General Account) and Page 20, Line 0399999, Column 7 (Separate Accounts).</td>
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<tr>
<td></td>
<td>Column 5: Report the total real estate from Page 32, Line 21, Column 6 (General Account) and from Page 17, Line 21, Column 6 (Separate Accounts), if applicable, plus the total other invested assets from Page 34, Line 8602999, Column 6 (General Account) and from Page 19, Line 8602999, Column 6 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0499999, Column 7 (General Account) and Page 20, Line 0499999, Column 7 (Separate Accounts).</td>
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<table>
<thead>
<tr>
<th>Line 9</th>
<th>Maximum Reserve (includes separate accounts assets, if applicable)</th>
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<tr>
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<td>Report the maximum reserve for each asset category as calculated on Pages 30 through 35 (General Account) and Pages 15 through 20 (Separate Accounts).</td>
</tr>
<tr>
<td></td>
<td>Column 1: Report the total bonds, preferred stock, short–term investments and derivative instruments from Page 30, Line 34, Column 10 (General Account) and Page 15, Line 34, Col. 10 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0199999, Column 9 (General Account) and Page 20, Line 0199999, Column 9 (Separate Accounts).</td>
</tr>
<tr>
<td></td>
<td>Column 2: Report the total mortgage loans from Page 31, Line 60, Column 10 (General Account) and Page 16, Line 60, Col. 10 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0299999, Column 9 (General Account) and Page 20, Line 0299999, Column 9 (Separate Accounts).</td>
</tr>
<tr>
<td></td>
<td>Column 4: Report the total common stock from Page 32, Line 17, Column 10 (General Account) and Page 17, Line 17, Col. 10 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0399999, Column 9 (General Account) and Page 20, Line 0399999, Column 9 (Separate Accounts).</td>
</tr>
<tr>
<td>Column 5:</td>
<td>Report the total real estate from Page 32, Line 21, Column 10 (General Account) and from Page 17, Line 21, Column 10 (Separate Accounts), if applicable, plus the total other invested assets from Page 34, Line 869799, Column 10 (General Account) and from Page 19, Line 86, Column 10 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0499999, Column 9 (General Account) and Page 20, Line 0499999, Column 9 (Separate Accounts).</td>
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**Line 10** | Reserve Objective (includes separate accounts assets, if applicable) |
<table>
<thead>
<tr>
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<tr>
<td>Report the reserve objective amount for each asset category as calculated on Pages 30 through 35 (General Account) and Pages 15 through 20 (Separate Accounts).</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 1:</th>
<th>Report the total bonds, preferred stock, short-term investments and derivative instruments from Page 30, Line 34, Column 8 (General Account) and Page 15, Line 34, Column 8 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0199999, Column 8 (General Account) and Page 20, Line 0199999, Column 8 (Separate Accounts).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 2:</td>
<td>Report the total mortgage loans from Page 31, Line 60, Column 8 (General Account) and Page 16, Line 60, Column 8 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0299999, Column 8 (General Account) and Page 20, Line 0299999, Column 8 (Separate Accounts).</td>
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<tr>
<td>Column 4:</td>
<td>Report the total common stock from Page 32, Line 17, Column 8 (General Account) and Page 17, Line 17, Column 8 (Separate Accounts), if applicable and the total for replication (synthetic asset) transactions contained on Page 35, Line 0399999, Column 8 (General Account) and Page 20, Line 0399999, Column 8 (Separate Accounts).</td>
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<tr>
<td>Column 5:</td>
<td>Report the total real estate from Page 32, Line 21, Column 8 (General Account) and from Page 17, Line 21, Column 8 (Separate Accounts), if applicable; plus the total other invested assets from Page 34, Line 869799, Column 8 (General Account) and from Page 19, Line 869799, Column 8 (Separate Accounts), if applicable; and the total for replication (synthetic asset) transactions contained on Page 35, Line 0499999, Column 8 (General Account) and Page 20, Line 0499999, Column 8 (Separate Accounts).</td>
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**Detail Eliminated to Conserve Space**
### Asset Valuation Reserve (Continued)

#### Basic Contribution, Reserve Objective and Maximum Reserve Calculations

**Equity and Other Invested Asset Component**

<table>
<thead>
<tr>
<th>Line</th>
<th>NAIC Designation</th>
<th>Description</th>
<th>Basic Contribution Adjusted Carrying Value</th>
<th>Restated Related Party Encumbrances</th>
<th>Add Other Party Encumbrances</th>
<th>Balance for AVR Reserve Calculations (Cols. 1-2-3)</th>
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</thead>
<tbody>
<tr>
<td>65</td>
<td>Unaffiliated Public</td>
<td>Investments with the Underlying Characteristics of Common Stock</td>
<td>XXX</td>
<td>XXX</td>
<td>0.000</td>
<td>0.1500(a)</td>
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<tr>
<td>66</td>
<td>Unaffiliated Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Affiliated Life with AVR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>68</td>
<td>Affiliated Certain Other (Sec/WO Purpose &amp; Procedures Manual)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Affiliated Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>70</td>
<td>Total with Common Stock Characteristics</td>
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</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>NAIC Designation</th>
<th>Description</th>
<th>Balance for AVR Reserve Calculations (Cols. 1-2-3)</th>
<th>Reserve Objective</th>
<th>Maximum Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>Home Office Property (General Account only)</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>72</td>
<td>Investment Portfolio</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
</tr>
<tr>
<td>73</td>
<td>Properties Acquired in Satisfaction of Debts</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

#### Low Income Housing Tax Credit Investments

- Guaranteed Federal Low-Income Housing Tax Credit
- Non-guaranteed Federal Low-Income Housing Tax Credit
- Guaranteed State Low-Income Housing Tax Credit
- Non-guaranteed State Low-Income Housing Tax Credit
- All Other Low-Income Housing Tax Credit

<table>
<thead>
<tr>
<th>Line</th>
<th>NAIC Designation</th>
<th>Description</th>
<th>Balance for AVR Reserve Calculations (Cols. 1-2-3)</th>
<th>Reserve Objective</th>
<th>Maximum Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>Total LIHTC (Lines 75 through 79)</td>
<td></td>
<td></td>
<td>XXX</td>
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</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>NAIC Designation</th>
<th>Description</th>
<th>Balance for AVR Reserve Calculations (Cols. 1-2-3)</th>
<th>Reserve Objective</th>
<th>Maximum Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Total LEHTC (Lines 81 through 79)</td>
<td></td>
<td></td>
<td>XXX</td>
<td>XXX</td>
</tr>
</tbody>
</table>

- Preferred Stock - Unaffiliated
- Preferred Stock - Affiliated
- Common Stock - Unaffiliated
- Common Stock - Affiliated
- Real Estate - Unaffiliated
- Real Estate - Affiliated
- Mortgages Loans - Unaffiliated
- Mortgages Loans - Affiliated
- Other - Unaffiliated
- Other - Affiliated
- Total Endowment Investments (A) (XXX)
- Total Retail Capital Finance Investments (A) (XXX)
- Total Other Investments (XXX)

(a) Times the company’s weighted average portfolio beta (Minimum: .1215, Maximum: .2431)
(b) Determined using same factors and breakdowns used for directly owned real estate.
(c) This will be the factor associated with the risk category determined in the company-generated worksheet.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FINANCIAL CONDITION (E) COMMITTEE/Accounting Practices and Procedures (E) TF/BWG/Art2H_2021-23BWG_Modified.docx
### Editorial Revisions to the Blanks and Instructions

*(presented at the March 29, 2022, Meeting)*

Statement Type:

- **H** = Health
- **L/F** = Life/Fraternal Combined
- **P/C** = Property/Casualty
- **SA** = Separate Accounts
- **T** = Title

<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
</table>
| 2022      | Supplemental Investment Risk Interrogatories | CHANGE TO BLANK  
Change description on line 3 for preferred stocks. P/RP is no longer used by SVO.  
Preferred Stocks  
- NAIC 1  
- NAIC 2  
- NAIC 3  
- NAIC 4  
- NAIC 5  
- NAIC 6 | L/F, H, P/C, T | Annual |
| 2022      | Underwriting and Investment Exhibit, Part 2A | CHANGE TO BLANK  
Modify footnote “(a)” to reflect the changes to Lines 13 and 15 by 2020-33BWG that expanded the line detail.  
(a) Including $...................................................for present value of life indemnity claims reported in Lines 13 and 15. | P/C | Annual |
| 2022      | General Interrogatories, Part 1 | CHANGE TO BLANK  
Modify the question as shown below to clarify subsidiary response to question.  
8.5 Is the reporting entity a depository institution holding company with significant insurance operations as defined by the Board of Governors of Federal Reserve System or a subsidiary of the depository institution holding company reporting entity? | L/F, H, P/C, T | Annual |
| 2022      | Analysis of Increase in Reserves During the Year – Group Life Insurance | CHANGE TO BLANK  
Reverse order of Columns 4 and 5 to be consistent with individual life page.  
Switch Columns 4 (Variable Life) and 5 (Universal Life) to Columns 4 (Universal Life) and 5 (Life Variable). | L/F, SA | Annual |
<table>
<thead>
<tr>
<th>Effective</th>
<th>Table Name</th>
<th>Description</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>Analysis of Operations by Lines of Business – Accident and Health</td>
<td>CHANGE TO BLANK&lt;br&gt;Add wording “Hospital &amp; Medical) to the Column 2 and Column 3 header as shown below.</td>
<td>L/F, SA</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive (Hospital &amp; Medical)</td>
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<tr>
<td></td>
<td></td>
<td>2                Individual</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3                Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>Cybersecurity and Identity Theft Insurance Coverage Supplement</td>
<td>CHANGE TO BLANK&lt;br&gt;Add the following sentence to clarify the supplement is reported on a calendar year basis.</td>
<td>P/C</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This supplement should be completed by those reporting entities including surplus line insurers and Risk Retention Groups that provide cybersecurity insurance and identity theft insurance in a stand-alone policy or as part of a package policy. If the reporting entity’s answer to Questions 1, 2, 4 and 5 of Part I would be “no,” the reporting entity should not complete the supplement. If the reporting entity answers “yes” to any of those questions, the supplement should be completed. The supplement should be reported on a direct basis (before assumed and ceded reinsurance).&lt;br&gt;The supplement is to be reported on a calendar year basis.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Cybersecurity Insurance</td>
<td></td>
<td></td>
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<tr>
<td>2022</td>
<td>Schedule BA – General Instructions</td>
<td>CHANGE TO INSTRUCTION&lt;br&gt;Joint Venture, Partnership or Limited Liability Company Interests for Which the Underlying Assets Have the Characteristics of:</td>
<td>L/F, H, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td>Effective</td>
<td>Table Name</td>
<td>Description</td>
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<tr>
<td>2022</td>
<td>Schedule BA – General Instructions</td>
<td>CHANGE TO INSTRUCTION Joint Venture, Partnership or Limited Liability Company Interests for Which the Underlying Assets Have the Characteristics of:</td>
<td>L/F, H, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2022</td>
<td>Schedule BA, Part 1</td>
<td>CHANGE TO INSTRUCTION Remove the second paragraph from the instructions for Column 12. The list no longer exists. Column 12 – Book/Adjusted Carrying Value Less Encumbrances Report the balance at December 31 of the current year. It should contain the amounts included in Column 10 after any encumbrances have been subtracted. Include all changes in value during the year. For surplus (and capital) notes, consider where appropriate the statement factor provided by the Securities Valuation Office and published on the Schedule BA Surplus Note List on the Securities Valuation Office website. (See accounting requirements for surplus notes held in the Accounting Practices and Procedures Manual.) Deduct: Any write-downs for a decline in the fair value of a long-term invested asset that is other-than-temporary. Exclude: Valuation allowance.</td>
<td>L/F, H, P/C, T</td>
<td>Annual</td>
</tr>
<tr>
<td>2023</td>
<td>Notes to Financial Statements</td>
<td>CHANGE TO INSTRUCTION Add formulas to the illustration for Note 5D(2) to clarify calculation of totals. D. Loan-Backed Securities (2) OTTI recognized 1st Quarter a. Intent to sell b. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
<td>L/F, H, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Table Name</td>
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<tr>
<td>Notes to Financial Statements</td>
<td>2023</td>
<td>C. Total 1st Quarter ((a+b)) OTTI recognized 2nd Quarter</td>
<td></td>
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<td></td>
<td>D. Intent to sell</td>
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<td>E. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<td>F. Total 2nd Quarter ((a+b)) OTTI recognized 3rd Quarter</td>
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<td>G. Intent to sell</td>
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<td>H. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<td>I. Total 3rd Quarter ((a+b)) OTTI recognized 4th Quarter</td>
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<td>J. Intent to sell</td>
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<td>K. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<td>L. Total 4th Quarter ((a+b)) OTTI recognized 4th Quarter</td>
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<td>M. Annual Aggregate Total ((c+f+i+l))</td>
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<td>Change to Instruction: Add formula to the illustration for Note 5M(2) to clarify calculation of totals.</td>
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<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Add formula to the illustration for Note 8A(8) to clarify calculation of total.</td>
<td>L/F, H, P/C, T</td>
<td>Quarterly</td>
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<tr>
<td></td>
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<td>A. Derivatives under SSAP No. 86—Derivatives</td>
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<td></td>
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<td>Fiscal Year</td>
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<td>4. 2026</td>
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<td></td>
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<td>5. Thereafter</td>
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<td>6. Total Future Settled Premiums (Sum of 1 through 5)</td>
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<tr>
<td>2023</td>
<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Add formula to the illustration for Note 8B(2) to clarify calculation of total.</td>
<td>L/F, H, P/C, T</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. Derivatives under SSAP No. 108—Derivative Hedging Variable Annuity Guarantees</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>(2) Recognition of gains/losses and deferred assets and liabilities</td>
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<tr>
<td></td>
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<td>a. Scheduled Amortization</td>
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<td><strong>Amortization Year</strong></td>
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<tr>
<td>2023</td>
<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong>&lt;br&gt;Add formulas to the illustration for Note 36B to clarify calculation of totals.</td>
<td>P/C</td>
<td>Quarterly</td>
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<td>B. Schedule of insured financial obligations at the end of the period</td>
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<td>1. Number of policies</td>
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<td>2. Remaining weighted-average contract period (in years)</td>
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<td>Insured contractual payments outstanding:</td>
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<td>3a. Principal</td>
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<td>3b. Interest</td>
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<td>3c. Total (3a+3b)</td>
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<td>4. Gross claim liability</td>
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<td>Less:</td>
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<td>5a. Gross potential recoveries</td>
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<td>5b. Discount, net</td>
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<td>6. Net claim liability (4-5a-5b)</td>
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<td>7. Unearned premium revenue</td>
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<td>8. Reinsurance recoverables</td>
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</table>
To: Pat Gosselin, Chair of the Blanks (E) Working Group
From: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Re: Year-End 2021 Disclosures / Instructional Revisions
Date: February 2, 2022

The purpose of this memo is for the Statutory Accounting Principles (E) Working Group to notify the Blanks (E) Working Group of revisions to the “Notes to the Financial Statements” that have been adopted for year-end 2021 reporting. As these agenda items have already been adopted within the Statements of Statutory Accounting Principles (SSAPs), which represents the highest level of authoritative guidance as promulgated by the Preamble, these additions to the financial statement notes do not require approval from the Blanks (E) Working Group.

It is recommended that this memo, detailing instructional revisions and changes to existing disclosure requirements, be posted to the NAIC website. If deemed necessary, specific proposals, if not yet submitted, will be submitted to the Blanks (E) Working Group to formalize the instruction revisions. This is consistent with the NAIC Policy Statement on Coordination of the Accounting Practices and Procedures Manual and the Annual Statement Blank located within the Accounting Practices & Procedures Manual. It is requested that this information be included in the next update to the Annual Statement Instructions.

- **Agenda Item 2019-04: Investment Classification Project** – Revisions update the definitions, measurement, and impairment guidance for investments in preferred stock. The agenda item, substantively revised SSAP No. 32—Preferred Stock effective Jan. 1, 2021. One of the changes included revisions to the valuation method of perpetual preferred stock. Perpetual preferred stock is required to be reported at fair value, not to exceed any currently effective call price. (The Working Group defined “currently effective call price” in agenda item 2021-10: Clarification of Effective Call Price and clarified that the valuation ceiling of an effective call price, for all instruments within scope of SSAP No. 32R, shall only apply if the call is currently exercisable by the issuer, or if the issuer has announced that the instrument will be redeemed/called.) Accordingly, a year-end review identified that the instructions in Schedule D, Part 2 on preferred stock need to be updated to be consistent with the SSAP No. 32R revision, because the valuation of perpetual preferred stock is no longer based on the NAIC designation. Below are proposed revisions to the applicable blank’s instructions:

For reporting entities maintaining an AVR:

**Redeemable Preferred**

- NAIC Designation 1 – 3  Enter book value.
- NAIC Designation 4 – 6  Enter the lower of book value or fair value.

**Perpetual Preferred**

- NAIC Designation 1 – 26  Enter book fair value not to exceed any currently effective call price.
- NAIC Designation 4 – 6  Enter the lower of book value or fair value.

For reporting entities not maintaining an AVR:

**Redeemable Preferred**

- NAIC Designation 1 – 2  Enter book value.
- NAIC Designation 3 – 6  Enter the lower of book value or fair value.
Perpetual Preferred

NAIC Designations 1 – 26 Enter fair value not to exceed any currently effective call price.
NAIC Designations 3 – 6 Enter the lower of book value or fair value.

- **Agenda Item 2021-31: Life Reinsurance Disclosure Clarifications** – Revisions clarify disclosure requirements in SSAP No. 61R—Life and Health Reinsurance which were initially effective in 2020. Among various other minor edits, the primary revisions clarify 1) that the disclosures required in paragraphs 79-84 may be included in the notes to the financial statements or in supplemental reporting schedules, 2) that the disclosures will reside in the supplementary schedules unless no such contracts subject to the disclosures were identified, in which case, the information that no such contracts were identified can be in either the audited note or the supplementary schedules, and 3) that if the reporting entity does not prepare U.S. GAAP financial statements or its financial statements are not part of upstream U.S. GAAP financial statements, that the disclosure can be answered “not applicable.” The revisions make clearer where to place the audited information and what is included in the disclosures. No new disclosure elements were added. The revisions are effective December 31, 2021, and are shown below. It is recommended that the revisions be reflected in the reinsurance note as applicable.

78. Disclosures for paragraphs 79-84 **apply to reinsurance contracts in effect for the current period covered by the statement and** are required to be included with the annual audit report financial statements beginning with the period ended December 31, 2020, regarding reinsurance contracts. The disclosures required within paragraphs 79-84 shall be included in accompanying supplemental schedules of the annual audit report beginning in year-end 2020. If the disclosures are not applicable, an affirmative statement that no such contracts were identified is acceptable in the notes to the financial statements or the supplemental schedules. These disclosures shall be limited to reinsurance contracts entered into, renewed or amended on or after January 1, 1996. This limitation applies to the annual audit report only and does not apply to the statutory annual statement interrogatories and the property and casualty reinsurance summary supplemental filing.

79. Disclose any ceded reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) subject to A-791 that includes a provision, which limits the reinsurer’s assumption of significant risks identified as in A-791. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. If true, indicate the number of reinsurance contracts to which such provisions apply. For contracts subject to A-791, indicate if deposit accounting was applied for all contracts, which limit significant risks.

80. Disclose any ceded reinsurance contracts (or multiple contracts with the same reinsurer or its affiliates) not subject to A-791, for which reinsurance accounting was applied and includes a provision that limits the reinsurer’s assumption of risk. Examples of risk-limiting features include provisions such as a deductible, a loss ratio corridor, a loss cap, an aggregate limit or similar effect. **Note that a stop loss or excess of loss reinsurance agreement with deductibles or loss caps which apply to the entire contract and are not adjustable based on other features, do not require disclosure under this paragraph.** If true, indicate the number of reinsurance contracts to which such provisions apply. If affirmative, indicate if the reinsurance credit was reduced for the risk-limiting features.

81. Disclose if any ceded reinsurance contracts contain features (except reinsurance contracts with a federal or state facility) described below which result in delays in payment in form or in fact:

a. Provisions which permit the reporting of losses, or settlements are made, less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date (unless there is no activity during the period).

b. Payment schedule, accumulating retentions from multiple years or any features inherently designed to delay timing of the reimbursement to the ceding entity.
82. Disclose if the reporting entity has reflected reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk-transfer requirements of SSAP No. 61R and identify the type of contracts and the reinsurance contracts.

   a. Assumption Reinsurance – as discussed in paragraph 60, which are new for the reporting period.

   b. Non-proportional reinsurance, which does not result in significant surplus relief. If yes, indicate if the insured events(s) triggering contract coverage has been recognized.

83. Disclose if the reporting entity ceded any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract (or multiple contracts with the same reinsurer or its affiliates) during the period covered by the financial statement, and either:

   a. Accounted for that contract as reinsurance under statutory accounting principles (SAP) and as a deposit under U.S. generally accepted accounting principles (GAAP); or

   b. Accounted for that contract as reinsurance under U.S. GAAP and as a deposit under SAP.

If the reporting entity does not prepare U.S. GAAP financial statements or its financial statements are not part of upstream U.S. GAAP financial statements, this disclosure can be answered not applicable.

84. If affirmative disclosure is required for paragraph 83, explain why the contract(s) is treated differently for GAAP and SAP.

Please contact NAIC staff Julie Gann (jgann@naic.org), Robin Marcotte (rmarcotte@naic.org), Jim Pinegar (jpinegar@naic.org), Jake Stultz (jstultz@naic.org) or Jason Farr (jfarr@naic.org) if you have any questions.

Cc: Mary Caswell, Calvin Ferguson, Julie Gann, Robin Marcotte, Jim Pinegar, Jake Stultz, Jason Farr
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The Capital Adequacy (E) Task Force met March 28, 2022. The following Task Force members participated: Judith L. French represented by Tom Botsko, Chair (OH); Doug Ommen represented by Mike Yanacheak, Vice Chair (IA); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Trinidad Navarro represented by Adrienne Lupo and Steve Kinion (DE); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Virginia Christy (FL); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Elizabeth Kelleher Dwyer represented by Jack Brocoli (RI); Raymond G. Framer represented by Michael Shull (SC); Cassie Brown represented by Jamie Walker (TX); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek represented by Amy Malm (WI).

1. **Adopted its Jan. 27, 2022; Dec. 20, 2021; and 2021 Fall National Meeting Minutes**

   Mr. Botsko said the Task Force met Jan. 27, 2022; Dec. 20, 2021; and Nov. 17, 2021. During these meetings, the Task Force took the following action: 1) adopted its Sept. 30, 2021, minutes; 2) discussed the formation of a new risk-based capital (RBC) working group and solicited membership for the RBC Investment Risk and Evaluation (E) Working Group; 3) adopted the 2021 Catastrophe Event List; and 4) adopted its working group reports. Ms. Malm asked that the commissioner representative be updated to reflect her name on the Jan. 27, 2022, minutes.

   Mr. Yanacheak made a motion, seconded by Mr. Chou, to adopt the Task Force’s Jan. 27, 2022, with the editorial change for Wisconsin (Attachment One); Dec. 20, 2021 (Attachment Two); and Nov. 17, 2021 (see NAIC Proceedings – Fall 2021, Capital Adequacy (E) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Reports of its Working Groups**

   a. **Health Risk-Based Capital (E) Working Group**

   Mr. Drutz said that the Health Risk-Based Capital (E) Working Group met March 18 and took the following action: 1) adopted its Feb. 25, 2022; Jan. 28, 2022; and Dec. 16, 2021, minutes; 2) discussed the American Academy of Actuaries’ (Academy’s) report on the H2 – Underwriting Risk Review; and 3) adopted its working agenda.

   b. **Life Risk-Based Capital (E) Working Group**

   The Life-Risk-Based Capital (E) Working Group met March 23 and took the following action: 1) Adopted its March 10, 2022; Jan. 20, 2022; Dec. 16, 2021; and 2021 Fall National Meeting minutes, which included the following action: 2) Discussed the Academy’s)C2 Work Group recommendation on mortality; 3) Discussed the asset valuation reserve (AVR) and bond factor changes; 4) Adopted guidance on bond factor changes; 5) Adopted its working agenda; 6) Discussed reinsurance and comfort trusts; and 7) Discussed bond funds.

   c. **Catastrophe Risk (E) Subgroup**

   The Catastrophe Risk (E) Subgroup met March 22 and took the following action: 1) adopted its Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021, minutes; 2) discussed its working agenda; and 3) discussed the insured loss threshold
for wildfire peril; 4) expose proposal 2021-17-CR-MOD (Wildfire Information-Only Reporting Exemption); 5) discussed the independent model review instruction in the Rcat component; and 6) discussed the issue of double counting in the R5 component.

d. Property and Casualty Risk-Based Capital (E) Working Group

Mr. Botsko said that the Property and Casualty Risk-Based Capital (E) Working Group met March 23 and took the following action: 1) adopted the Catastrophe Risk (E) Subgroup’s Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021, minutes; 2) adopted the report of its subgroup; 3) adopted the following proposals: a) 2021-15-CR (Adding KCC Model); b) 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only); and c) 2021-14-P (R3 factor Adjustment); 4) exposed proposal 2022-01-P (Removing Trend Test Footnote); 5) discussed its working agenda; and 6) heard updates on current property/casualty (P/C) RBC projects from the Academy.

e. RBC Investment Risk and Evaluation (E) Working Group

Mr. Barlow said that the RBC Investment Risk and Evaluation (E) Working Group met March 22 to consider comments received in response to a Jan. 12 exposure on the RBC treatment of asset-backed securities (ABS), including collateralized loan obligations (CLOs), collateralized fund obligations (CFOs), or other similar securities with similar types of tail risk.

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the reports of the Health Risk-Based Capital (E) Working Group (Attachment Three), the Life Risk-Based Capital (E) Working Group (Attachment Four), the Property and Casualty Risk-Based Capital (E) Working Group (Attachment Five), the Catastrophe Risk (E) Subgroup (Attachment Five-A), and the RBC Investment Risk and Evaluation (E) Working Group (Attachment Six). The motion passed.


Mr. Drutz said that the Health Risk-Based Capital (E) Working Group adopted proposal 2021-18-H-MOD on Feb. 25, using alternative language that provides guidance for evaluating the investment income adjustment within the underwriting risk factors. Additional clarity was incorporated into the guidance for the time period in which the Working Group will evaluate the investment yield prior to considering an adjustment.

Mr. Drutz made a motion, seconded by Mr. Chou, to adopt proposal 2021-18-H-MOD (Investment Income Guidance) (Attachment Seven). The motion passed.


Mr. Chou said the purpose of this proposal is to include the Karen Clark & Company (KCC) model as one of the approved third-party commercial vendor catastrophe models. The Subgroup received one supporting letter, which stated appreciation for the Subgroup keeping the approval list current with market usage.

Mr. Chou made a motion, seconded by Mr. Reedy, to adopt proposal 2021-15-CR (Approve Third-Party Vendor) (Attachment Eight). The motion passed unanimously.

5. Adopted Proposal 2021-17-CR (Information Only Wildfire Peril)

Mr. Chou said the purpose of this proposal is to include wildfire peril in the Rcat component for informational purposes filing until all the concerns are addressed before incorporated into the RBC calculation. He stated that the Subgroup received three comment letters during the exposure period. However, Mr. Chou indicated that the
Subgroup agreed to take time to evaluate the impact and allow more time for the modelers to enhance their modeling approach with this new peril.

Mr. Chou made a motion, seconded by Mr. Yanacheak, to adopt proposal 2021-17-CR (Information Only Wildfire Peril) (Attachment Nine). The motion passed unanimously.

6. **Adopted Proposal 2021-14-P (R3 Factor Adjustment)**

Mr. Botsko said this proposal intends to eliminate the double-counting effect of the operational risk charge on the component. He said NAIC staff performed an analysis to determine the impact on the RBC action levels by reducing the 2% reinsurance recoverable RBC charge for all reinsurance designation equivalents. The result indicated that the impact is insignificant, as there are only three companies with total adjusted capital (TAC) between zero to 75 million that will change the RBC results from action level to no action. He also stated that the Working Group received no comments during the exposure period.

Mr. Drutz made a motion, seconded by Mr. Chou, to adopt proposal 2021-14P (R3 Factor Adjustment) (Attachment Ten). The motion passed.

7. **Adopted its Working Agenda**

Mr. Botsko summarized the changes of the Task Force’s 2022 working agenda, which included the following substantial changes: 1) adding the exposure and/or adoption dates to the items of “evaluate other catastrophe risks for possible inclusion in the charge” and “evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses”; 2) changing the expected completion dates for “evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments,” “continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate,” “evaluate if changes should be made to the P/C formula to better assess companies in runoff,” and “evaluate the Underwriting Risk Line 1 Factors in the P/C formula” items; 3) removing the “modify instruction to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories” and “evaluate R3 Adjustment for Operational Risk Charge items; 4) adding the adoption date to the “implement wildfire peril in the Rcat component (for informational purposes only) item; and 5) adding “evaluate the possibility of modifying exemption criteria for different cat perils in the PR027 interrogatories,” “evaluate the possibility of enhancing the independent model instructions,” and “remove the trend test footnote in PR033” items under the new items section.

Mr. Drutz said the Health Risk-Based Capital (E) Working Group made the following updates to its working agenda for 2022: 1) combined item 27 and item 28 into one item and changed the expected completion date to “ongoing”; 2) updated the priority status and expected completion for item 28; 3) updated the expected completion and working agenda description for item 30; 4) combined item 31, 34, and 35 into one item and updated the expected completion date; 5) updated the expected completion dates for item 32 and item 33; and 6) updated the working item description for item 34.

Mr. Barlow mentioned that C2 mortality work was added because it was inadvertently left off the working agenda and that no other notable items changed from the current Life Risk-Based Capital (E) Working Group’s agenda items. He mentioned that the RBC Investment Risk and Evaluation (E) Working Group contains many referrals from this Task Force and that he may add one more referral from the Life Risk-Based Capital (E) Working Group.

Mr. Chou made a motion, seconded by Mr. Yanacheak, to adopt the working agenda (Attachment Eleven). The motion passed.
8. **Discussed Other Matters**

Mr. Botsko said that the results of the Affiliated Investment Ad Hoc Group will be shared in the coming weeks with the Life Risk-Based Capital (E) Working Group, the Health Risk-Based Capital (E) Working Group, and the Property and Casualty Risk-Based Capital (E) Working Group for continued discussion on the proposed adjustments to the affiliated investment instructions. Comments and suggestions will be reviewed and discussed at the Task Force level. Mr. Barlow stressed that the Ad Hoc Group did strive for consistency across the three formulas and that any suggested changes should be considered for consistency.

Mr. Botsko added that the Property and Casualty Risk-Based Capital (E) Working Group will be discussing a referral letter regarding run-off companies. Once direction is provided, the Working Group will share their findings with the Life Risk-Based Capital (E) Working Group and Health Risk-Based Capital (E) Working Group. Mr. Botsko also welcomed Mr. Yanacheak as the new vice chair commissioner representative for Iowa.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
The Capital Adequacy (E) Task Force conducted an e-vote that concluded Jan. 27, 2022. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Doug Ommen, Vice Chair, represented by Mike Yanacheak (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier (FL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy and Bill Clark (KY); Chlora Lindley-Myers represented by John Rehagen (MO); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Cassie Brown represented by Mike Boerner and Rachel Hemphill (TX); Mike Kreidler represented by Steve Drutz (WA), and Nathan Houdek represented by Amy Malm (WI).

1. **Adopted the Updated 2021 U.S. and Non-U.S. Catastrophe Risk Event Lists**

The Task Force conducted an e-vote to consider adoption of proposal 2021-16-CR (2021 U.S. and Non-U.S. Catastrophe Risk Event Lists).

Mr. Barlow made a motion, seconded by Mr. Chou, to adopt the 2021 U.S. and Non-U.S. Catastrophe Risk Event Lists (Attachment One-A). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

https://naiconline.sharepoint.com/:f:/r/teams/FRSRBC/Capital%20Adequacy%20CapAd%20Task%20Force/2022%20Calls/Jan%202022?csf=1&web=1&e=H9A4kO
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<td>Hurricane</td>
<td>Isaac</td>
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<td>Tropical Storm</td>
<td>Debby</td>
<td>2012</td>
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<td>$105,000,000</td>
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<tr>
<td>Earthquake</td>
<td>Patrick</td>
<td>2014</td>
<td>California</td>
<td>25+ million</td>
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<td>Hurricane</td>
<td>Joaquin</td>
<td>2015</td>
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<td>25+ million</td>
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<tr>
<td>Hurricane</td>
<td>Matthew</td>
<td>2016</td>
<td>Florida, North Carolina, South Carolina, Georgia and Virginia</td>
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<td>Hurricane</td>
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<td>Harvey</td>
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<td>2017</td>
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<td>Nate</td>
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<tr>
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<tr>
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<tr>
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<tr>
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<tr>
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<tr>
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<td>Imelda</td>
<td>2019</td>
<td>Plains, Southeast</td>
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<td>Nestor</td>
<td>2019</td>
<td>Southeast</td>
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<tr>
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<td>Lorenzo</td>
<td>2019</td>
<td>Louisiana, Mississippi, Texas and Arkansas</td>
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<tr>
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<td>Cristobal</td>
<td>2020</td>
<td>Southeast, Plains, Midwest</td>
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<tr>
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<td>Fay</td>
<td>2020</td>
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<tr>
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<td>Hanna</td>
<td>2020</td>
<td>Texas</td>
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<tr>
<td>Hurricane</td>
<td>Isaias</td>
<td>2020</td>
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<tr>
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<td>Laura</td>
<td>2020</td>
<td>Plains, Southeast, Mid-Atlantic</td>
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<tr>
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<td>Sally</td>
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<td>Gulf coast of the United States, Southeastern United States, Mid-Atlantic</td>
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<td>Gulf Coast of the United States, Georgia, Carolinas</td>
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<td>Elsa</td>
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<td>Fred</td>
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<td>Eastern United States (particularly Florida and North Carolina)</td>
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<td>Henri</td>
<td>2021</td>
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<td>Ida</td>
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<td>Gulf Coast of the United States (especially Louisiana), East Coast of the United States (especially the Northeastern United States)</td>
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<tr>
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<td>Nicholas</td>
<td>2021</td>
<td>LA, TX</td>
<td>&gt;1.1b</td>
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<tr>
<td>Tropical Storm</td>
<td>Wanda</td>
<td>2021</td>
<td>Southern United States, Mid-Atlantic United States, Northeastern United States</td>
<td>&gt;200 million</td>
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</table>

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U.S. List of Catastrophes for Use in Reporting catastrophe Data in PR036 and PR100+
<table>
<thead>
<tr>
<th>Year</th>
<th>Event Type</th>
<th>Begin</th>
<th>End</th>
<th>Event</th>
<th>Country</th>
<th>Affected Area (Details)</th>
<th>Munich Re NatCATService</th>
<th>Swiss Re Sigma: Insured Loss Est.</th>
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<td>04/04/2010</td>
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<td>Bio Bíd, Concepción, Talcahuano, Coronel, Dichato, Chillán, Del Maule, Talca, Curicó, Constitución, Caleta, Duao, Ilo, Pellihue, Pintas, Metropolitana, Santiago, Valparaiso, Putaendo; La Araucanía, Angol, Temuco, Del General Libertador Bernardo O’Higgins, Rancagua, Angol; Juan Fernández Islands</td>
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<td>Emilia-Romagna, San Fele del Panaro, Cava, Zevio, Rovereto del Novi, Carpi, Concarno, Bologna, Meldiando, Asola Valley, Venice, Miranda</td>
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<td>07/18/2015</td>
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<td>Storm Desmond</td>
<td>Ireland, Isle of Man, United Kingdom, Iceland, Norway, and Sweden</td>
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### Non-U.S. List of Catastrophes For Use in Reporting Catastrophe Data in PR036 and PR100+

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<td>10/24/20</td>
<td>10/30/20</td>
<td>Hurricane Zeta, Cayman Islands, Jamaica, Central America, Yucatan Peninsula, Ireland, United Kingdom</td>
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<td>04/01/20</td>
<td>04/11/20</td>
<td>Cyclone Harold, Solomon Islands, Cana, Fiji, Tonga</td>
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<td>11/04/20</td>
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<td>2021</td>
<td>Earthquake</td>
<td>06/21/21</td>
<td>06/21/21</td>
<td>China, Yunnan Dali</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Earthquake</td>
<td>06/21/21</td>
<td>06/21/21</td>
<td>China, Southern Qinghai</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Hurricane</td>
<td>07/01/21</td>
<td>07/14/21</td>
<td>Hurricane Elsa, Lesser Antilles, Greater Antilles, Venezuela, Colombia, Atlantic Canada, Greenland, Iceland</td>
<td>&gt; 50+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Typhoon</td>
<td>07/16/21</td>
<td>07/31/21</td>
<td>Typhoon In-fa (Fabian), Philippines, Ryukyu Islands, Taiwan, China, North Korea</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Tropical Storm</td>
<td>08/11/21</td>
<td>08/20/21</td>
<td>Tropical Storm Fred, Lesser Antilles, Greater Antilles, Southern Quebec, The Bahamas</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2021</td>
<td>Hurricane</td>
<td>08/13/21</td>
<td>08/21/21</td>
<td>Hurricane Grace, Lesser Antilles, Greater Antilles, Yucatan Peninsula, Central Mexico</td>
<td>&gt; 513 million</td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>08/14/21</td>
<td>08/14/21</td>
<td>Haiti</td>
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<td>2021</td>
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<td>08/26/21</td>
<td>09/04/21</td>
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<td>09/07/21</td>
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<td>2021</td>
<td>Earthquake</td>
<td>09/16/21</td>
<td>09/16/21</td>
<td>China</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2021</td>
<td>Hurricane</td>
<td>09/18/21</td>
<td>09/24/21</td>
<td>Hurricane Nicholas, Yucatan Peninsula, Texas, Louisiana</td>
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<td>Cyclone</td>
<td>10/02/21</td>
<td>10/02/21</td>
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<td>&gt; 25+ million</td>
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<td>2021</td>
<td>Earthquake</td>
<td>10/07/21</td>
<td>10/07/21</td>
<td>Japan</td>
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<tr>
<td>2021</td>
<td>Tropical Storm</td>
<td>10/10/21</td>
<td>10/14/21</td>
<td>Tropical Storm Kompasu, Philippines, Hong Kong, China</td>
<td>245 million</td>
</tr>
<tr>
<td>2021</td>
<td>Earthquake</td>
<td>10/16/21</td>
<td>10/16/21</td>
<td>Indonesia</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2021</td>
<td>Tropical Cyclone</td>
<td>10/24/21</td>
<td>11/02/21</td>
<td>Tropical Cyclone Apollo, Italy, Malta, Tunisia, Algeria, Libya, Turkey</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Tropical Storm</td>
<td>10/31/21</td>
<td>11/07/21</td>
<td>Tropical Storm Wanda, Mauritania, Azores, Brazil</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Earthquake</td>
<td>11/14/21</td>
<td>11/14/21</td>
<td>Haiti</td>
<td>&gt; 25+ million</td>
</tr>
<tr>
<td>2021</td>
<td>Tropical Cyclone</td>
<td>12/14/21</td>
<td>12/15/21</td>
<td>Tropical Cyclone Rui Odette, Saint Pierre and Miquelon, Antilles, Philippines</td>
<td>&gt; 25+ million</td>
</tr>
</tbody>
</table>

Source: Munich Re NAT CAT Service, Swiss Re Sigma and Aon Benfield
The Capital Adequacy (E) Task Force met Dec. 20, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Cassie Brown, Vice Chair, represented by Mike Boerner and Rachel Hemphill (TX); Lori K. Wing-Heier represented by Wally Thomas (AK); Jim L. Ridling represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Kathy Belfi (CT); David Altmaier represented by Virginia Christy and Ray Spudeck (FL); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Vincent Tsang (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented Michael Muldoon (NE); Mike Kreidler represented by Steve Drutz (WA); and Nathan Houdek represented by Amy Malm (WI). Also participating were: Philip Barlow (DC); Kevin Clark (IA); Lindsay Crawford and Justin Schrader (NE); and Bill Carmello (NY).

1. Discussed the RBC Investment Risk and Evaluation (E) Working Group

Mr. Botsko said the Financial Condition (E) Committee recently adopted the formation of the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group. He asked if there are any questions on the charges of the Working Group. He also mentioned that two tasks were sent down from the Committee for the Working Group: 1) follow-up on Phase II of the Moody’s bond study, which is a modernization of the analysis; and 2) review Statement of Statutory Accounting Principles (SSAP) No. 43—Loan-Backed and Structured Securities in regard to residual tranches and the potential for an extremely high-risk default and that impact on RBC. The Statutory Accounting Principles (E) Working Group recently adopted changes to have this investment move from Schedule D reporting to Schedule BA.

Mr. Barlow added that it would be important to have members of the RBC Investment Risk and Evaluation (E) Working Group include members from the Health Risk-Based Capital (E) Working Group, the Life Risk-Based Capital (E) Working Group, the Property and Casualty Risk-Based Capital (E) Working Group, the Valuation of Securities (E) Task Force, and the Statutory Accounting Principles (E) Working Group to further promote coordination between the working groups under the Financial Condition (E) Committee.

Mr. Botsko said past referrals that were tabled by the Capital Adequacy (E) Task Force will be prioritized by the RBC Investment Risk and Evaluation (E) Working Group, and a long-term goal of the Working Group will be to conduct a holistic review of the investment schedules in the RBC formulas and coordinate consistency where it is warranted or categorize the investments in a consistent manner.

Mr. Carmello asked if the RBC Investment Risk and Evaluation (E) Working Group would be defining what a bond is and whether other assets would be considered if they were not considered a bond. Mr. Botsko said the Working Group should be looking at the investments as a whole (e.g., the residual tranches are currently treated as a bond, but that does not mean it will be treated that way in the future; it may be treated as an equity investment). Mr. Clark said he has joined the Working Group, been heavily involved as vice chair of the Statutory Accounting Principles (E) Working Group and the Valuation of Securities (E) Task Force, and can help with the coordination of the groups. Mr. Spudeck confirmed Florida’s involvement with the RBC Investment Risk and Evaluation (E) Working Group, as well as Mr. Boerner and other members with investment expertise for Texas. Mr. Leung said Missouri will be participating, as well as Mr. Andersen from Minnesota who has been following on the reserve side. Mr. Tsang confirmed his membership to the Working Group. Ms. Crawford confirmed her and Mr. Schrader’s participation, as well as others on her staff that have experience with macroprudential efforts that will be useful to the Working Group. Mr. Botsko said any interested parties should reach out to Jane Barr (NAIC) to be included on the list for meeting notifications. Edward L. Toy (Risk & Regulatory Consulting LLC) said he would be happy to assist with historical RBC investment schedules, and he suggested that the Working Group look at the inconsistencies regarding granularity between the life formula and the property/casualty (P/C) and health formulas. Mr. Botsko concurred that this is an important issue, and the Affiliate Investment Ad Hoc Group will be referring its proposals to the Health Risk-Based Capital (E) Working Group, the Life Risk-Based Capital (E) Working Group, the Property and Casualty Risk-Based Capital (E) Working Group, and the Capital Adequacy (E) Task Force for further discussion on when inconsistencies are warranted. Mr. Barlow said that specific topic should occur at the task force level.
Ms. Barr said a call is tentatively set for Jan. 12, 2022, and will be a joint call with the Financial Condition (E) Committee. The Committee web page has been set up for the RBC Investment Risk and Evaluation (E) Working Group, and the call information will be posted.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

12_CapitalAdequacyTFmin.docx
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 18, 2022. The following Working Group members participated: Steve Drutz, Chair (WA); Matthew Richard, Vice Chair, and Sean Fulton (TX) Wanchin Chou and Stephen Flick (CT); Kyle Collins (FL); Tish Becker (KS); Danielle Smith (MO); Michael Muldoon and Lindsay Crawford (NE); Ergys Shanaj (NY); and Jeffery Smith (PA). Also participating was: Tom Botsko (OH).

1. **Adopted is Feb. 25, 2022; Jan. 28, 2022; and Dec. 16, 2021, Minutes**

The Working Group met Feb. 25, 2022; Jan. 28, 2022; and Dec. 16, 2021. During these meetings, the Working Group took the following action: 1) exposed and referred the Health Test Language Proposal to the Blanks (E) Working Group; 2) exposed and referred a memo to the Health Actuarial (B) Task Force regarding asset adequacy testing; 3) adopted proposal 2021-18-H as modified for instructions in evaluating the investment yield adjustment in the underwriting risk factors; 4) received and exposed the American Academy of Actuaries (Academy) report on the H2 – Underwriting Risk component; and 5) reviewed the investment yields of the six-month U.S. Treasury bonds for the investment income adjustment.

Mr. Chou made a motion, seconded by Mr. Muldoon, to adopt the Working Group’s Feb. 25, 2022 (Attachment Three-A); Jan. 28, 2022 (Attachment Three-B); and Dec. 16, 2021 (Attachment Three-C) minutes. The motion passed unanimously.

2. **Discussed the Academy’s H2 – Underwriting Risk Component Report**

Mr. Drutz said the Academy’s H2 – Underwriting Risk report was exposed for a 45-day comment period, and no comments were received. The Academy outlined six options for better aligning the H2 risk factors to economic risk: 1) refresh factors based on updated insurer data; 2) develop factors at a more granular product level; 3) develop factors specific to more relevant block sizes and consider indexing factors for cut points to change over time; 4) model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly; 5) refresh the managed care credit formula and factors to be more relevant and reflective of common contracting approached and other risk factors associated with these contracting approaches; and 6) analyze long-term care insurance (LTCI) underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time.

Mr. Muldoon said the Academy laid out several other methodologies in their report, such as Best’s Capital Adequacy Relativity (BCAR), the property/casualty (P/C) risk-based capital (RBC) formula, etc. He asked if there would be any follow-up or educational sessions on the varying methodologies evaluated by the Academy to gain a better understanding that could be done simultaneously with moving forward to evaluate what data would be needed. Derek Skoog (Academy) said the Academy could provide a presentation on the BCAR and the P/C RBC formula approach, as well as more detailed suggestions for how the factors could be updated considering these alternative approaches. He said the Academy worked with AM Best to gain an understanding of how those factors were developed, and he suggested that the Academy may also be willing to present to the Working Group also. Mr. Chou suggested that the Working Group had an educational session before moving forward with the next steps. Mr. Muldoon asked if there is a way to compare what a company might look like under the BCAR versus the
current health RBC formula. Mr. Botsko said it is a great idea to have the discussion; however, RBC is about minimum solvency standards, and the BCAR is based on more of a going concern perspective, which is a little bit different than RBC. Mr. Drutz said it is his hope that as these conversations move forward, it will help the Working Group understand the purposes and the differences for those purposes.

The Working Group agreed to schedule a call for an educational session on the various methodologies prior to requesting that the Academy move forward.

3. **Adopted its 2022 Working Agenda**

Mr. Drutz said each year, the Working Group reviews the working agenda for the upcoming year based on its priorities and needs. He provided a summary of the changes: 1) combined items 26 and 27 into one item and changed the expected completion date to “Ongoing”; 2) updated the priority status and expected completion for item 28; 3) updated the expected completion and working agenda description for item 30; 4) combined items 31, 34, and 36 into one item and updated the expected completion date; 5) updated the expected completion dates for items 32 and 33; and 6) updated the working item description for item 35.

Mr. Chou made a motion, seconded by Mr. Muldoon, to adopt its 2022 working agenda (*see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Eleven*). The motion passed unanimously.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 25, 2022. The following Working Group members participated: Steve Drutz, Chair (WA); Wanchin Chou and Stephen Flick (CT); Kyle Collins (FL); Tish Becker (KS); Debbie Doggett and Danielle Smith (MO); Tom Dudek (NY); and Aaron Hodges and Matthew Richard (TX).

1. **Referred the Health Test Language Proposal to the Blanks (E) Working Group**

Mr. Drutz said the Working Group re-exposed the Health Test Language Proposal for 15 days, which included minor modifications to add further clarity to the language, and no comments were received.

Mr. Dudek made a motion, seconded by Mr. Chou, to refer the Health Test Language Proposal (Attachment Three-A1) to the Blanks (E) Working Group. The motion passed unanimously.

2. **Referred a Memo to the Health Actuarial (B) Task Force**

Mr. Drutz said the referral letter to the Health Actuarial (B) Task Force was exposed for 15 days, and no comments were received. He said the referral asks the Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) for long-term care (LTC) business that would state that regardless of the blank an entity files, asset adequacy testing is required if the criteria are met.

Ms. Doggett made a motion, seconded by Ms. Becker, to refer the memo (Attachment Three-A2) to the Health Actuarial (B) Task Force. The motion passed unanimously.

3. **Adopted Proposal 2021-18-H-Modified**

Mr. Drutz said proposal 2021-18-H was re-exposed with alternative language for a 15-day public comment period, and no comments were received. The alternative language provides additional clarity for the time in which the Working Group will evaluate the investment yield prior to considering an adjustment.

Mr. Chou made a motion, seconded by Mr. Dudek, to re-adopt proposal 2021-18-H-MOD (see *NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Seven*) with the alternative language. The motion passed unanimously.

4. **Discussed Other Matters**

Mr. Drutz asked for a volunteer to hold the vice chair position. He said if more than one person volunteers, a vote would be held.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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<thead>
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<th>DATE: 11-3-21</th>
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<tr>
<td>CONTACT PERSON: Crystal Brown</td>
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<tr>
<td>TELEPHONE: 816-783-8146</td>
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<tr>
<td>EMAIL ADDRESS: <a href="mailto:cbrown@naic.org">cbrown@naic.org</a></td>
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<td>ON BEHALF OF: Health Risk-Based Capital (E) WG</td>
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<tr>
<td>NAME: Steve Drutz</td>
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<tr>
<td>TITLE: Chair</td>
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<td>AFFILIATION: WA Office of the Insurance Commissioner</td>
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FOR NAIC USE ONLY

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<tr>
<td>Changes to Existing Reporting</td>
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<tr>
<td>New Reporting Requirement</td>
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REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT

| No Impact | [ ] |
| Modifies Required Disclosure | [ ] |

DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date __________________
[ ] Rejected Date __________________
[ ] Deferred Date __________________
[ ] Other (Specify) __________________

BLANK(S) TO WHICH PROPOSAL APPLIES

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<th>INSTRUCTIONS</th>
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<td>[ ] QUARTERLY STATEMENT</td>
<td>[ x ] INSTRUCTIONS</td>
<td>[ ] CROSSCHECKS</td>
</tr>
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</table>

ANTICIPATED EFFECTIVE DATE: __________________

IDENTIFICATION OF ITEM(S) TO CHANGE

Revise the Health Annual Statement Test language

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the change is to move those filers who write predominantly health business and file on the life blank to begin filing on the health blank.

NAIC STAFF COMMENTS

Comment on Effective Reporting Date: __________________

Other Comments:
The Health Test Ad Hoc Group of the Health Risk-Based Capital (E) Working Group continues to discuss and review any potential modifications to premium and reserve ratios. The group will continue to evaluate if there should be changes and if so, will propose this to the Blanks (E) Working Group in a separate proposal for consideration in future years.

The references to the Life & Property & Casualty General Interrogatories were changed from pulling from RBC to instead pull from the Analysis of Operations By Lines of Business – Accident and Health and Underwriting & Investment Exhibit, Part 1B, respectively. The life General Interrogatory references will be further updated if proposal 2021-17BWG is adopted.

12-16-21 – Exposed to the Health and Life Risk-Based Capital (E) Working Groups for 40 days.
1-5-22 – Revised Health Annual Statement Instructions – General Interrogatories – Line 2.1 – Premium Numerator for additional clarity.
1-28-22 – Two comment letters received. Re-exposed to the Health and Life Risk-Based Capital (E) Working Groups for changes to the Reserve Numerator for 15 days. Comments due 2-14-22.
2-14-22 – No comments were received.
2-25-22 – Health Risk-Based Capital Working Group agreed to refer the proposal to the Blanks (E) Working Group for exposure and consideration.

** This section must be completed on all forms. Revised 7/18/2018
Health

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**
   
   If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.
   
   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   **Passing the Test:**
   
   A reporting entity is deemed to have passed the Health Statement Test if the values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

   **Failing the Test:**
   
   If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

   **Variances from following these instructions:**
   
   If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   All reporting entities should file the test.

   Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.
### Life, Accident and Health /Fraternal

#### Health Test

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions and Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   **Passing the Test:**
A reporting entity is deemed to have passed the Health Statement Test if:

The values for the **premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year**.

**AND**

The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

**AND**

At least seventy-five percent (75%) of the entity’s current year premiums are written in its domiciliary state.

**OR**

The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end.

**Variances from following these instructions:**

If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

### General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

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<tr>
<th>Item</th>
<th>Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
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<td>2.1</td>
<td>Premium Numerator</td>
<td><strong>Health Premium</strong> values listed in <strong>the Analysis of Operations By Lines of Business – Accident and Health</strong> statement value column (Column 1) of the reporting year’s Life RBC report.</td>
<td><strong>Health Premium</strong> values listed in the statement value column (Column 1) of the reporting year’s Life RBC report Analysis of Operations By Lines of Business – Accident and Health.</td>
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<tr>
<td></td>
<td>Individual Lines</td>
<td>Usual and Customary Major Medical and Hospital Comprehensive (Individual &amp; Group) – (Columns 1 &amp; 2, Line 1) Medicare Supplement (Column 4, Line 1) Medicare Part D (Columns 13 (in part), Line 1) Dental and Vision (Columns 5 &amp; 6, Line 1) Medicaid (Column 8, Line 1) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Column 9, Line 1)</td>
<td>Medicare Supplement (Column 4, Line 1) Medicare Part D (Columns 13 (in part), Line 1) Dental and Vision (Columns 5 &amp; 6, Line 1) Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Column 9, Line 1)</td>
</tr>
<tr>
<td></td>
<td>Group Lines:</td>
<td>Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Stop Loss and Minimum Premium (Column 13 (in part), Line 1) Dental and Vision Federal Employee Health and Benefit Plan (Column 7, Line 1)</td>
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</tbody>
</table>
2.2 Premium Denominator Premium and Annuity Considerations (Page 4, Line 1) of the reporting year’s annual statement

2.3 Premium Ratio 2.1/2.2

2.4(a) Reserve Numerator Net A&H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and Column 11 excluding Dread Disease, Disability Income and Long-Term Care) plus Aggregate Reserves for A&H Policies without Credit Health (Exhibit 6, Column 1 less Columns 10, 11, 12 and Dread Disease included in Column 13) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)

2.5 Reserve Denominator Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2 minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)

2.6 Reserve Ratio 2.4/2.5

(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

Property/Casualty

Health Test

GENERAL

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

AND

The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

AND

At least seventy-five percent (75%) of the entity’s current year premiums are written in its domiciliary state.

OR

The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter’s statement for the second year following the reporting year.
in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end.

**Variances from following these instructions:**

If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**General Interrogatories**

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Premium Numerator</td>
<td>Health Premium values listed in the statement of the reporting year’s P&amp;C RBC report:</td>
<td>Health Premium values listed in the statement of the prior year’s P&amp;C RBC report:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual Lines:</td>
<td>Individual Lines:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usual and Customary Major Medical and Hospital Comprehensive (hospital and medical) (individual and group) (Lines 13.1 and 13.2)</td>
<td>Usual and Customary Major Medical and Hospital Medicare Supplement Medicare Part D Dental and Vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Supplement (Line 15.4)</td>
<td>Medicare Supplement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Part D (Line 15.9, in part)</td>
<td>Medicare Part D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental and Vision (Lines 15.1 and 15.2)</td>
<td>Dental and Vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare (Line 15.6)</td>
<td>Medicare (Lines 15.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Line 15.5)</td>
<td>Medicaid (including Medicaid Pass-Through Payments Reported as Premium) (Line 15.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Group Lines:</strong></td>
<td><strong>Group Lines:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Usual and Customary Major Medical and Hospital</td>
<td>Usual and Customary Major Medical and Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Supplement</td>
<td>Medicare Supplement</td>
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<tr>
<td></td>
<td></td>
<td>Medicare Part D</td>
<td>Medicare Part D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stop Loss and Minimum Premium (Line 15.9, in part)</td>
<td>Stop Loss and Minimum Premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental and Vision</td>
<td>Dental and Vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Federal Employee Health and Benefit Plan (Line 15.8)</td>
<td>Federal Employee Health and Benefit Plan</td>
</tr>
<tr>
<td>2.2</td>
<td>Premium Denominator</td>
<td>Premiums Earned (Page 4, Line 1) of the reporting year’s annual statement</td>
<td>Premiums Earned (Page 4, Line 1) of the prior year’s annual statement</td>
</tr>
<tr>
<td>2.3</td>
<td>Premium Ratio</td>
<td>2.1/2.2</td>
<td>2.1/2.2</td>
</tr>
<tr>
<td>2.4(a)</td>
<td>Reserve Numerator</td>
<td>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only) of the reporting year’s annual statement.</td>
<td>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15 excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15 excluding Line 15.3 Disability Income, Line 15.7 Long-Term Care, Line 15.9 Other Health - Dread Disease only) of the prior year’s annual statement.</td>
</tr>
<tr>
<td>2.5</td>
<td>Reserve Denominator</td>
<td>Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the reporting year’s annual statement.</td>
<td>Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year’s annual statement.</td>
</tr>
<tr>
<td>2.6</td>
<td>Reserve Ratio</td>
<td>2.4/2.5</td>
<td>2.4/2.5</td>
</tr>
</tbody>
</table>
(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).
MEMORANDUM

TO: Commissioner Andrew N. Mais (CT), Chair of the Health Actuarial (B) Task Force and
Fred Andersen (MN), Chair of the Long-Term Care Valuation (B) Subgroup

FROM: Steve Drutz (WA), Chair of the Health Risk-Based Capital (E) Working Group

DATE: Feb. 25, 2022

RE: AG 51 – Asset Adequacy Testing

The Health Risk-Based Capital (E) Working Group established the Health Test Ad Hoc Group in 2018 to review the health test language within the Annual Statement Instructions due to inconsistencies in reporting of health business across the different blanks, as well as a significant amount of health business reported on the life and fraternal blank. Currently, a company passes the health test if the following requirements are met:

- The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

AND

- The entity passing the Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

AND

- At least 75% of the entity’s current year premiums are written in its domiciliary state.

OR

- The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

The intent of the Ad Hoc Group was to evaluate if changes were warranted to the health test because of industry changes since its original development. The Ad Hoc Group has drafted a phase 1 proposal that will delete the requirements for an entity being licensed and actively issuing and/or renewing business in five states or less and at least 75% of the entity’s current year premiums being written in their domicile state. The Ad Hoc Group is continuing to evaluate the current 95% premium and reserve ratios.

Through the evaluation and discussion of the 95% reserve ratio, there was a question brought up as to whether an entity would still be required to perform asset adequacy testing of long-term care (LTC)
business if the entity moved from the life blank to the health blank. It is the Ad Hoc Group’s understanding that asset adequacy testing is required, regardless of the blank if the criteria for asset adequacy testing are met. The Working Group is asking the Health Actuarial (B) Task Force to consider adding a sentence to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) that would indicate that regardless of the blank the entity files, asset adequacy testing is required by the entity if the criteria are met.

This clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.

If you have any questions regarding the suggested clarification, please contact Crystal Brown (cbrown@naic.org).

cc: Eric King, Crystal Brown
Health Risk-Based Capital (E) Working Group
Virtual Meeting
January 28, 2022

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 28, 2022. The following Working Group members participated: Steve Drutz, Chair (WA); Wanchin Chou and Stephen Flick (CT); Kyle Collins (FL); Tish Becker (KS); Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges, Matthew Richard, and Sean Fulton (TX).

1. **Discuss Comments Received on the Health Test Language Proposal**

Mr. Drutz said the Health Test Language Proposal was exposed for 40 days on Dec. 16, 2021, and two comment letters (Attachment Three-B1) were received. He said the Health Test Ad Hoc Group met Jan. 5 and Jan. 25 to: 1) discuss the language in the premium numerator section of the Health General Interrogatories; and 2) review the comment letters. The Ad Hoc Group suggested a friendly amendment to the language that included removing “in part,” replacing it with “excluding,” deleting the sentence “Column 10 of the reporting year’s annual statement,” and adding “of the reporting year’s annual statement.” Mr. Drutz said the Ad Hoc Group believed these changes were not material but clarifying. He said additional questions were brought forward regarding the exclusion of disability income, long-term care (LTC), credit accident and health (A&H), and dread disease in the reserve numerator for the life and property/casualty (P/C) General Interrogatory instructions, and clarifying language was added to show that these items should be excluded from the numerator portion of the reserve ratio.

Mr. Richard said his comments were in relation to the presentation of the reserve ratio. He said the amounts in the numerator and denominator are pulled from different schedules, and it would be clearer if they could be pulled from the same schedules, where possible, to be more consistent. He said it would also help to understand what drives the results of the calculation. Mr. Drutz said the Ad Hoc Group found that Texas’ comments were very well founded; however, the Ad Hoc Group wanted to further review the premium and reserve ratio over the course of this year and utilize these suggestions in that review.

Ray Nelson (America’s Health Insurance Plans—AHIP) said AHIP is supportive of the language included in the exposure and the friendly amendment.

Hearing no objections, the Working Group agreed to re-expose the Health Test Language Proposal with the friendly amendment changes for a 15-day public comment period ending Feb. 14. The exposure will be distributed to both the Health Risk-Based Capital (E) Working Group and the Life Risk-Based Capital (E) Working Group.

2. **Exposed a Referral Letter to the Health Actuarial (B) Task Force**

Mr. Drutz said through the Health Test Ad Hoc Group’s evaluation and discussion of the 95% reserve ratio, a question was brought up as to whether an entity would still be required to perform asset adequacy testing of LTC business if the entity moved from the life blank to the health blank. He said the referral letter asks the Health Actuarial (B) Task Force to consider adding a sentence to Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) that would indicate, regardless of the annual statement blank that the entity files, that asset adequacy testing is required by the entity if the criteria are met. He said this clarification would help to make it abundantly clear that all companies with LTC exposure that are subject to asset adequacy testing would still be required to meet these requirements, regardless of the blank they are filing on.
Hearing no objections, the Working Group agreed to expose the referral letter for a 15-day public comment period ending Feb. 14.

3. Received an Academy H2 – Underwriting Risk Report

Derek Skoog (American Academy of Actuaries—Academy) summarized the Academy’s report “Request for Comprehensive Review of the H2 – Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula.” He said that the Academy spent a fair bit of time discussing the factors themselves and the degree to which they have been updated since their inception, and it has investigated some of the significant changes that have taken place in the health insurance industry since the factors were originally contemplated. He said there have been changes in the claims distributions in the last 20 years; the high cost of beneficiaries and patients because of advances in medical care; asymmetric claims risk, as there may be limits on the level of profitability on health plans due to regulations; provider contracting; and the product basis and reform of the market for individual, small, and large group, as well as Medicare Advantage. He said there has been a lot that has changed in the industry, and the Academy wants to understand how others have evolved their views on underwriting risk in the health sector. He said to do this, the Academy spent quite a bit of time studying Best’s Capital Adequacy Relativity (BCAR), the NAIC P/C Risk-Based Capital (RBC) formula, Solvency II, and the Department of Managed Health Care Tangible Net Equity (TNE) requirements. He said the Academy saw some consistent themes, particularly that most of those approaches take a more granular view of products and a few split-out pricing versus reserving risk. He said the BCAR, P/C RBC formula, and Solvency II tend to take a more contemporaneous view of underwriting risk; they evolve over time; and the factors tend not to be static for a long stretch of time.

Mr. Skoog said with that background, in terms of understanding how the industry has evolved and what other approaches have been, the Academy has produced six potential recommendations or changes for the Working Group’s consideration: 1) refresh factors based on updated insurer data; 2) develop factors at a more granular product level; 3) develop factors specific to more relevant block sizes and consider any indexing factors for cut points to change over time; 4) model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly; 5) refresh the managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches; and 6) analyze long-term care insurance (LTCI) underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time. He said the current theme is to bring the factors to reflect the current risk profile of underwriting strategies and approaches those insurers face today.

Mr. Muldoon said the six recommendations proposed by the Academy are a good set of recommendations, the points made regarding a more granular product level are well taken, and there is a lot of room to look at it in more granularity. Mr. Chou asked the Academy to provide a timeline and a path forward. Mr. Skoog said the path forward for items 1–5 is clear in that some of the approaches taken by the P/C RBC formula and a similar approach taken by the BCAR provide clarity for the underwriting approach of net written premium and a standard process for updating those factors based on safety levels observed in the industry. He said what will require more consideration is the data sources to be used. He said page 7 of the Annual Statement would be a good place to start because it already has many data fields that feed into the RBC formula. He said a longer-term goal would be to move towards the Accident and Health Policy Experience Exhibit level of detail. In the nearer term, a goal would be to mirror many of the approaches taken in the P/C RBC formula around thinking about underwriting risks and matching page 7 to that approach. He said the Academy could provide the Working Group with a work plan if requested. He said item 6 for LTC would require some additional study as to what that would look like because it is a challenging issue. Mr. Chou asked if there had been coordination between the various Academy groups to look at LTC. Mr. Skoog said the Academy connected internally, and there will need to be collaboration to make sure the right considerations are folded into any new risk factors.
Hearing no objections, the Working Group agreed to expose the report (Attachment Three-B2) for a 45-day public comment period ending March 16.

4. **Reviewed the Investment Yields of Six-Month Treasury Bonds for Investment Income Adjustment in Underwriting Risk**

Mr. Drutz said the Working Group adopted changes to the underwriting factors for year-end 2021 to incorporate an investment yield adjustment and adopted guidance into the instructions for the investment yield. The investment yield for the six-month treasury bond through the first four weeks of the month of January (Mondays were utilized as the basis day except for the week of Jan. 16 due to the holiday) remained below 0.5%, and as a result, there would be no changes to the factors for year-end 2022.

Mr. Drutz recommended that the Working Group consider modifying proposal 2021-18-H that was previously adopted on Dec. 16, 2021, to clarify the time period for which the investment yield is evaluated based on the previous analysis. He said alternative language was included in the proposal. He suggested that the proposal be re-exposed for a brief time period with the alternative language.

Hearing no objections, the Working Group agreed to re-expose proposal 2021-18-H (Attachment Three-B3) for a 15-day public comment period ending Feb. 14.

5. **Discussed Other Matters**

Mr. Drutz asked that any states interested in joining the Working Group please contact Crystal Brown (NAIC).

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
January 24, 2022

Steve Drutz, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

By Email to Crystal Brown at CBrown@NAIC.org and Steve Drutz at steved@oic.wa.gov

Re:  Health Test Language Proposal Exposed on 12.16.21

Dear Mr. Drutz:

On behalf of the members of America’s Health Insurance Plans (AHIP), we appreciate the opportunity to provide comments on the Health Test Language Proposal discussed (and exposed) during the Working Group’s meeting on December 16, 2021.

AHIP is generally supportive of the language included in this December 16, 2021 exposure. Furthermore, we would like to express our appreciation to the Chair for including interested parties (including AHIP) and regulators during the discussion and evaluation process that has taken place on this topic at the ad hoc group level.

Thank you for the opportunity to provide these comments, and we look forward to continuing to work with the Health Risk-Based Capital (E) Working Group in the future.

Sincerely,

Bob Ridgeway
Bridgeway@ahip.org
501-333-2621

Ray Nelson – Consultant to AHIP
rnelson@triplusservices.com
224-217-9036
Good morning Crystal & Amy,

Regarding the Health Test Language Proposal, my comments are as follows:

In the current presentation of the Reserve Ratio, the calculation is very straightforward:

<table>
<thead>
<tr>
<th>2.4(a)</th>
<th>Reserve Numerator</th>
<th>Net A&amp;H Policy and Contract Claims without Credit Health (Exhibit 8, Part 1, Line 4.4, Columns 9 and 11) plus Aggregate Reserves for A&amp;H Policies without Credit Health (Exhibit 6, Column 1 less Column 10) for Unearned Premiums (Line 1) and Future Contingent Benefits (Line 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5</td>
<td>Reserve Denominator</td>
<td>Aggregate Reserve (Page 3, Column 1, Lines 1+2+4.1+4.2) minus additional actuarial reserves (Exhibit 6, Column 1, Lines 3+11 plus Exhibit 5, Misc. Reserves Section, Line 0799999)</td>
</tr>
<tr>
<td>2.6</td>
<td>Reserve Ratio</td>
<td>$2.4/2.5$</td>
</tr>
</tbody>
</table>

However, it’s less straightforward to explain what drives the results, or to explain the changes from year to year.

A general issue is that when amounts are duplicated in the Annual Statement, we select the amount that appears earliest. So then the denominators are often calculated from the first few pages, and the numerators are calculated from later exhibits, and it becomes a little opaque.

In this case, the denominator references Page 3, but the numerator references Exhibits 6 and 8.

This obscures that we are effectively performing this calculation:

$$\text{Reserves for A&H (Non - Credit Products)} - \text{Reserves for Life and Other Products}$$

It would be more clear if the references were consistent between the numerator and the denominator, where practical.
For example, the references in the Denominator to Page 3 could be replaced with references to Exhibits 5 & 6.

Once these are harmonized, the calculation of the Reserve Ratio could be presented as follows:

<table>
<thead>
<tr>
<th></th>
<th>Health</th>
<th>Non-Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4(a) Reserve Numerator</td>
<td>A</td>
<td>N/A</td>
<td>A</td>
</tr>
<tr>
<td>2.5 Reserve Denominator</td>
<td>A</td>
<td>B</td>
<td>A + B</td>
</tr>
<tr>
<td>2.6 Reserve Ratio</td>
<td></td>
<td></td>
<td>2.4/2.5</td>
</tr>
</tbody>
</table>

With both the health and the non-health reserves clearly identified, it would be straightforward to determine which items were driving the results of the Health Test.

All the best,

Matthew Richard, ASA, MAAA, CEBS
Life & Health Actuary
Financial Regulation Division – Actuarial Office
512-676-6855

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---

From: Lopez, Amy <alopez@naic.org>
Sent: Thursday, December 16, 2021 2:25 PM
To: Brown, Crystal <CBrown@naic.org>
Subject: Exposure Draft Notice: Health Risk-Based Capital (E) Working Group ending 1/24/22

**ATTENTION:** This email came from an external source. Do not open attachments or click on links from unknown or unexpected emails.

Distributed Health Risk-Based Capital (E) Working Group Members, Interested Regulators and Interested Parties

The Health Risk-Based Capital (E) Working Group is exposing the following proposal for a 40-day comment period. Please submit comments to Crystal Brown by COB January 24, 2022.
• Health Test Language Proposal

NAIC Staff Contact:
Crystal Brown
816.783.8146
cbrown@naic.org

Amy Lopez
Sr. Administrative Assistant – FRS
O: 816-783-8423
W: www.naic.org

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January 21, 2022

Steve Drutz
Chair, Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Re: Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula

Dear Mr. Drutz:

On behalf of the American Academy of Actuaries (Academy) Health Solvency Subcommittee, I am pleased to provide this report to the National Association of Insurance Commissioners (NAIC) Health Risk-Based Capital (HRBC) (E) Working Group. This report is in response to the request from the working group to analyze and comprehensively review the H2—Underwriting Risk component and the managed care credit calculation in the health risk-based capital (RBC) formula.

1. Introduction

In this report, the subcommittee presents a discussion of the current H2 — Underwriting Risk factors, key changes affecting health insurers that have impacted underwriting risk since the factors were originally developed, alternative views of underwriting risk from other regulating entities, and a set of targeted recommendations for improving the H2 — Underwriting Risk factors.

Our approach surveyed other methods of evaluating risk, and in particular underwriting risk taken by other risk quantification formulas (e.g., health, life, property and casualty (P&C) RBC formulas; credit rating agencies) and summarized their respective merit for health underwriting risk. The subcommittee recommends a constructive dialogue with the NAIC’s HRBC Working Group to determine the best approach before beginning detailed analysis and factor development.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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2. Review of the H2 Risk Factor in Current HRBC Formula

History of H2 in Health Organizations’ Risk-Based Capital Formula

In the early 1990s, the Academy fulfilled a request from the NAIC to assist in the development of a risk-based capital formula - similar to those in place for life Insurers and P&C Insurers - that could be applied to a variety of traditional and nontraditional risk-assuming enterprises in the health insurance space. The objective in developing an RBC formula was to calculate the minimum amount of capital that the reporting entity should hold to support the risk associated with the business venture. In doing so, monitoring and regulatory agencies would be able to identify entities that were exhibiting signals of financial weakness and could take steps to promote their solvency. The RBC formula was also to be constructed in such a way that results would be the same for companies engaged in the same health insurance business activity, regardless of organizational structure.

Over time, refinements have been made leading to today’s health risk-based capital (HRBC) model. Like the life and P&C risk-based capital formulas, multiple risk categories are included in the calculation of the minimum capital amount for an entity. In the case of HRBC, five categories are employed (emphasis added to H2 - Underwriting Risk):

<table>
<thead>
<tr>
<th>Category Title</th>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Affiliates and Misc. Other</td>
<td>H0</td>
<td>This is the risk from the declining value of insurance subsidiaries as well as risk from off-balance sheet and other miscellaneous accounts (e.g., deferred tax assets (DTAs)).</td>
</tr>
<tr>
<td>Asset Risk - Other</td>
<td>H1</td>
<td>This is the risk of asset losses due to default of principal and interest or fluctuation in market value.</td>
</tr>
<tr>
<td>Underwriting Risk</td>
<td>H2</td>
<td>This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year.</td>
</tr>
<tr>
<td>Credit Risk</td>
<td>H3</td>
<td>Creditor risk of not recovering receivable amounts owed</td>
</tr>
<tr>
<td>Business Risk</td>
<td>H4</td>
<td>This category includes several miscellaneous risks not captured elsewhere, such as those associated with administrative expenses, administrative services contracts/administrative services only (ASC/ASO) business, guaranty fund assessment, and excessive growth.</td>
</tr>
</tbody>
</table>
To develop the original H2 (underwriting risk) component of the HRBC formula, the Academy employed statistical modeling based on health insurance and provider data available at that time. Stochastic modeling was performed using a five-year modeling time horizon, and formulas and factors were developed to calculate capital levels that allowed each product to remain solvent in 95% of the modeled scenarios. Ultimately, the original modeling was used to develop relative risk values (RVs) for most lines of business which would be referenced by the NAIC to establish risk factors, based on the NAIC’s risk tolerance.

**Calculation of H2 in HRBC Formula**

The total H2 risk charge is calculated through several sub-formulas within the HRBC calculation, denoted as XR013 through XR019. The following is a summary of each sub-formula that contributes to the overall calculation of H2 for a reporting entity:

**XR013 — Underwriting Risk**

For most health reporting entities, underwriting risk constitutes the largest share of the overall risk-based capital charge, representing the general risk of fluctuations in underwriting experience — i.e., the risk that premiums (which are an expected value of future costs and considerations) are insufficient to cover actual plan costs. In such a scenario, the next dollar of cost is funded by the reporting entity’s capital and surplus. Depending on the policy type and the level of provider contracting, the reporting entity may not be fully exposed to this potential fluctuation in claims experience, as the risk may be transferred to another entity (e.g., a provider group or a reinsurer). However, this could introduce a separate and material credit risk that the assuming entity may default on its obligation(s).

To calculate the charge for this risk, six general lines of business are utilized:

1. Comprehensive Medical & Hospital
2. Medicare Supplement
3. Dental and Vision
4. Stand-alone Medicare Part D Coverage
5. Other Health Coverages
6. Other Non-Health Coverages

For each line of business, risk factors are applied to the reported incurred claims for the reporting entity, sourced from the Annual Statement. The risk factors are the same for all reporting entities, but generally decrease as the premiums for a particular line of business increases. Applying the risk factors to the estimated incurred claims generates Base Underwriting Risk RBC. See an illustration in Table 1 of the Underwriting Risk Factors by premium tier:
To the subcommittee’s collective knowledge, aside from the adoption of investment income adjustments into the Comprehensive Medical & Hospital, Medicare Supplement, and Dental and Vision factors in 2021, the premium tiers have not been adjusted over time to capture market dynamics that influence risk, such as medical cost growth.

A Managed Care Credit (sourced from XR018) is then applied to the Base Underwriting Risk RBC, which can reduce the risk charge for certain lines of business if the managed care contracts in place limit the financial risk of adverse claims fluctuations on the reporting entity.

The ultimate calculation of Net Underwriting Risk RBC compares the calculated Underwriting Risk (including the Managed Care Credit) to an Alternate Risk Charge that is dependent on the amount of risk borne by the reporting entity, after adjusting for any reinsurance arrangements.

**XR014 — Annual Statement Source**

This page contains no RBC calculations; however, it does illustrate to the user where information can be retrieved to perform RBC calculations on XR013. Some pieces of information are obtained from the reporting entity’s annual statement, while others must be sourced from internal company records (e.g., all premium and claims data for stand-alone Medicare Part D coverage).
**XR015 — Other Underwriting Risk**

This page contains the risk charge calculation for the following, where the risk charge, unless otherwise specified, is a risk factor applied to earned premium:

1. Business with rate guarantees split by a rate guarantee period of 15 to 36 months and a rate guarantee period of over 36 months
2. Federal Employees Health Benefits Program (FEHBP) and TRICARE, where the risk factors are applied to incurred claims
3. Stop Loss and Minimum Premium
4. Supplemental Benefits within Stand-Alone Medicare Part D Coverage, where the risk factors are applied to incurred claims
5. Medicaid pass-thru payments reported as premium
6. Disability income split by the first $50 million in earned premium and earned premium over $50 million for the following with the risk factor varying by premium tier:
   a. Noncancellable morbidity risk
   b. Other than non-cancellable morbidity risk
   c. Credit monthly balance plans
   d. Group long-term
   e. Credit single premium with additional reserves
   f. Credit single premium without additional reserves
   g. Group short-term

For single premium credit insurance with additional reserves, the premium is reduced for the change in additional reserves held.

The premium and additional reserves used in the risk charge calculation are based on company records.

**XR016 — Long-Term Care (LTC) Insurance Premium/Loss Ratio Experience**

The majority of the risk charge is for morbidity risk plus an additional risk charge for rate risk on noncancellable LTC insurance. The rate risk factor is 0.100 for all noncancellable premium and the morbidity charge is 0.100 and 0.030 for all LTC insurance premiums up to $50 million and over $50 million, respectively.

Then, additional charges for morbidity risk are based on experience. The average loss ratio is calculated for the current and prior year. Actual claims are adjusted to the average loss ratio and this adjusted claim amount is used to calculate the risk charge. The risk charge is calculated as follows:
1. For the first $35 million, the risk factor is 0.250 if current year premium is positive; otherwise, the factor is 0.370.
2. For adjusted claims in excess of $35 million, the risk factor is 0.080 if current year premium is positive; otherwise, the factor is 0.120.
3. A risk factor of 0.050 is applied to LTC Insurance claim reserves.

The premium and claim information used in the risk charge calculation are based on company records.

**XR017 — Limited Benefit Plan**

This page contains the risk charge calculation for the following limited benefit plans:

1. Hospital Indemnity and Specified Disease
2. Accidental Death and Dismemberment
3. Other Accident
4. Premium Stabilization Reserves—this is a credit to RBC and it is limited to the total Underwriting RBC for all lines, excluding stand-alone Part D.

The premium and reserve information used in the risk charge calculation are based on company records.

**XR018 — Underwriting Risk — Managed Care Credit**

The managed care credit seeks to account for volatility in claims costs relative to the coverage period. For instance, if an actuary was aware of capitation rates during the rating cycle, that would improve the likelihood of rate adequacy.

The managed care credit calculation utilizes five factors that reflect the impact of different types of provider contracts on medical claim predictability and volatility. The factor associated with each contract category is applied to the level of incurred claims in that category and an overall discount or credit is calculated based on the relative claims weights. The discount factors have remained unchanged since they were first adopted.

For example, fully capitated provider contracts (i.e., when providers are accepting 100% of the underwriting risk) are generally assumed to provide a health insurer with substantial financial protection and, accordingly, the substantial credit noted in the below table. Other provider contracts may also provide the health insurer with a range of financial protection less than full capitation (e.g., from discounted fee-for-service contracts to partial capitation and/or withholding funds from the provider that may only be paid after financial results have been evaluated against the provider contract agreement). The factors in Table 2 that vary by type of provider contract reflect this range of financial protection for the health insurer.
Table 2.

<table>
<thead>
<tr>
<th>Category</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 0—Arrangements not Included in Other</td>
<td>0%</td>
</tr>
<tr>
<td>Category 1—Contractual Fee Payments</td>
<td>15%</td>
</tr>
<tr>
<td>Category 2—Bonus / Withhold Arrangements</td>
<td>0-25%</td>
</tr>
<tr>
<td>Category 3—Capitation</td>
<td>60%</td>
</tr>
<tr>
<td>Category 4—Non-Contingent Expenses and Aggregate Cost Arrangements and</td>
<td>75%</td>
</tr>
<tr>
<td>Certain PSO Capitated Arrangements</td>
<td></td>
</tr>
</tbody>
</table>

As Medicare Part D was implemented in 2006, the managed care credit was adapted to include a credit for stand-alone Part D plans in 2009 to reflect the reduction in risk to health plans attributable to the various risk adjustment programs implemented in accordance with the Affordable Care Act (ACA).

**XR019 — Calculation of Category 2 Managed Care Factor**

Category 2 in the managed care credit has a scaling factor determined by how significant the bonus / withhold payments are relative to the total claims subject to these programs. For example, if providers have been paid a 20% bonus on contracts subject to bonus, the managed care credit applicable is 20%.

3. **Evolution in Underwriting Risk Since Original Development of the H2 Risk Factor**

**Changes in Health Care Economics and Provider Systems**

There has been considerable evolution in health economics since HRBC was first developed in the 1990s. The most obvious is the significant rise in the size of the health care sector, which has grown by 6.8% annually over the last 25 years\(^2\), amounting to nearly a fourfold increase over that period. As part of that growth, there have been major regulatory and industry changes as well.

**Changes in Claims Distributions**

Among the many changes brought about by the ACA, is the distribution of claim cost risk. For instance, the elimination of annual and lifetime coverage limits, the elimination of medical underwriting, and the establishment of essential health benefits, while addressing issues from a public policy standpoint, have contributed to higher frequencies of high-cost individual claimants (often referred to as catastrophic claims).

Additionally, there has been significant progress made in modern medicine, both from a medical/surgical and prescription drug standpoint. These advanced procedures and drugs often serve a niche market and can command very high prices. For example, gene therapies driving $1

\(^2\) Center for Medicare and Medicaid Services (CMS) National Health Expenditure Data.
million or higher price tags have become more common, and that trend is likely to continue moving forward.

**Asymmetric Claims Risks**

The profitability distribution for insurance carriers is often asymmetrical due to the introduction of minimum loss ratios and other risk sharing arrangements across many lines of business. In favorable years, carriers are required to rebate premiums to policy holders or government entities, while in unfavorable years they might have to absorb losses.

**Provider Contracting Developments**

The nature of insurer / provider relationships has also evolved significantly over the past 25 years. While fee-for-service payments are still common, there has been a significant increase in risk arrangements, particularly for government lines of business.

Insurance carriers have continued to move providers toward risk-based contracts as providers’ risk tolerances have grown; frequently, this has led to improvement in member medical management and increasing insurer predictability of claims costs. Illustration 1 shows several new ways of contracting that are not currently contemplated in the formula.

**Illustration 1.**
Specific H2 Risk Considerations by Health Insurance Line of Business

Since the HRBC formula was developed, there have been significant changes in the lines of business that make up the health insurance industry. In addition to the introduction of the exchanges through the ACA, Medicare Advantage was implemented, and Medicaid Managed Care has become common for state Medicaid programs. Additionally, the LTC insurance market has changed materially as well.

Commercial Insured—Individual Market

The most significant event contributing to changes in underwriting risk in the individual market was the passage of the ACA in 2010 with the implementation largely phased in through calendar year 2014. Several changes affecting the individual health insurance underwriting risks include (not exhaustive):

- Elimination of annual and lifetime coverage limits
- Minimum medical loss ratio (MLR) requirement of 80%
- Pricing cycle requiring development and approval of rates well in advance of their implementation
- Increasingly robust rate review processes and provisions that influence the risk of adverse rate determinations and administrative actions (e.g., exchange exclusion)
- Elimination of pre-existing condition exclusions
- Revised and limited rating practices
- Risk mitigation programs (e.g., reinsurance, risk corridor, and risk adjustment mechanisms)

Commercial Insured—Small Group Market

Like the individual market, the commercial small group market was drastically altered by the ACA. Though similar changes were put in place (including the same minimum MLR requirement of 80%), it should be noted that usually the small group market is a separate risk pool from the individual market exhibiting its own risk characteristics.

Commercial Insured—Large Group Market and Self-Insured/Administrative Services

The ACA also affected commercial large group products, but to a lesser extent due to ERISA preemption of self-insured benefit programs. The minimum MLR requirement of 85% for large group insured coverage is somewhat more restrictive than the 80% minimums for individual and small group, reflective of the typically higher MLRs for large groups. Notably, there has been advancement in the type of medical insurance plans offered in the marketplace. At the time of original HRBC development, indemnity products were prevalent in the marketplace, with Health Maintenance Organization (HMO) plans offered by managed care organizations (MCOs). However, in the last 25 years, growth in preferred provider organizations (PPOs) and high-deductible health plans (HDHPs) have grown significantly. These products have different benefit
administration and provider payment characteristics than the indemnity products, which are far less prevalent today. For instance, per the Kaiser Family Foundation’s 2021 Employer Health Benefits Survey,³ the proportion of covered workers enrolled in conventional (e.g., indemnity) health plans decreased from 26% in 1996 to ~1% in 2021. During that same period, enrollment in HDHPs, which were not tracked until 2006, has grown to 28%.

In addition, due to potential administrative cost savings of self-insured services and increases in employer risk appetite, there has been a shift from large group fully insured policies (loosely defined as groups with >100 employees) to self-insurance and analogs (e.g., minimum premium arrangements). From a payer underwriting risk perspective, this has reduced the proportion of claims expense and associated risk attributed to large employer groups. However, a corollary to this secular trend has been the growth in employer stop-loss products that hedge the claims risk to these clients.

*Medicare*

Since the creation of the original HRBC formula, four of the largest drivers of change impacting Medicare health insurer underwriting risk have been (1) the growth of the Medicare Population, (2) the creation of Medicare Part C with the Balanced Budget Act of 1997, (3) the creation of Part D prescription drug benefits and the modification of the Medicare Advantage managed care program with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and (4) Medicare provisions included in the ACA.

Under the Medicare Part C and Part D programs, beneficiaries can enroll for medical and/or prescription drug coverage under a private-sector payer. In return, the payer receives prospective, risk-adjusted capitation payments and member premiums. Under the ACA, payer capitation payments are tied to operational and clinical quality through the Star quality rating system, and a minimum medical loss ratio requirement of 85% was instituted, capping favorable payer surplus gains.

The net effect of these drivers has been an increase in Medicare spending, growth in the amount of Medicare underwriting risk borne by health payers, and increased complexity in the underwriting risk, due to the nature of risk adjustment, and quality and minimum loss ratio requirements. As a point of comparison, in 1998 under the prior Medicare HMO program, Medicare enrollment through private-sector plans was approximately 6 million.⁴ In 2020, approximately 24 million beneficiaries were served by Medicare Advantage. Medicare Advantage-share of enrollment had grown from 24% in 2010 to approximately 42% in 2021.⁵

⁴ Squire, Daniel et al. *Group Insurance*, 7th Ed. Pg. 139.
⁵ Medicare Advantage in 2021: Enrollment Update and Key Trends | KFF
**Medicaid and CHIP**

Since the inception of the HRBC formula, there has been an overall expansion of the Medicaid program. In addition, there has been a shift to Medicaid Managed Care programs managed by private health payers, as opposed to state-based fee-for-service programs. Two drivers of change impacting health insurer underwriting risk have been (1) the enactment of Title XXI of the Social Security Act, which created the State Children’s Health Insurance Program (CHIP), and (2) Medicaid enrollment expansions provided for in the ACA. As of 2019, 54.2% of all Medicaid expenditures were managed care and provider capitation payments.

Each state is unique in their requirements for Medicaid Managed Care products (i.e., risk adjustment protocols, minimum medical loss ratios, risk corridors, etc.). While a state is not required to establish a minimum medical loss ratio minimum medical loss ratio for Medicaid MCOs, CMS requires that (i) each contract calculate and report its medical loss ratio and (ii) for any state that does establish a minimum medical loss ratio, that the minimum may not be less than 85%.

**Long-Term Care (LTC) Insurance**

There are several characteristics of the LTC insurance market that have evolved since the product’s inception that affect its underwriting risk profile.

When LTC insurance was initially developed, there was little to no applicable experience to use to price the product. As experience developed, the accuracy of the pricing has improved. This has led to three market segments: original (oldest generation) products that are the most underpriced, a middle generation with improved pricing, and a newer generation based on more credible experience leading to more appropriate pricing. The accuracy of the pricing, or lack thereof, impacts the level of rate increases being requested by the insurers, with the older blocks of business typically needing higher rate increases than the newer blocks.

With some exceptions, most insurers are managing closed blocks of business. There are challenges to managing the rates on closed blocks, particularly on the older and smaller blocks. On blocks that are smaller and older, even very large rate increases will generally have little to no impact to the financials of the insurer.

Large, actuarily justified rate increases are typically not being approved by the regulators, and in some cases, not being requested by insurers, due to concern for the impact on the consumer. This is a key difference between LTC insurance repricing and other health blocks. With other health blocks, there typically is not a large discrepancy between actuarially justified, requested, and approved rate increases, as is seen with LTC insurance. Also, because rate increases have been consistently occurring, there may be “rate-increase fatigue” on the part of regulators – leading to potentially fewer or less approvals of rate increases.

Other characteristics and developments in the LTC insurance market that affect the risk profile are the following:
More credible data now exists for mortality and morbidity assumptions, used in rate increase and cash flow testing projections.

The persistent low interest rate environment suppresses investment income.

Possible increased litigation against insurers and reputational risk due to rate actions.

Existence of LTC insurance hybrid products that have a different risk profile than stand-alone LTC insurance products.

Actuarial Guideline (AG)-51—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves.

These developments in the market affect the amount of risk that an insurer bears and may impact the fit-for-purpose of the current RBC H2 framework. Insurers will have different risk profiles that are dependent on the age of the business, the adequacy of rates, and the ability to receive future rate increases, none of which are fully addressed in the current framework.

4. Alternative Views of Underwriting Risk

There are a number of other capital evaluation/requirement frameworks that consider underwriting risk. Based on the subcommittee’s review, several of these frameworks utilize risk quantification measures that would be valuable to consider as part of the health underwriting risk formula. The frameworks we found most instructive were Best’s Capital Adequacy Relativity (BCAR), P&C RBC, Solvency II, and DMHC Tangible Net Equity (TNE) requirements.

BCAR

There are two main components of risk charges for underwriting risk within BCAR—net earned premium risk and reserve risk. The following summaries are based largely on descriptions of the BCAR methodology provided by AM Best.

Net Earned Premium Risk

The net premiums risk is related to risk of underwriting losses on a book of business written in the next year. AM Best created an industry database of profit and losses for each line of business, using each insurer’s historical underwriting profit or loss based on the actual reported results. The industry database was then split based on the size of the net premiums written for that line of business, and statistical methods were applied to create distributions of profit and loss ratios.

The following blocks of business are evaluated separately:

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6 California Department of Managed Health Care
When calculating company-specific capital requirements, the industry factors can be adjusted based on the rating unit’s own historical profitability. Implicitly, this assumes that historical underwriting performance is correlated with future underwriting performance. The company-specific factors are based on the most recent three years of profitability and can adjust the base factors by as much as 20% (positively or negatively). Like the H2 component of the health RBC formula, the rating unit’s current year written premium is used in the model as a proxy for the premium to be written next year. Using this assumption, the company-specific factors are applied to current year premium to calculate the capital requirement.

Reserving Risk

Unlike health RBC, BCAR includes a reserving risk component as part of underwriting risk. The applied risk charges are intended to cover the possibility of negative reserve development due to adverse claims experience. Like premium risk, AM Best’s reserve risk factors are based on an industry database of each company’s reserve adequacy generated from the annual statements by line of business and a company’s specific experience can adjust the base factor by as much as 20%. The BCAR formula utilizes the following reporting segments to develop reserving risk factors.
Diversification Credit

AM Best calculates diversification factors using correlation matrices based on industry-aggregated data across lines of business—for both premium risk and reserving risk. This intent behind the calculation is that often underwriting profits and losses in one line of business might offset underwriting profits and losses in another line of business. Similar to written premium, because reserves are largely set based on line of business, adverse or favorable reserve development for one line of business might offset development for another line of business.

Managed Care Credit

The managed care credit within the BCAR formula reflects the reduction in the overall premium risk charge for companies with managed care arrangements that reduce uncertainty regarding future claim payments.

This credit is reduced for the risk that the MCO will pay the capitation to a provider but not receive the agreed-upon services and will encounter unexpected expenses in arranging for alternative coverage, essentially introducing a credit risk that a provider might default on its obligations. This credit risk charge is based on the contractual relationship between the MCO and a provider. Higher credit risk charges apply to capitation payments made to unaffiliated or third-party care providers than to capitation payments made to affiliated care providers.

P&C RBC

Similar to BCAR, P&C underwriting risk is broken into two components in the P&C RBC formula: reserves and net written premiums.

Reserve Risk

The reserve risk RBC is developed by multiplying a set of RBC factors, which are discounted for investment income and adjusted for each individual company’s own relative experience of its net reserves for each line of business. The reserve risk is also adjusted downward with a credit for diversification among the lines of business.

The major lines of business largely correspond to the breakdowns in the annual statement (e.g., the Underwriting and Investment Exhibit). Calculations for some, generally smaller, lines are combined.

Net Written Premium

The net written premium component is developed by multiplying a risk factor (based on an analysis historical industry-wide underwriting performance at the 87.5th percentile) by the current year’s net written premiums, by line of business. The actual risk charge is based on the excess of a discounted combined ratio adjusted for investment income over 100%. As with the reserve risk factors, individual company experience is also considered in computing the RBC factor.
Solvency II

Solvency II divides health insurance into Similar to Life Techniques (SLT) and Non-Similar to Life Techniques (Non-SLT)—the distinction based on how products are priced. Products like long-term care insurance and individual disability income insurance would likely be examples of SLT Health, while typical medical products would be examples of Non-SLT Health.

The nature of how the Solvency II capital requirement is constructed is very different between SLT Health and Non-SLT Health. Solvency II discusses three main risks for Non-SLT Health:

1. Premium Risk
2. Reserve Risk
3. Catastrophe (CAT) risk

The time horizon for Solvency II is one year. In keeping with that, the definition of premium risk relates to both unexpired risks on existing contracts and policies to be written/renewed during the coming year. As a result, the inputs into the Solvency II calculation are prospective in nature, rather than retrospective in nature like current HRBC. The issuer is expected to estimate not just its expected premiums for the coming year from the unexpired term on existing contracts, but also its expected premiums for the coming year on both new and renewal business. Keeping with the one-year time horizon, the focus is on the risk of loss within the coming year and not on the risk of cumulative losses over a longer time frame.

DMHC Tangible Net Equity (TNE)

The DMHC\textsuperscript{7} maintains a simple capital requirement driven by underwriting risk. Full-service health plans must maintain a TNE of at least:

1. $1 million; or
2. the sum of two percent (2%) of the first $150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $150 million; or
3. an amount equal to the sum of:
   (A) eight percent (8%) of the first $150 million of annualized health care expenditures except those paid on a capitated basis or managed hospital payment basis; plus
   (B) four percent (4%) of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus
   (C) four percent (4%) of annualized hospital expenditures paid on a managed hospital payment basis.

This approach of excluding capitated payments demonstrates one potential approach for the managed care credit. It is worth noting that risk-bearing organizations (i.e., those that accept capitation) are regulated by the DMHC and themselves must meet minimum capital requirements, and requirements for risk-bearing organizations vary considerably from state-to-state.

\textsuperscript{7} Cal. Code Regs. Title 28, §1300.76 - Plan Tangible Net Equity Requirement.
5. Options for Better Aligning H2 Risk Factors to Economic Risk

Based on the subcommittee’s review of the current H2 risk factors, the evolution of health insurance underwriting risk since those risk factors were originally contemplated, and the alternative approaches utilized by other regulating entities, we recommend further study and potential implementation of, the following changes to the H2 underwriting risk factors.

1. Refresh factors based on updated insurer data
2. Develop factors at a more granular product level
3. Develop factors specific to more relevant block sizes and consider an indexing factor for cut points to change over time
4. Model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly
5. Refresh of managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches
6. Analyze long-term care insurance underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time

Refresh factors based on updated insurer data

Because the underwriting risks taken by health insurers has changed significantly since many of the H2 underwriting risk factors were adopted, we recommend utilizing updated data to understand the current risk profile of health insurers. This could be achieved utilizing underwriting performance and volatility over the past 10 years—between 2011 and 2020—to consider pre-ACA, post-ACA and pandemic years to create new risk factors.

Develop factors at a more granular product level

Because many health products carry a range of underwriting risk—even within comprehensive medical coverage—a more detailed product view can be utilized to create new risk factors. For example, Commercial Group and Individual products are currently both included within the Comprehensive Medical column but have significantly different levels of volatility and associated financial risk.

This recommendation could be accomplished in the immediate term by utilizing reporting data from Page 7—Analysis of Operations by Line of Business. Over time, factors should be developed even more granularly. This can be accomplished by utilizing the Accident and Health Policy Experience Exhibit but would either require a change to when that filing would be submitted or via company records within the RBC filing.

Develop factors specific to more relevant block sizes and consider an indexing factor for cut points to change over time

As blocks grow, underlying volatility declines given the law of large numbers, but the relevant cut points to reflect that decline in volatility are likely well above what is currently utilized within the Underwriting Risk formula (e.g., $3M, $25M). Given the high prevalence of claimants
reaching costs well in excess of anything contemplated 20 years ago, these cut points should be revised to reflect more relevant block sizes and shifts in volatility.

Model risk factors over an NAIC-defined prospective time horizon with a defined safety level that can be refreshed regularly

Because risk factors are applied to historical claims to calculate capital buffers for losses against future premiums, the updated risk factor analysis should analyze prospective future losses over a defined time horizon. There are a range of defensible time horizons and safety levels that could be utilized within the risk factor modeling. While a one-year time horizon is most common, multiyear horizons could arguably better reflect the underwriting cycle. A range of safety levels could also be reasonably justified. Ultimately, these two modeling elements require regulatory discretion but should be well-defined and generally consistent over time to enable business management.

Refresh of managed care credit formula and factors to be more relevant and reflective of common contracting approaches and other risk factors associated with these contracting approaches

Because many of the common provider contracting mechanisms that existed when the factors were originally created are no longer widely used, an update to the managed care credit would better account for approaches like gain sharing and bundled payments. Additionally, the subcommittee encourage revisiting the bonus calculation for Category 2 claims in light of typical bonus levels available to providers and whether those bonuses have reduced underwriting volatility for health plans.

Analyze long-term care insurance underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time

Because the underwriting environment for LTC insurance policies has undergone multiple somewhat discrete phases, it would likely be appropriate to evaluate LTC insurance underwriting risk charges according to the groups of policy issue years (e.g., before 2000, between 2000 and 2010, after 2010).

6. Potential Next Steps for Working Group Consideration

As a next step, the Subcommittee recommends first focusing on developing new factors on XR013 and XR018/XR019 consistent with recommendations 1 - 6 above. This would involve collecting historical statutory financial data from the analysis of operations by lines of business as well as Exhibit 7 Part 1—Summary of Transactions with Providers. Then, a data analysis exercise would be required to develop risk factors at a range of safety levels for the working group’s consideration.

Following that analysis, other underwriting risk factors (e.g., those on XR015 and XR016) could be evaluated utilizing the working group-approved approach—likely with special consideration for LTC insurance.
Thank you for the opportunity to provide this report in response to the request of the working group to provide analysis to perform a comprehensive review of the H2—Underwriting Risk component and the managed care credit calculation within the health RBC formula. We welcome the opportunity to speak with you in more detail and answer any questions you might have regarding this report. If you would like to discuss anything pertaining to this report and its recommendations, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org to make arrangements.

Sincerely,
Derek Skoog, MAAA, FSA
Chairperson
Health Solvency Subcommittee
American Academy of Actuaries

CC: Crystal Brown
Senior Insurance Reporting Analyst
cbrown@naic.org
Capital Adequacy (E) Task Force

RBC Proposal Form

[  ] Catastrophe Risk (E) Subgroup  [  ] Investment RBC (E) Working Group  [  ] SMI RBC (E) Subgroup
[  ] C3 Phase II/ AG43 (E/A) Subgroup  [  ] P/C RBC (E) Working Group  [  ] Stress Testing (E) Subgroup

DATE: 10/25/2021

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FOR NAIC USE ONLY
Agenda Item # 2021-18-H
Year 2022

DISPOSITION
[  ] ADOPTED
[  ] REJECTED
[  ] DEFERRED TO
[  ] REFERRED TO OTHER NAIC GROUP
[ x ] EXPOSED Dec. 3, 2021
[  ] OTHER (SPECIFY)

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED
[  ] Health RBC Blanks  [ x ] Health RBC Instructions  [  ] Other ________________
[  ] Life and Fraternal RBC Blanks  [  ] Life and Fraternal RBC Instructions
[  ] Property/Casualty RBC Blanks  [  ] Property/Casualty RBC Instructions

DESCRIPTION OF CHANGE(S)
Incorporate benchmarking guidelines for the Working Group to follow in updating the investment income adjustment in the underwriting risk factors for Comprehensive Medical, Medicare Supplement and Dental & Vision.

REASON OR JUSTIFICATION FOR CHANGE **
The reason for the change is to clearly identify the frequency and parameters to use in adjusting the underwriting risk factors for investment income in the Comprehensive Medical, Medicare Supplement and Dental & Vision lines.

Additional Staff Comments:
11-4-21 cgb The WG exposed for 30-day public comment period ending on Dec. 3, 2021.
12-16-21 cgb One comment letter received.
12-16-21 cgb The Working Group adopted the proposal.

** This section must be completed on all forms. Revised 11-2013
UNDERWRITING RISK - L(1) THROUGH L(21)
XR013

Detail Eliminated to Conserve Space

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>$0 – $3</th>
<th>$3 – $25</th>
<th>Over $25</th>
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<tbody>
<tr>
<td>Comprehensive Medical &amp; Hospital</td>
<td>0.1493</td>
<td>0.1493</td>
<td>0.0893</td>
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<td>Medicare Supplement</td>
<td>0.1043</td>
<td>0.0663</td>
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<tr>
<td>Dental &amp; Vision</td>
<td>0.1195</td>
<td>0.0755</td>
<td>0.0755</td>
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<td>Stand-Alone Medicare Part D Coverage</td>
<td>0.251</td>
<td>0.251</td>
<td>0.151</td>
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<tr>
<td>Other Health</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
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<tr>
<td>Other Non-Health</td>
<td>0.130</td>
<td>0.130</td>
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</table>

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will evaluate the yield of the 6-month Treasury Bond as of January 1st and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).

Detail Eliminated to Conserve Space

Alternative Language:

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will evaluate the yield of the 6-month Treasury Bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.
Health Risk-Based Capital (E) Working Group
Virtual Meeting
December 16, 2021

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 16, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Wanchin Chou (CT); Tish Becker (KS); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges and Matthew Richard (TX).


Mr. Drutz said the Working Group adopted a previous proposal to incorporate a 0.5% investment income adjustment in the underwriting risk factors and agreed to draft guidance and benchmarks for updating the adjustment on an annual basis. These benchmarking guidelines were exposed under proposal 2021-18-H for a 30-day public comment period. The Working Group received one comment letter from UnitedHealth Group (UHG).

Jim Braue (UHG) summarized the comment letter (Attachment Three-C1). He said the letter addressed two key points: the maturity assumption and the reference period. He said UHG believes the assumption period of six months is still very conservative because even fairly conservative assumptions of business runoff would produce a rate of somewhere in the one- to two-year range. He said UHG understands the concern about consistency with rate filings; however, this is a company-specific issue that would have to be addressed through the filings process, and risk-based capital (RBC) must be based on broad assumptions. He said the proposed rounding adjustment could alleviate some of the difference; however, depending on the slope of the yield curve, using a six-month rate with that rounding adjustment could still produce something that is either too low or too high.

Mr. Braue said the second key point of the UHG letter relates to the reference period and the proposed wording that the Working Group will evaluate the yield as of Jan. 1 each year. He said taken literally, that would mean using the rate as of Jan. 1, and fixed income markets will typically be closed and a rate will normally not be published. He also noted that using a single day is probably not optimal because there could be some anomalous results due to a news report that came out the day before that could result in a dramatic change to the rate one day and recover the next. He suggested using a short period, such as the first 10 business days of the year.

Mr. Drutz said the current language states that the Working Group will evaluate the yield as of Jan. 1 each year. He said taken literally, that would mean using the rate as of Jan. 1, and fixed income markets will typically be closed and a rate will normally not be published. He also noted that using a single day is probably not optimal because there could be some anomalous results due to a news report that came out the day before that could result in a dramatic change to the rate one day and recover the next. He suggested using a short period, such as the first 10 business days of the year.

Mr. Chou made a motion, seconded by Ms. Rankin, to adopt proposal 2021-18-H (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Three-B3). The motion passed unanimously.

2. Exposed Health Test Language Proposal

Mr. Drutz said the Health Test Ad Hoc Group draft recommended changes to the health test language (Attachment Three-C2) within the Annual Statement Instructions. Revisions included: 1) references in the health General Interrogatories; 2) a sentence regarding separate accounts in the life health test language; 3) deleted the requirements for licensed and actively writing in five states or less, 75% of the current premiums are written in the domiciliary state, and the “or” statement for the premium and reserve ratio equal to 100% in both the life and property/casualty (P/C) health test language; 4) updates to the reference pulls in the life General Interrogatories from the Life RBC to the Analysis of Operations by Lines of Business – Accident and Health; and 5) updates to the reference pulls in the P/C General Interrogatories from the P/C RBC to the Underwriting and Investment Exhibit,
Part 1B in the current year column. Mr. Drutz noted that the references in the life General Interrogatories could be further refined if the health test language is adopted by the Blanks (E) Working Group. He also noted that the prior year column in the P/C General Interrogatories will be updated in subsequent years, as the changes for the Underwriting and Investment Exhibit, Part 1B are only effective beginning in 2022.

Mr. Drutz said the Health Test Ad Hoc Group will continue to discuss and evaluate if there will be further recommendations to the premium and reserve ratios; however, these recommendations will be considered on a separate proposal for 2023 or later.

Hearing no objections, the Working Group agreed to expose the health test language proposal for a 40-day public comment period ending Jan. 24. The exposure will be distributed to both the Health Risk-Based Capital (E) Working Group and the Life Risk-Based Capital (E) Working Group.

3. **Discussed Other Matters**

Mr. Drutz said the Financial Condition (E) Committee approved the formation of the Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group at its Dec. 13 meeting. Philip Barlow (DC) will chair the Working Group. The Capital Adequacy (E) Task Force will meet Dec. 20 to review the charges and responsibilities of the Working Group. Interested members should contact Jane Barr (NAIC) for either membership or interested regulator participation.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
November 30, 2021

Mr. Steven Drutz, Chair
Health Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO  64106-2197

Via electronic mail to Crystal Brown.

Re:  Proposal 2021-18-H.

Dear Mr. Drutz:

I am writing on behalf of UnitedHealth Group in regard to Proposal 2021-18-H, as exposed for comment on 11/4/21.  As we have stated in previous comment letters, we are supportive of investment income being reflected in the Health Risk-Based Capital formula, and we appreciate the work that your Working Group has done to implement that concept.

Proposal 2021-18-H bases the investment income adjustment on “the yield of the 6-month Treasury bond as of January 1st each year.”  We will comment on two aspects of this proposal: the 6-month maturity assumption and the January 1 reference period.

Six-month maturity assumption.

As explained in our comment letters of 1/6/21 and 4/16/21, we believe that a longer maturity assumption than 6 months is warranted.  In particular, we have suggested that a 5-year maturity assumption would be reasonable, given that the bond risk factors were based on an assumed 5-year maturity.  The same portfolio that generates the bond risk is also generating the investment income that is being reflected in the underwriting risk factors.

Two objections have been raised to using a 5-year maturity: a concern about asset/liability mismatch; and a concern about consistency with premium rate filings.  We will address both concerns below.

1. Asset/liability mismatch.

Considerable emphasis has been placed on the fact that most claims are paid within a few months of when they were incurred.  The analysis that the American Academy of Actuaries
performed to determine the investment income adjustment indicated that the average lag until payment for a comprehensive medical claim is less than two months. However, as we noted in our 1/6/21 letter, the run-out period of a single incurral date’s claims is not really relevant from an investment standpoint. As a going concern, a health entity does not repeatedly run its assets down to zero as claims are paid; there is a continual inflow of cash from premiums and other revenues, and investments are held for a longer term. Generally speaking, investment maturities would not be needed for as long as the entity’s business is stable or growing, except in cases where cash outflows exceeded cash inflows because of abnormally high levels of claims or other expenses.

Over what period might we assume that an entity’s volume of business will remain stable? For purposes related to the underwriting risk charges, we can look at what the Academy assumed in developing those charges. In the December 1994 report (as revised) of the Academy’s Health Organizations Risk Based Capital Task Force to the NAIC’s Health Organizations Risk-Based Capital Working Group, the Academy explained the following about the model used in determining the underwriting risk charges:

The purpose of this model is to simulate the financial results of a block of business over a five year period. … The block of business that is simulated is assumed to represent a stationary population. This means that as old business lapses, new business is written, and the characteristics of the inforce remains steady over time.

This, by itself, would suggest that a five-year investment maturity is indeed consistent with the assumptions underlying the development of the underwriting risk factors. It might be legitimately objected that, while the Academy may have evaluated risk assuming five years of steady volume, the modeled entity would not necessarily have made that same assumption in its investment strategy. That is true, but likewise the entity would not necessarily assume the imminent termination of all of its business. The use of a six-month maturity assumption could mean, as an example, that the entity expected more than 50% of its business to be terminated immediately, and the remainder to be terminated in one year. (The percentage is “more than” 50% because the run-off of the claims would add, as noted above, something more than a month to the average maturity.) While some entities, with concerns about the stability of their business, might make such an assumption, it does not seem like a reasonable assumption for the broad majority of entities covered by the Health RBC formula.

During a previous discussion, one regulator pointed out that, while immediate termination of most or all of an entity’s business might not be a reasonable assumption, in some markets a 30% termination rate would be quite reasonable. Consider that, if 30% of an entity’s business terminated immediately (net to any new business added), and another 30% of the remaining business terminated at the beginning of each subsequent year, on average the business would be on the books for about 2.3 years. If we wanted to be more conservative than to assume that the 30% annual termination continued indefinitely, and instead assumed that all remaining business would terminate at the end of the third year, the average life of the business would still be more than 1.5 years. Because that number represents an average, and because the yield curve is currently convex upwards, the resulting interest rate might
correspond to a maturity somewhat less than 1.5 years, but still more than one year. To reduce that rate further, to represent a six-month maturity, seems overly conservative.

Another potential objection is that the RBC formula does in fact assume that there will be losses, and that therefore cash outflows might indeed be assumed to exceed cash inflows, resulting in a need for shorter maturities. However, two things should be considered: first, that the underwriting risk charges (approximating the excess outflows) will in most cases be less than the claim reserves; and second, that the underwriting risk charges represent a cumulative loss over five years, which would not necessarily all need to be funded in the first year or two. Therefore, the capital that covers the excess outflows would not necessarily be invested to a shorter horizon than the claim reserves themselves, and accordingly would not significantly impact the average maturity of the investment portfolio.

In summary, even rather conservative assumptions about business volume would lead to an assumed maturity in the range of one to two years. Less conservative assumptions could easily justify a maturity above two years, since, for example, an entity experiencing a 30% loss of business might adjust its pricing and/or marketing to reduce further losses, rather than allow the 30% to continue or worsen.

2. Consistency with premium rate filings.

Regulators have raised the concern that the assumption of any non-trivial amount of investment income would be inconsistent with the assumptions that they have seen in premium rate filings, where, they state, investment income is typically dismissed as being immaterial. First, we must note that there may legitimately be differences between what is assumed for RBC purposes and what is assumed for rate filings, because of, for instance, differing standards of materiality.

However, even if we suppose that the same assumption should be used for both purposes, it does not follow that the rate filings should be driving the RBC outcome. RBC should be based on the best available data and reasoning. If those data and rationales seem at odds with what is being assumed elsewhere, it is those other assumptions that should be considered suspect.

Further, we point out that the RBC formula is applied to a broad population of health entities, whereas rate filings are entity-specific. If a regulator is concerned about whether an entity has appropriately reflected investment income in its rate filing, that entity can be required to provide further justification for its assumptions. RBC, on the other hand, must be appropriate for a wide variety of circumstances, and there is a practical limitation on how much it can be tailored to individual entities.

In summary, it does not seem appropriate to base RBC assumptions on what is depicted in premium rate filings.

We recognize that the proposal to round the investment income rate up to the next higher multiple of 0.5% was intended, at least in part, to effectively lengthen the maturity assumption.
However, while a fix of that sort might produce a reasonable result at a given point in time, it is unlikely to work properly in the long term. When the yield curve has a steep positive slope, the adjustment will be inadequate. When the yield curve is flat or, especially, inverted, the adjustment will be excessive. To avoid such outcomes, the maturity assumption should be set appropriately, and a lesser degree of rounding should be used.

In regard to that rounding convention, we will also note that the proposal states, “Any adjustments will be rounded up to the nearest 0.5%.” We suggest that, to avoid confusion, the sentence should begin, “The investment income yield will be rounded …” The word “adjustment” might be construed to mean the change in the underwriting risk factor, rather than the yield assumption underlying that change.

January 1 reference period.

Proposal 2021-18-H provides, “The Working Group will evaluate the yield of the 6-month Treasury bond as of January 1st each year …” We have some concerns regarding the phrase “as of January 1st.” To begin with, the fixed income markets typically will not be open on January 1, and many rate sources (e.g., the U.S Treasury department’s Daily Treasury Yield Curve Rates) will not supply a value for that date, leaving open to question what value should be used. More importantly, it may be inadvisable to use any single date as the basis for the yield determination, because the rate on a single date may be anomalous, e.g., because of overreactions to certain news items. It would be better to use the average yield over a somewhat longer period, such as the first ten business days of the year, or even the first month of the year. This would tend to minimize the impact of any one anomalous rate, while still allowing the determination to be made early in the calendar year.

* * * * *

We would be happy to discuss these comments with you and the Working Group.

James R. Braue
Director, Actuarial Services
UnitedHealth Group

cc: Crystal Brown, NAIC
    Randi Reichel, UnitedHealth Group
**NAIC BLANKS (E) WORKING GROUP**

**Blanks Agenda Item Submission Form**

<table>
<thead>
<tr>
<th>DATE: 11-3-21</th>
<th>FOR NAIC USE ONLY</th>
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<tbody>
<tr>
<td>CONTACT PERSON: Crystal Brown</td>
<td>Agenda Item #</td>
</tr>
<tr>
<td>TELEPHONE: 816-783-8146</td>
<td>Year 2022</td>
</tr>
<tr>
<td>EMAIL ADDRESS: <a href="mailto:cbrown@naic.org">cbrown@naic.org</a></td>
<td>Changes to Existing Reporting [ ]</td>
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<tr>
<td>ON BEHALF OF: Health Risk-Based Capital (E) WG</td>
<td>New Reporting Requirement [ ]</td>
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<tr>
<td>NAME: Steve Drutz</td>
<td>REVIEWED FOR ACCOUNTING</td>
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<tr>
<td>TITLE: Chair</td>
<td>PRACTICES AND PROCEDURES IMPACT</td>
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<td>AFFILIATION: WA Office of the Insurance Commissioner</td>
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<td>ADDRESS:</td>
<td>Modifies Required Disclosure [ ]</td>
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**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [x] INSTRUCTIONS
- [x] BLANK
- [x] Life, Accident & Health/Fraternal
- [x] Property/Casualty
- [x] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)

Anticipated Effective Date:

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Revise the Health Annual Statement Test language

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the change is to move those filers who write predominantly health business and file on the life blank to begin filing on the health blank.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date:

Other Comments:
The Health Test Ad Hoc Group of the Health Risk-Based Capital (E) Working Group continues to discuss and review any potential modifications to premium and reserve ratios. The group will continue to evaluate if there should be changes and if so, will propose this to the Blanks (E) Working Group in a separate proposal for consideration in future years.

The references to the Life & Property & Casualty General Interrogatories were changed from pulling from RBC to instead pull from the Analysis of Operations By Lines of Business – Accident and Health and Underwriting & Investment Exhibit, Part 1B, respectively. The life General Interrogatory references will be further updated if proposal 2021-17BWG is adopted.

**This section must be completed on all forms.**

Revised 7/18/2018
Health

GENERAL

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity completes the health annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if the values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

Failing the Test:

If a reporting entity, licensed as a life, accident and health or property and casualty insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it will revert to the annual statement form and risk-based capital report associated with the type of license held in its domestic state in the first quarter of the second year following the reporting year. If a reporting entity, licensed as a health insurer in its domiciliary state, is required to file the health annual statement for the reporting year and does not pass the Health Statement Test in the reporting year, it should continue to file the health annual statement.

Variance from following these instructions:

If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

General Interrogatories

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Premium Numerator</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1, Column 1 through Column 9 (in part for credit A&amp;H and dread disease coverage, LTC, Disability Income), Column 10 of the reporting year’s annual statement.</td>
<td>Health Premium values listed in the Analysis of Operations by Line of Business (Gain and Loss Exhibit), Line 1, Column 1 through Column 9 (in part for credit A&amp;H and dread disease coverage, LTC, Disability Income) Column 10 of the reporting year’s annual statement.</td>
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<td>2.2</td>
<td>Premium Denominator</td>
<td>Net Premium IncomePremium and Annuity Considerations (Page 4, Line 2, Column 2) of the reporting year’s annual statement.</td>
<td>Premium and Annuity ConsiderationsNet Premium Income (Page 4, Line 2, Column 2) of the prior year’s annual statement.</td>
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<td>2.3</td>
<td>Premium Ratio</td>
<td>2.1/2.2</td>
<td>2.1/2.2</td>
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<tr>
<td>2.4 (a)</td>
<td>Reserve Numerator</td>
<td>Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&amp;H + Part 2D (Line 8, Column 1 minus Column 9) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&amp;H, LTC, Disability Income, etc. of the reporting year’s annual statement.</td>
<td>Health Reserve – Underwriting and Investment Exhibit, Part 2B (Column 3 + 4, Line 13 minus Line 11) exclude Line 10 health care receivables, dread disease coverage, and credit A&amp;H + Part 2D (Line 8, Column 1 minus Column 9) include stand-alone health care related plans only (i.e. stand-alone prescription drug plans, etc.), exclude dread disease coverage, credit A&amp;H, LTC, Disability Income, etc. of the reporting year’s annual statement.</td>
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<td>2.5</td>
<td>Reserve Denominator</td>
<td>Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the reporting year’s annual statement.</td>
<td>Claims Unpaid and Aggregate Reserves (Page 3, Column 3, Lines 1 + 2 + 4 + 7) of the prior year’s annual statement.</td>
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<td>2.6</td>
<td>Reserve Ratio</td>
<td>2.4/2.5</td>
<td>2.4/2.5</td>
</tr>
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(a) Alternative Reserve Numerator – Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).

**Life, Accident and Health /Fraternal**

**Health Test**

**GENERAL**

The annual statement is to be completed in accordance with the *Annual Statement Instructions* and *Accounting Practices and Procedures Manual* except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the life, accident and health annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. **Health Statement Test:**

   If a reporting entity is licensed as a life and health insurer and completes the life, accident and health annual statement for the reporting year, the reporting entity must complete the Health Statement Test. However, a reporting entity that is required to also file the Separate Accounts Statement is not subject to the results of the Health Statement Test, and should continue to complete the life, accident and health/fraternal blank.

   The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

   **Passing the Test:**

   A reporting entity is deemed to have passed the Health Statement Test if:
The values for the **premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.**

**AND**

The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

**AND**

At least seventy-five percent (75%) of the entity’s current year premiums are written in its domiciliary state.

**OR**

The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

If a reporting entity is a) licensed as a life and health insurer; b) completes the Life, Accident and Health annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the life supplements for that year-end.

**Variances from following these instructions:**

If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**General Interrogatories**

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

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<thead>
<tr>
<th>Item</th>
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<tr>
<td>2.1</td>
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<td>Health Premium values listed in the statement value column (Column 1) of the reporting year’s Life RBC report</td>
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<td>Stop Loss and Minimum Premium</td>
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<td>Federal Employee Health and Benefit Plan</td>
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<td>2.2</td>
<td>Premium Denominator</td>
<td>Premium and Annuity Considerations (Page 4, Line 1) of the reporting year’s annual statement</td>
<td>Premium and Annuity Considerations (Page 4, Line 1) of the prior year’s annual statement</td>
</tr>
</tbody>
</table>
Property/Casualty

Health Test

GENERAL

The annual statement is to be completed in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual except to the extent that state law, rules or regulations are in conflict with these publications. In cases of conflict, the property and casualty annual statement will be filed pursuant to such state’s filing requirements. The domiciliary state’s insurance regulatory authority shall maintain full discretion in determining which NAIC annual statement blank must be filed. The annual statement blank filed with the domiciliary state shall be the blank submitted to, and maintained by, the NAIC, and barring conflict as described above, should be filed with all jurisdictions in which the reporting entity is licensed.

1. Health Statement Test:

If a reporting entity is licensed as a property and casualty insurer and completes the property and casualty annual statement for the reporting year, the reporting entity must complete the Health Statement Test.

The Health Statement Test is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers’ compensation, accidental death and dismemberment policies and long-term care policies.

Passing the Test:

A reporting entity is deemed to have passed the Health Statement Test if:

The values for the premium and reserve ratios in the Health Statement Test equal or exceed 95% for both the reporting and prior year.

AND

The entity passing Health Statement Test is licensed and actively issuing and/or renewing business in five states or less.

AND

At least seventy-five percent (75%) of the entity’s current year premiums are written in its domiciliary state.

OR

The values for the premium and reserve ratios in the Health Statement Test equal 100% for both the reporting and prior year, regardless of the number of states in which the entity is licensed.

If a reporting entity is a) licensed as a property and casualty insurer; b) completes the property and casualty annual statement for the reporting year; and c) passes the Health Statement Test (as described above), the reporting entity must complete the health statement beginning with the first quarter’s statement for the second year following the reporting year in which the reporting entity passes the Health Statement Test and must also file the corresponding risk-based capital report and the property/casualty supplements for that year-end.

Variances from following these instructions:
If a reporting entity’s domestic regulator requires the reporting entity to complete an annual statement form and risk-based capital report that differs from these instructions, the domestic regulator shall notify the reporting entity in writing by June 1 of the year following the reporting year in which a Health Statement Test is submitted.

**General Interrogatories**

2. This General Interrogatory is designed to determine whether a reporting entity reports predominantly health lines of business. Health lines include hospital or medical policies or certificates, comprehensive major medical expense insurance and managed care contracts and exclude other health coverage such as credit insurance, disability income coverage, automobile medical coverage, workers compensation, accidental death and dismemberment policies and long-term care policies.

All reporting entities should file the test.

Premium and reserve information is obtained from the annual statement sources referenced on the form or from the related risk-based capital report for the corresponding premium descriptions relating to the current and prior reporting periods.

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<thead>
<tr>
<th>Item</th>
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<th>Reporting Year Annual Statement Data</th>
<th>Prior Year Annual Statement Data</th>
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<td>Health Premium values as listed in the statement value column (Column 1) of the prior year’s P&amp;C RBC report:</td>
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<td>Individual Lines:</td>
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<td>Usual and Customary Major Medical and Hospital Comprehensive (hospital and medical) (individual and group) (Lines 13.1 and 13.2)</td>
<td>Usual and Customary Major Medical and Hospital Medicare Supplement (Line 15.4)</td>
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<td>Part 2A, Unpaid Losses and Loss Adjustment Expenses (Columns 8+9, Lines 13+15) plus Part 1A, Recapitulation of all Premiums (Columns 1+2, Lines 13+15) of the prior year’s annual statement.</td>
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<td>2.5</td>
<td>Reserve Denominator</td>
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<td>Unpaid Loss and LAE (Page 3, Column 1, Lines 1+2+3) plus Part 1A, Recapitulation of all Premiums (Line 35, Columns 1+2) of the prior year’s annual statement.</td>
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<td>Reserve Ratio</td>
<td>2.4/2.5</td>
<td>2.4/2.5</td>
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(a) Alternative Reserve Numerator – Company records may be used to adjust the reserve numerator to provide consistency between the values reported in the reserve numerator (2.4) and the premium numerator (2.1).
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 23, 2022. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Derek Wallman (NE); Kevin Clarkson (NJ); Bill Carmello and Amanda Fenwick (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted its March 10, 2022; Jan. 10, 2022; Dec. 16, 2021; and 2021 Fall National Meeting Minutes

The Working Group met March 10, 2022; Jan. 20, 2022; and Dec. 16, 2021. During these meetings, the Working Group took the following action: 1) discussed the American Academy of Actuaries’ (Academy’s) recommendation on mortality; 2) exposed the changes to the asset valuation reserve (AVR) for a public comment period ending March 25; 3) discussed the Academy’s comment letter on longevity reinsurance; and 4) adopted the guidance document on bond factor changes.

Mr. Yanacheak made a motion, seconded by Mr. Reedy, to adopt the Working Group’s March 10, 2022 (Attachment Four-A); Jan. 20, 2022 (Attachment Four-B); Dec. 16, 2021 (Attachment Four-C); and Nov. 9, 2021 (see NAIC Proceedings – Fall 2021, Capital Adequacy (E) Task Force, Attachment Three) minutes. The motion passed unanimously.

2. Adopted its Working Agenda

Mr. Barlow said a request to add two items to the working agenda was received. Dave Fleming (NAIC) said one was to add the C-2 mortality work being done and another was to add an item for securities lending as it relates to the C-0 charge. Mr. Barlow suggested adding the C-2 item but not the C-0 item as it has yet to be discussed by the Working Group and could affect the other risk-based capital (RBC) formulas.

Mr. Yanacheak made a motion, seconded by Mr. Leung, to adopt the Working Group’s working agenda (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Eleven) with the modification to add the C-2 item. The motion passed unanimously.

3. Discussed Reinsurance and Comfort Trusts

Andrew Holland (Sidley Austin LLP) said he is presenting on behalf of J.P. Morgan and thanked the Working Group for the opportunity to introduce this topic (Attachments Four-D and Four-E). He said life reinsurance transactions with licensed or accredited reinsurers would not require collateral in order to receive credit for that reinsurance. He said the life RBC instructions provide for an adjustment when there is a reinsurer that is licensed or accredited, but collateral is nonetheless provided, whether it is funds withheld or trusteed collateral, to prevent an overstatement of RBC. He said there are many life reinsurance transactions done where, notwithstanding a licensed or accredited status, the parties agree to the provision of collateral and when that collateral is provided, it is often something that is not a pure statutory credit for reinsurance trusts, but something referred to as a comfort trust. For a ceding company to avail itself of the RBC credit with the current instructions, he said the collateral needs to be in the form of a trust. He said what is being introduced to the Working Group is another collateral mechanism, which is the functional equivalent with a request to amend the instructions to provide for...
a similar credit. Mr. Holland stated that the comfort trust is a custodial account that is established by the reinsurer that is coupled with an account control agreement in favor of the ceding company and provides the same benefits that a trust agreement does. He said the collateral is provided by the reinsurer and acts as security to the ceding company, where the ceding company has the ability to draw down on that collateral. He said this is an interesting time to discuss this topic given the implementation of the reciprocal jurisdiction reinsurer provisions, which stand to loosen the requirement for statutory collateral going forward.

Phil Prince (J.P. Morgan) made the point that custody control accounts are widely used in the finance industry already. He said it is the way in which collateral is held for pledges to the Federal Home Loan Banks (FHLBs), as well as being used in the derivatives area. He said J.P. Morgan has thousands of these custodial control accounts already in place and has a much smaller number of insurance trusts, as those are a much more narrowly used mechanism, and they are asking that custody control accounts be treated in the same manner for purposes of the RBC calculation. Brian Eckert (J.P. Morgan) described how custody control accounts offer the same operational control as a trust arrangement but at a reduced cost due to a larger number of providers and automation. Brad Drake (J.P. Morgan) described the specific instructional changes requested, which he said provides a specific definition of custodied collateral.

Mr. Andersen asked about liquidation of the reinsurer and how the ceding company would be taken care of. Similar to a trust arrangement where the mechanism for segregating assets is through the transfer to a trustee, Mr. Drake said it is the control agreement, paired with the custody account, which creates the security interest and makes the ceding company a secured creditor and provides the same functionality as a trust. Mr. Tsang said it would be beneficial to the Working Group to have a sample transaction to review to see that the cash flows, and the end result, work as they are being described and that there are no risks unaccounted for between the different structures. Mr. Holland said they would be happy to provide sample documentation. Mr. Barlow said the Working Group will continue discussion on this topic as that additional information is provided.

4. Discussed Bond Funds

Michael Ceccarelli (Vanguard) presented the proposal (Attachment Four-F). He said clients have long asked why most bond mutual funds are not afforded RBC treatment aligned with their underlying bond holdings. Instead, the current standard is that most bond mutual funds receive an equity charge of 30%, despite owning the same bonds that are directly owned by insurers and receive C-1 bond factors. Mr. Ceccarelli said this unaligned RBC treatment is deterring insurers from selecting the mutual fund structure as a means to access a diversified portfolio of bonds. For decades, under limited circumstances, he said the mutual fund structure has received more favorable RBC treatment, in the form of money markets and pure-government bond mutual funds. He said the long-standing RBC exempt treatment for these mutual funds indicates a general comfort with the fixed income mutual fund structure, a structure that has been around for nearly a century and proven itself during varying market conditions. However, appropriately aligned RBC has always been limited to these two types of fixed income mutual funds, excluding all other mutual funds from receiving capital charges based on their bond holdings.

Mr. Ceccarelli said in the past few years, the Statutory Accounting Principles (E) Working Group and the Valuation of Securities (E) Task Force have made regulatory strides to create a more inclusive standard for fixed income mutual funds by permitting NAIC designation reporting outside of the bond schedule and opening the Securities Valuation Office (SVO) review to all U.S. Securities and Exchange Commission (SEC)-registered fixed income funds. He said this could allow for RBC factors to more adequately reflect the underlying risk of a fund that owns bonds, based on a thorough, established look-through risk evaluation conducted by the SVO.

Mr. Ceccarelli said Vanguard is asking that bond mutual funds be given the opportunity to receive RBC charges that reflect the risks of the bond securities held in the fund. He said Vanguard is not asking for unmitigated
application of more favorable charges, but that a non-equity factor is applied only after the bond mutual fund has submitted for approval through the SVO and the fund has undergone a risk review and assignment of an NAIC designation. Given the bond securities that make up these funds, he said it would be an appropriate proxy to use the highly scrutinized C-1 bond factors that have already been established. Importantly, these 20 factors provide a granular range, and a factor can be dictated and applied to a fund based on the aggregate risk of the bonds held within each uniquely composed fund. Because of the unique composition of each mutual fund, exactness of new, pre-established factors would seem an impossibility but also far less important than having an incrementally increasing range that can be applied to each fund based on the quantitative evaluation of credit quality, and qualitative discretion.

Mr. Ceccarelli said investment RBC charges should ensure adequate, appropriate capitalization based on risk but should not be a leading and determining factor in investment vehicle decisions for insurers. He said this is especially important for small and mid-size insurers that may be at a disadvantage when accessing the bonds they need for their portfolio but are being deterred from accessing those bonds through a mutual fund structure due to the currently associated equity charge. He said Vanguard believes this will provide clear guidance for insurers, align capital charges with the underlying risk of these investments, and give insurers another proven investment vehicle to access additional diversification to complement, not replace, their existing bond portfolios

Mr. Barlow asked if this proposal could also be applicable to the other RBC formulas. Mr. Ceccarelli said that it could. Mr. Barlow suggested the appropriate place for consideration of this proposal might be the RBC Investment Risk and Evaluation (E) Working Group. Mr. Fleming agreed since it could impact the other formulas and suggested a formal referral. Mr. Leung made a motion, seconded by Mr. Boerner, to refer this proposal to the RBC Investment Risk and Evaluation (E) Working Group. The motion passed unanimously.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Life Risk-Based Capital (E) Working Group
Virtual Meeting
March 10, 2022

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 10, 2022. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Mike Yanacheak and Carrie Mears (IA); Ben Slutsker (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. **Discussed the Academy C2 Mortality Work Group Recommendation**

Mr. Barlow said there was one comment letter received. Brian Bayerle (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter (Attachment Four-A1). He said the ACLI has one main recommendation with respect to the tiered charges and is suggesting treatment similar to what is currently done for disability income, where the product category with the highest risk charges is considered first, followed by the product category with the next highest risk charges but with recognition of the amount of net amount at risk (NAR) in the first category before determining which tiered charge to use. The third product category would then consider the NAR in the first two categories. He also noted the ACLI’s request for greater clarification of the definitions and improved tie-outs. He said the ACLI prefers option one in the American Academy of Actuaries’ (Academy’s) recommendation because of greater transparency. Mr. Barlow asked if the ACLI would be supportive if the suggested alternative tiering resulted in higher factors. He said it appears the ACLI is supportive of having amounts objectively pulled from the annual statement, but he asked for clarification if the ACLI is suggesting changes to the way certain items are reported. Mr. Bayerle said the ACLI would need to review any change in the proposed factors because of a change in the proposed tiering, but consistency with the analysis would be preferable. With respect to reporting changes, he said changes might be straightforward, and if state insurance regulators think this is a good idea, it might make sense as an area to explore to get direct tie-outs, but it appears that something to be considered for 2023. Mr. Slutsker expressed appreciation for the ACLI’s suggestion on tiering, as he believes it addresses the risk on a more objective measure, rather than reliance on the name of a product group. Chris Trost (Academy), chair of the Academy C2 Mortality Work Group, said the Work Group has already done some preliminary work on this suggestion, but he said the proposed tiering was just to recognize that the volatility risk declines the bigger the block size is, so it makes sense to look at the aggregate mortality exposure as opposed to the break points for each of the categories. He said the Work Group plans to formally respond to this suggestion, along with other comments made previously, so it can be considered by the Working Group on a future call. Mr. Slutsker said he appreciates the desire to be able to tie out to amounts from the annual statement, but he also appreciates the appeal of option two and asked if something similar to option two was done with the adoption of the longevity risk charges. Paul Navratil (Academy), chair of the Academy C2 Longevity Risk Work Group, said longevity risk-based capital (RBC) treatment referred to reserves in the annual statement but on an in-part basis because not all products aggregated in a single line were in scope, and company records were needed. Mr. Barlow asked if there is a desire to go with option two and adjust the reporting in the annual statement. Mr. Bayerle asked which option the factors were based on. Mr. Trost said option two is offered because it is more of a principle-based approach, but it will require companies to populate the exposure for the different categories. He said the key aspect is the adjustment capacity, and option two involves more intensive categorization, which would require underlying calculations by companies. While option one is also based on company records, he said it is more explicit, as there is already a basis in the annual statement for the different categories.
With both options using company records, possible adjustments to the annual statement reporting, and option two perhaps being more involved, Mr. Barlow said it appears that there is a desire to move forward with one of the two options for 2022 RBC with reporting changes in 2023 to reduce the reliance on company records. He suggested considering longevity when thinking about the reporting changes to possibly lessen the reliance on company records for that RBC item as well. With a requirement to adopt the structural changes by the end of April for year-end 2022 RBC, he asked if both options offer the same ability to address issues. Mr. Trost said he believes the Working Group could adopt either option for the structure, and it will be a matter of modifying the definition of categories in the instructions. He said the Academy would like to address that, along with previous questions, and present it to the Working Group, but this could be done on a call prior to the end of April. Mr. Barlow asked if another exposure of the structural changes would be needed before the end of April. Dave Fleming (NAIC) said while there are some differences between the structural presentation of the two options, they are line-item descriptions, so he does not believe an additional exposure of the structure would be needed. He said there is time for the Working Group to have one call in April to hear additional input from the Academy and then another call to adopt the structural changes if two calls are needed. Mr. Barlow said the Working Group will schedule a call when the Academy has its updated information. Mr. Leung asked if the Academy will be able to provide the annual statement changes contemplated for both options. Mr. Trost said he believes the Academy could include that in its update, but he said he will discuss it with the Academy C2 Mortality Work Group.

2. Exposed the AVR Changes for Comment

Mr. Fleming reminded the Working Group that the changes being proposed to the asset valuation reserve (AVR) are a result of the changes to the RBC bond factors adopted for year-end 2021, and as was done with RBC changes done for tax reform, these changes are mechanical and retain the existing relationships. He said it starts with the AVR maximum reserve factor, which is to equal the after-tax RBC factor, and the AVR basic contribution and reserve objective factors are then percentages of the maximum reserve. He said these changes will be exposed for comment by the Blanks (E) Working Group at the Spring National Meeting and considered for year-end 2022 implementation. He said the Working Group does not need to adopt this proposal, but he suggested a short exposure by the Working Group to address any technical comments, and while none are expected, any comments received can be addressed as a modification to the Blanks (E) Working Group exposure. The Working Group agreed to expose the changes to the AVR (Attachment Four-A2) for a public comment period ending March 25.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Brian Bayerle  
Senior Actuary  

March 7, 2022  

Mr. Philip Barlow  
Chair, NAIC Life Risk-Based Capital (E) Working Group (Life RBC)  

Re: C-2 Mortality Structure Proposal

Dear Mr. Barlow:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the American Academy of Actuaries (the Academy) C-2 mortality structure proposal.

ACLI is supportive of the efforts to get updated C-2 mortality factors in place for yearend 2022 based on the best available information we currently possess. We have the following comments:

• Tiered Charges: Under the current structure, only one grouping of tiered charges exist so companies receive the benefit of aggregation in the factor as they move up to the lower charges associated with the 3 tiers of charges. Under the proposed framework, companies would not see such benefit as there are three grouping of tiered charges. Today a company begins to receive the full benefit of tiering above $25B NAR; under the proposed structure a company may need to have $75B NAR before receiving the full benefit of the lower charges.

We suggest a structure similar to what is done for disability income factors whereby the product category with the highest risk charges is considered first, followed by the product category with the next highest risk charges but recognize the amount of NAR in the first category before determining which tiered charge to use for the second product category. Subsequently the third product category considers the amount of NAR in the first two categories. For ULSG, there will be no change of their values for the tiers; “First 500 Million; Next 24,500 Million; Over 25,000 Million”. For Term, there would be recognition of the amount of ULSG NAR before determining the first charge to use for Term NAR. Similarly, All Other Life would recognize the amounts for both ULSG and Term before determining its first charge. For example, a company with $20B in ULSG, and $10B in Term: ULSG would use the factors as proposed, Term would apply $5B NAR using the Next 24,500 Million Term risk charge and $5B NAR at the Over 25,000 Million Term risk charge. Other approaches, such as pro-rata allocation by NAAR, could be developed as well.
• Clarification of definitions: We would appreciate greater clarification of relevant category definitions, particularly as it relates to pre-PBR business. We would like to understand if the definitions being proposed in the RBC instructions are consistent with definitions underlying the Academy’s analysis. We would suggest explicitly defining the terms (particularly UL with secondary guarantees) in the instructions, rather than referencing another source.

• Improved tie-out: We believe that for greater consistency, it would be beneficial to develop tie-outs to the Annual Statement. Given our assumption in the prior comment, we believe it would be beneficial to update another Annual Statement component so the reported net amount of risk values can tie to something explicitly (perhaps on the Analysis of Increase or Exhibit of Life). We suggest that given the timing this change be contemplated for 2023 Annual Statement reporting, with appropriate changes made to the C-2 mortality instructions for the 2023 RBC reporting.

• Support Option 1: ACLI supports the Academy recommendation of “Option 1”. We believe this approach fosters greater transparency and avoids confusion of business shifting between categories.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

[Signature]

cc:  Dave Fleming, NAIC
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

DATE: 3/10/2022

FOR NAIC USE ONLY
Agenda Item # ________________
Year 2022

Changes to Existing Reporting [ X ]
New Reporting Requirement [ ]

REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT
No Impact [ ]
Modifies Required Disclosure [ ]

DISPOSITION
[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES
[ X ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT [ X ] INSTRUCTIONS
[ ] CROSSCHECKS
[ ] BLANK

[ X ] Life, Accident & Health/Fraternal [ ] Separate Accounts [ ] Title
[ ] Property/Casualty [ ] Protected Cell [ ] Other
[ ] Health [ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

IDENTIFICATION OF ITEM(S) TO CHANGE
Update the AVR factors to correspond with the adopted RBC factors for the expanded bond designation categories.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**
The AVR factors are linked to the after-tax RBC factors. The Life Risk-Based Capital (E) Working Group adopted changes to the life and fraternal RBC factors for the expanded NAIC Designation Categories for bonds for 2021 yearend reporting. The AVR factors will need to be adjusted where the RBC factors have been changed.

NAIC STAFF COMMENTS
Comment on Effective Reporting Date:

Other Comments:
A worksheet showing comparison of AVR and after-tax RBC factors for 2017, the changes made for the 2018 tax changes and the AVR factors being proposed for 2022 is posted at the Life Risk-Based Capital (E) Working Group website.
The AVR maximum reserve factors were updated to reflect the existing relationship to the RBC after-tax factors. The AVR basic contribution and reserve object factors were updated to reflect the existing relationships to the maximum reserve factors.

** This section must be completed on all forms. Revised 7/18/2018
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#### Basic Contribution, Reserve Objective and Maximum Reserve Calculations
##### Default Component

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</tbody>
</table>
## Asset Valuation Reserve (Continued)

### Basic Contribution, Reserve Objective and Maximum Reserve Calculations

#### Default Component

| Line Number | NAIC Designation | Description | 1 Book/Adjusted Carrying Value | 2 Reclassify Related Party Encumbrances | 3 Add Third Party Encumbrances | 4 Balance for AVR Reserve Calculations (Cols. 1+2+3) | 5 Basic Contribution Factor (Cols. 4x5) | 6 Reserve Objective Factor (Cols. 4x6) | 7 Maximum Reserve Factor (Cols. 4x7) | 8 Amount (Cols. 4x8) | 9 Amount (Cols. 4x9) |
|-------------|------------------|-------------|---------------------------------|----------------------------------------|-------------------------------|-----------------------------------------------|-----------------------------------------|-------------------------------------|--------------------------------------|--------------------------------钱币|-------------------------------------|
| 35          |                  | In Good Standing: |                                |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 36          |                  | Farm Mortgages - CM1 - Highest Quality |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 37          |                  | Farm Mortgages - CM2 - High Quality    |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 38          |                  | Farm Mortgages - CM3 - Medium Quality  |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 39          |                  | Farm Mortgages - CM4 - Low Medium Quality |                                 |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 40          |                  | Farm Mortgages - CM5 - Low Quality     |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 41          |                  | Residential Mortgages - Insured or Guaranteed |                       |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 42          |                  | Residential Mortgages - All Other - CM1 - Highest Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 43          |                  | Residential Mortgages - All Other - CM2 - High Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 44          |                  | Residential Mortgages - All Other - CM3 - Medium Quality |                          |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 45          |                  | Residential Mortgages - All Other - CM4 - Low Medium Quality |                        |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 46          |                  | Residential Mortgages - All Other - CM5 - Low Quality |                        |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 47          |                  | Residential Mortgages - All Other - CM6 - Lowest Quality |                        |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 48          |                  | Overdue, Not in Process: |                                |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 49          |                  | Farm Mortgages - Insured or Guaranteed |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 50          |                  | Residential Mortgages - All Other - CM1 - Highest Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 51          |                  | Commercial Mortgages - All Other - CM2 - High Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 52          |                  | Commercial Mortgages - All Other - CM3 - Medium Quality |                           |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 53          |                  | In Process of Foreclosure: |                                |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 54          |                  | Farm Mortgages - Insured or Guaranteed |                            |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 55          |                  | Residential Mortgages - All Other - CM1 - Highest Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 56          |                  | Commercial Mortgages - All Other - CM2 - High Quality |                             |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 57          |                  | Commercial Mortgages - All Other - CM3 - Medium Quality |                           |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 58          |                  | Total Schedule B Mortgages (Sum of Lines 35 through 57) |                      |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 59          |                  | Schedule DA Mortgages |                                    |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |
| 60          |                  | Total Mortgage Loans on Real Estate (Lines 58 + 59) |                          |                                        |                               |                                               |                                        |                                     |                                       |                                     |                                      |

**Note:** The table continues with additional rows for each category of loans and mortgages, detailing their specific characteristics, contributions, and reserve calculations. The final rows summarize the total mortgage loans and the related reserve calculations.
### Asset Valuation Reserve

#### Basic Contribution, Reserve Objective and Maximum Reserve Calculations

**Equity and Other Invested Asset Component**

<table>
<thead>
<tr>
<th>Line Number</th>
<th>NAC Designation</th>
<th>Description</th>
<th>1 Book/Adjusted Carrying Value</th>
<th>2 Reclassify Related Party Encumbrances</th>
<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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<td>17</td>
<td>Total Common Stock (Sum of Lines 1 through 16)</td>
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#### Other Invested Assets

**Investments with the Underlying Characteristics of Bonds**

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<thead>
<tr>
<th>Line Number</th>
<th>NAC Designation</th>
<th>Description</th>
<th>1 Book/Adjusted Carrying Value</th>
<th>2 Reclassify Related Party Encumbrances</th>
<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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<td>22</td>
<td>Exempt Obligations</td>
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<td>24</td>
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<td>0.0263</td>
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### INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF PREFERRED STOCKS

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<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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</thead>
<tbody>
<tr>
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#### CHARACTERISTICS OF MORTGAGE LOANS

<table>
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<tr>
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<th>1 Book/Adjusted Carrying Value</th>
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<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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</table>

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**ANNUAL STATEMENT FOR THE YEAR 2022**

**ASSET VALUATION RESERVE (Continued)**

**EQUITY AND OTHER INVESTED ASSET COMPONENT**

**INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF MORTGAGE LOANS**

**In Good Standing Affiliated:**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>1 Book/Adjusted Carrying Value</th>
<th>2 Reclassify Related Party Encumbrances</th>
<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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</thead>
<tbody>
<tr>
<td>38</td>
<td>Mortgages - CM1 - Highest Quality</td>
<td>XXX</td>
<td>XXX</td>
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<td>39</td>
<td>Mortgages - CM2 - High Quality</td>
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<tr>
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<td>Mortgages - CM3 - Medium Quality</td>
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<tr>
<td>41</td>
<td>Mortgages - CM4 - Low Medium Quality</td>
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<tr>
<td>42</td>
<td>Mortgages - CM5 - Low Quality</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>43</td>
<td>Residential Mortgages - Insured or Guaranteed</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>44</td>
<td>Residential Mortgages - All Other</td>
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<tr>
<td>45</td>
<td>Commercial Mortgages - Insured or Guaranteed</td>
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**In Process of Foreclosure Affiliated:**

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<th>3 Add Third Party Encumbrances</th>
<th>4 Balance for AVR Reserve Calculations (Cols. 1+2+3)</th>
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</thead>
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<tr>
<td>46</td>
<td>Farm Mortgages</td>
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<td>Residential Mortgages - Insured or Guaranteed</td>
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<td>49</td>
<td>Commercial Mortgages - Insured or Guaranteed</td>
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**Unaffiliated:**

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<th>3 Add Third Party Encumbrances</th>
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**Total Affiliated (Sum of Lines 38 through 55):**

<table>
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<tr>
<th>Line</th>
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<th>2 Reclassify Related Party Encumbrances</th>
<th>3 Add Third Party Encumbrances</th>
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</table>
## Asset Valuation Reserve (Continued)

### Basic Contribution, Reserve Objective and Maximum Reserve Calculations

**Equity and Other Invested Asset Component**

<table>
<thead>
<tr>
<th>Line Number</th>
<th>NAIC Designation</th>
<th>Description</th>
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<th>2</th>
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<th>Basic Contribution</th>
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<th>Maximum Reserve</th>
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<td>Book/</td>
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<td>Reclassify Related Party Encumbrances</td>
<td>Add Third Party Encumbrances</td>
<td>Balance for AVR Reserve Calculations (Cols. 1+2+3)</td>
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<td>Amount (Cols. 4x5)</td>
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(a) Times the company’s weighted average portfolio beta (Minimum .1215, Maximum .2431).
(b) Determined using same factors and breakdowns used for directly owned real estate.
(c) This will be the factor associated with the risk category determined in the company generated worksheet.
# Asset Valuation Reserve

**Basic Contribution, Reserve Objective and Maximum Reserve Calculations**

### Replications (Synthetic) Assets

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<p>| 0599999 | Totals | | | | | | | |</p>
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Draft: 3/22/22

Life Risk-Based Capital (E) Working Group
Virtual Meeting
January 20, 2022

The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 20, 2022. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak and Carrie Mears (IA); Vincent Tsang (IL); Ben Slutsker (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Discussed Comments Received on the Academy C2 Mortality Work Group Recommendation

Brian Bayerle (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter (Attachment Four-B1) and said the ACLI is generally supportive of an update to the mortality factors. He highlighted the ACLI’s desire for more analysis on the risk exposure periods and the ability for companies to adjust the mortality rate for emerging experience, along with greater analysis on the margins. Mr. Slutsker presented Minnesota’s comments (Attachment Four-B2) highlighting a request to the American Academy of Actuaries (Academy) to reflect additional uncertainty on future mortality in light of the COVID-19 pandemic. He also noted the Academy’s current proposed category breakdown and Minnesota’s recommendation to have the categorization done based on guarantee duration similar to how valuation rates are assigned in the Standard Valuation Law (#820). Additionally, he noted Minnesota’s suggestion to determine the C-2 mortality component based on the underlying guarantee duration in the policy with appropriate adjustments for certain types of policies. Mr. Barlow said he believes the categorization is a topic that will require more discussion, but his hope is that it can align with how information is presented in the annual statement to make it as objective as possible. Chris Trost (Academy) said there is always the challenge of relying on what is available in the annual statement versus more of a principle-based approach and having companies put products into specific categories based on their analysis. He said the reason the Academy chose the categories in the recommendation is they most closely follow the information in the annual statement and for principle-based reserves as well. While acknowledging that there will always be some imperfections, he said the Academy believes the higher level of differentiation is appropriate. He also commented that with respect to questions about pandemics, and specifically COVID-19, the Work Group added a component for an unknown sustained type of risk establishing a 2.5% annual probability that such an event can occur with a 5% severity so mortality rates would be 5% higher, and that would last for either the exposure period or for 10 years. He said the Academy could provide additional sensitivities around those assumptions to show the impact on factors. Mr. Carmello spoke to New York’s comments (Attachment Four-B3) and highlighted New York’s focus on the current pandemic and its concern that it may not be reflected sufficiently in the development of the proposed factors. He said he supports having more sensitivity tests included for the Working Group’s consideration. To New York’s comment on mortality improvement, Mr. Trost said the Academy could also provide sensitivities on that as well.

Mr. Barlow said it appears the two primary issues are the factors and categorization, and he asked if changes to the categorization would be structural. Dave Fleming (NAIC) said the categorization could change the structural presentation, but that presentation can be modified as a result of comments received from the exposure. He noted that the instructions, which include the factors, are included for information only, are not final, and are subject to a later exposure deadline. The Working Group agreed to expose the Academy’s proposed structural changes (Attachment Four-B4) for a 45-day public comment period.
2. **Discussed the Academy’s Comment Letter on Longevity Reinsurance**

Mr. Barlow thanked Ms. Eom for volunteering to chair the Longevity Risk (E/A) Subgroup and reminded Working Group members that the Subgroup’s work is pending some of the work on the reserve side. Paul Navratil (Academy), chair of the Academy C2 Longevity Risk Work Group, said the purpose of the Academy’s comment letter (Attachment Four-B5) is to continue the conversation, knowing that longevity reinsurance remains an item to be addressed by the Working Group, and to make the connection with VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, and consistency between the reserve work and what is ultimately done for capital.

3. **Discussed the AVR and Bond Factor Changes**

Mr. Barlow reminded the Working Group that changes to the asset valuation reserve (AVR) need to be made to correspond to the bond factor changes. Mr. Fleming said, as was done with the changes to AVR related to the risk-based capital (RBC) changes for tax reform, these changes are largely mechanical and retain the existing relationships. He said these are changes that will need to be adopted by the Blanks (E) Working Group, and he has been working with the ACLI to draft these to meet the needed timeline for year-end 2022 implementation.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Brian Bayerle  
Senior Actuary  

January 11, 2022  

Mr. Philip Barlow  
Chair, NAIC Life Risk-Based Capital (E) Working Group (Life RBC)  

Re: C-2 Mortality Factor Proposal  

Dear Mr. Barlow:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the American Academy of Actuaries (the Academy) C-2 mortality factor proposal.  

ACLI appreciates the diligent efforts of the Academy in the development of these factors, and the thoughtful questioning and efforts from Life RBC working group members. ACLI is generally supportive of the initiative to update the C-2 mortality factors. We believe the structural changes to the methodology to determine the factors makes sense, and particularly updating the mortality assumptions underlying the factors is appropriate. However, ACLI would like more analysis and justification for the assumptions regarding the risk exposure periods and the ability of companies to adjust mortality rates for emerging experience because we are unsure as to the consistency of these assumptions across product types. In addition, ACLI would support greater analysis of the margins. We note that both the proposed factors include a 5% margin, while both pre-PBR and post-PBR reserves likely include margins that significantly exceed this level.  

Additionally, ACLI is supportive of Life RBC’s goal of more frequent updates to the mortality factors. ACLI believes the frequency of updates should reflect the greater percentage of in-force on a PBR-basis over time, greater availability of relevant data, and evolving reserves and practices.  

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.  

Sincerely,  

[Signature]  

cc: Dave Fleming, NAIC
Date: 01/07/2022
To: Phillip Barlow, Chair of the Life Risk-Based Capital (E) Working Group
Subject: Life C-2 Mortality Factor Update

Thank you for the opportunity to provide comments on the Life C-2 Mortality Factor proposal. We applaud the Academy C-2 Mortality Work Group’s efforts, and think this is a great analysis. There are a few comments we would like to make to consider as potential refinements to the proposed factor updates, which are discussed below.

Catastrophe Risk Component

The impact of updating the catastrophic component of the C-2 risk in the proposal, inclusive of removing the HIV scenarios, is a large decrease to the C-2 factors (-35% for large inforce size and -20% for small inforce size). However, the Academy C-2 Mortality Work Group mentioned on a prior NAIC Life RBC Working Group call that, due to timing, the analysis does not include impacts due to the emergence of COVID-19. Given that we are in the midst of a two-year pandemic and that C-2 factors are not frequently revised, we believe it would be prudent to reflect the current environment in the update.

Therefore, we would like to ask whether the Academy C-2 Mortality Working Group would be open considering an adjustment to reflect additional uncertainty of future mortality in light of COVID-19. Such uncertainty may reflect the impact of “long COVID”, additional variants, or an increased likelihood of future pandemics. Given the status of the proposal, we acknowledge it may be challenging to come up with a sophisticated approach at this point, so we would be open to exploring any higher-level adjustments, such as employing sensitivity tests to pandemic shock probabilities and distribution of severities to determine a COVID-19 adjustment. In addition, one of the sensitivity tests in the report shows a small impact from increasing the probability of an unknown sustained catastrophe from 2.5% probability to 5.0% probability, but it may be worth considering higher probabilities or severities for this component in coming up for an adjustment to COVID-19 (to reflect the risk of future respiratory issues or long COVID), in addition to sensitivity testing pandemic risk.

Product Categories

The Academy’s proposal to differentiate risks based on product duration is a welcome development, which permits companies to more accurately reflect C-2 mortality risk for their mix of inforce business. The current proposal breakdown categories into “ULSG”, “Term”, and “Other” with exposure periods of 20 years, 10 years, and 5 years respectively. Although the simplicity of this approach for differentiating product groups is consistent with the overall RBC framework, it also creates some unintuitive results:

- **ULSG Categorization** – The proposal contains separate charges for “ULSG” vs. “other”, where “other” is about half the ULSG charge. However, “ULSG” is defined at issue as a secondary guarantee less than or equal to 5 years. This results in a universal life policy with a 5-year secondary guarantee having half the
charge of a universal life with a 6-year secondary guarantee. In contrast, a 40-year secondary guarantee will have the same mortality risk charge as a 6-year secondary guarantee.

- **Whole Life Categorization** – Similar to the ULSG observation described above, a non-participating whole life with low funding values would also get half the charge of universal life with a 6-year secondary guarantee. This is due to the underlying assumption that the non-participating whole life mortality risk is based on a 5-year exposure period, which is shorter than the average contract life of a whole life policy.

- **Term Categorization** – The term category is based on a 10-year liability exposure period. Therefore, the C-2 term charge (less than ULSG) might work for 10-year level term to 20-year level term, but the ULSG charge may be more appropriate for reflecting the associated risk for a 30-year level term.

As an alternative, we recommend differentiating the assignment to the 5, 10, and 20-year exposure period factors based on the guarantee duration, similar to how valuation rates are assigned in the Standard Valuation Law:

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<th>Exposure Period</th>
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</thead>
<tbody>
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<td>10 or less</td>
<td>5 Years</td>
</tr>
<tr>
<td>More than 10, but not more than 20</td>
<td>10 Years</td>
</tr>
<tr>
<td>More than 20</td>
<td>20 Years</td>
</tr>
</tbody>
</table>

We believe this modification would maintain simplicity (as this split is already required for valuation purposes), while also avoiding some of the unintuitive impacts in the original proposal described above.

In addition, we would recommend the NAIC Life RBC Working Group’s consideration of using an exposure period of 30 years for even longer guarantees, as the Academy C-2 Mortality Working Group has already calculated the factors associated with 30 years, which is disclosed in the exposed report.

**Experience Pass-Through**

One challenge with proposing factor differentiation, whether by other product line (as initially proposed) or guarantee duration (as described in this letter), is how to reflect the reduction in mortality risk for policies that are able to pass mortality experience to the policyholder through a non-guaranteed element. Examples include dividends on a participating whole life policies and cost of insurance charges on universal life policies without a secondary guarantee, where unfavorable company mortality experience could be offset by modifying these features on inforce policies. The Academy C-2 Morality Working Group attempts to address this issue by assigning policies with these non-guaranteed elements to proposed factors based on a 5-year exposure period (i.e., “other” category).

We would be interested in analysis to support why participating whole life or universal life without secondary guarantees should be assigned to a 5-year exposure period. If this was only intended to be a simplistic
conceptual adjustment to reflect less mortality risk in light of non-guarantee elements, then we would be interested if the Academy C-2 Mortality Working Group has any additional thoughts on how to more accurately quantify the decrease in mortality risk due to the presence of such features. For example, running a participating vs. non-participating whole life policy, or universal life with a secondary guarantee vs. without a secondary guarantee.

In the absence of this type of analysis, we think that assigning factors associated with a 5-year exposure may be too low (as this is about half of a 20-year exposure period). Instead, we would suggest determining the C-2 mortality component based on the underlying guarantee duration in the policy, and then subsequently adjusting the C-2 component downward for certain types of policies. For example, allow participating whole life policies and universal life policies with no or short secondary guarantees (e.g., 10 years or less) to receive a reduction factor that is closer to -20% (rather than -50%). Although non-guaranteed elements can offset some of the company mortality experience volatility, permanent policies still contain long-term death benefit guarantees that may have material mortality risk (even if lower than policyholder behavior risk on a relative basis).

**Conclusion**

We believe the Academy C-2 Mortality Work Group has a great proposal, and that the adjustments described in this letter for catastrophe risk and guarantee duration will only make it stronger. Regardless, we are pleased to see the proposed updates to C-2, which would serve as a significant and more update-to-date improvement over the current factors. As always, we appreciate the Academy’s hard work and intellectual rigor on this project, as well as the NAIC Life RBC Working Group providing us with the opportunity to comment.
Submitted via email:

We have the following comments regarding the C-2 mortality factor proposal:

1. The proposal replaces the 1% mortality improvement factor in the current model with the 2017 improvement scale from VM-20. We do not support the inclusion of any mortality improvement in the C-2 mortality factors.
2. The proposal for pandemic risk seems rather low given that we are currently in a pandemic with much higher mortality.

William B. Carmello, Jr., FSA, MAAA

Chief Life Actuary

New York State Department of Financial Services
January 20, 2022

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Via e-mail: Dave Fleming (dfleming@naic.org)

Re: Structural Updates to Life RBC C-2 Mortality

Dear Philip,

On behalf of the C-2 Mortality Work Group of the American Academy of Actuaries, we are providing two options for structural updates to the Life RBC C-2 Mortality factors for consideration to be exposed by 1/31/2022. Also included are draft instructions for informational purposes which are subject to a different exposure deadline of 4/30/2022.

Sincerely,

Chris Trost, MAAA, FSA
Chairperson, C-2 Mortality Work Group
Ryan Fleming, MAAA, FSA
Vice Chairperson, C-2 Mortality Work Group
American Academy of Actuaries

1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
## Capital Adequacy (E) Task Force
### RBC Proposal Form

| [ ] Catastrophe Risk (E) Subgroup   | [ ] Investment RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [ ] P/C RBC (E) Working Group       |

**DATE:** 1/20/22

**CONTACT PERSON:** Ryan Fleming, MAAA, FSA

**TELEPHONE:** (414) 665-5020

**EMAIL ADDRESS:** ryanfleming@northernmutual.com

**ON BEHALF OF:** AAA C-2 Mortality Work Group

**NAME:** Ryan Fleming, MAAA, FSA

**TITLE:** Vice Chairperson

**AFFILIATION:** American Academy of Actuaries

**ADDRESS:** 1850 M Street NW, Suite 300

### Agenda Item #

- **FOR NAIC USE ONLY**
  - [ ] ADOPTED
  - [ ] REJECTED
  - [ ] DEFERRED TO
  - [ ] REFERRED TO OTHER NAIC GROUP
  - [ ] EXPOSED
  - [ ] OTHER (SPECIFY)

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

- [ ] Health RBC Blanks
- [ ] Property/Casualty RBC Blanks
- [ ] Life and Fraternal RBC Instructions
- [ ] Health RBC Instructions
- [ ] Property/Casualty RBC Instructions
- [X ] Life and Fraternal RBC Blanks
- [ ] OTHER

### DESCRIPTION OF CHANGE(S)

Updated blank for C2 Life Mortality on LR025, LR030 and LR031. Draft instructions are included for informational purposes and are subject to a different exposure deadline of 4/30/22.

### REASON OR JUSTIFICATION FOR CHANGE **

Structural changes necessary to facilitate the implementation of updated C2 life mortality factors and expanded categories.

**Additional Staff Comments:**

**REvised 2-2019**
<table>
<thead>
<tr>
<th>(1)</th>
<th>Ordinary Life In Force</th>
<th>Life of Life Insurance Column 4 Line 2 x 1000</th>
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<tr>
<td>(2)</td>
<td>Plus Individual Life Insurance</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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<tr>
<td>(4)</td>
<td>Total Individual &amp; Subordinated Life Reserve</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
</tr>
<tr>
<td>(5)</td>
<td>Less Ordinary Life Reserves</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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<tr>
<td>(6)</td>
<td>Less Group Life Reserves</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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<tr>
<td>(7)</td>
<td>Less Credit Life Reserves</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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<td>(8)</td>
<td>Plus Total Individual &amp; Subordinated Life Reserve</td>
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<tr>
<td>(9)</td>
<td>Total Individual &amp; Subordinated Life Reserve</td>
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<td>(10)</td>
<td>Less Ordinary Life Reserves</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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<td>(11)</td>
<td>Less Group Life Reserves</td>
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<tr>
<td>(12)</td>
<td>Less Credit Life Reserves</td>
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<tr>
<td>(13)</td>
<td>Total Individual &amp; Subordinated Life Reserve</td>
<td>Life of Life Insurance Column 4 Line 2 x 1000</td>
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</tbody>
</table>

* The definitions are specified in the Life Insurance section of the risk-based capital instructions.
* The tiered calculation is illustrated in the Life Insurance section of the risk-based capital instructions.
* Include only the portion which relates to policy reserves that, if written on a direct basis, would be included on Exhibit 5.
<table>
<thead>
<tr>
<th>Description</th>
<th>Formula/Notes</th>
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<tbody>
<tr>
<td>Total Life Requirement</td>
<td>Less Factor = Exhibit of Life Insurance Column 6 Line 23 x 1000</td>
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<tr>
<td>Total Group &amp; Credit Life In Force</td>
<td>Plus Factor = Exhibit of Life Insurance Column 9 Line 23 x 1000</td>
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<tr>
<td>Group Life In Force</td>
<td>Plus FEGLI = Separate Accounts Exhibit 3 Column 3 Line 0199999</td>
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<tr>
<td>Credit FEGLI</td>
<td>Plus Credit Life In Force = Exhibit of Life Insurance Column 2 Line 23 x 1000</td>
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<tr>
<td>Group FEGLI</td>
<td>Plus Group Life In Force = Exhibit of Life Insurance Column 4 Line 23 x 1000</td>
</tr>
<tr>
<td>Ordinary Life In Force</td>
<td>Plus Ordinary Life Reserves = Exhibit 5 Column 4 Line 0199999</td>
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<tr>
<td>Industrial Life In Force</td>
<td>Plus Industrial Life Reserves = Exhibit 5 Column 3 Line 0199999</td>
</tr>
<tr>
<td>Separate Accounts</td>
<td>Plus Ordinary &amp; Industrial Life Reserves = Schedule S Part 1 Section 1 Column 12, in part ‡</td>
</tr>
<tr>
<td>Modified Coinsurance Assumed Reserves Schedule</td>
<td>Less Ordinary &amp; Industrial Life Reserves = Schedule S Part 3 Section 1 Column 14, in part ‡</td>
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<tr>
<td>Life Policies with Pricing Flexibility</td>
<td>Less Life Policies with Pricing Flexibility Reserves = Company Records*</td>
</tr>
<tr>
<td>Term Life Policies without Pricing Flexibility</td>
<td>Less Term Life Policies without Pricing Flexibility Reserves = Company Records*</td>
</tr>
<tr>
<td>Permanent Life Policies without Pricing Flexibility</td>
<td>Less Permanent Life Policies without Pricing Flexibility Reserves = Company Records*</td>
</tr>
<tr>
<td>Individual &amp; Industrial Life Net Amount at Risk</td>
<td>Lines (11) - (12) X†</td>
</tr>
<tr>
<td>Group &amp; Credit Life Net Amount at Risk</td>
<td>Lines (35) - (36) X†</td>
</tr>
<tr>
<td>Group &amp; Credit Life In Force with Remaining Rate Terms 36 Months and Under</td>
<td>Less Group &amp; Credit Life Reserves with Remaining Rate Terms 36 Months and Under = Company Records*</td>
</tr>
<tr>
<td>Group &amp; Credit Life Net Amount at Risk with Remaining Rate Terms Over 36 Months</td>
<td>Less Group &amp; Credit Life Reserves with Remaining Rate Terms Over 36 Months = Company Records*</td>
</tr>
<tr>
<td>Total Group &amp; Credit Life Lines</td>
<td>Lines (37) + (40) + (41) + (42) + (20) + (42)</td>
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## Calculation of Tax Effect for Life and Fraternal Risk-Based Capital

### Asset Risks

<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
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<tbody>
<tr>
<td>Bonds</td>
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<tr>
<td>(001) Long-term Bonds - NAIC 1</td>
<td>LR002 Bonds Column (2) Line (2.8) + LR018 Off-Balance Sheet Collateral Column (3) Line (2.8)</td>
<td>X 1.000</td>
<td>=</td>
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<tr>
<td>(002) Long-term Bonds - NAIC 2</td>
<td>LR002 Bonds Column (2) Line (3.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (3.4)</td>
<td>X 1.000</td>
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<td>(003) Long-term Bonds - NAIC 3</td>
<td>LR002 Bonds Column (2) Line (4.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (4.4)</td>
<td>X 1.000</td>
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<tr>
<td>(004) Long-term Bonds - NAIC 4</td>
<td>LR002 Bonds Column (2) Line (5.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (5.4)</td>
<td>X 1.000</td>
<td>=</td>
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<tr>
<td>(005) Long-term Bonds - NAIC 5</td>
<td>LR002 Bonds Column (2) Line (6.4) + LR018 Off-Balance Sheet Collateral Column (3) Line (6.4)</td>
<td>X 1.000</td>
<td>=</td>
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<tr>
<td>(006) Long-term Bonds - NAIC 6</td>
<td>LR002 Bonds Column (2) Line (7) + LR018 Off-Balance Sheet Collateral Column (3) Line (7)</td>
<td>X 2.010</td>
<td>=</td>
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<tr>
<td>(007) Short-term Bonds - NAIC 1</td>
<td>LR002 Bonds Column (2) Line (10.8)</td>
<td>X 1.000</td>
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<tr>
<td>(008) Short-term Bonds - NAIC 2</td>
<td>LR002 Bonds Column (2) Line (11.4)</td>
<td>X 1.000</td>
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<tr>
<td>(009) Short-term Bonds - NAIC 3</td>
<td>LR002 Bonds Column (2) Line (12.4)</td>
<td>X 1.000</td>
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<tr>
<td>(010) Short-term Bonds - NAIC 4</td>
<td>LR002 Bonds Column (2) Line (13.4)</td>
<td>X 1.000</td>
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<tr>
<td>(011) Short-term Bonds - NAIC 5</td>
<td>LR002 Bonds Column (2) Line (14.4)</td>
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<tr>
<td>(012) Short-term Bonds - NAIC 6</td>
<td>LR002 Bonds Column (2) Line (15.4)</td>
<td>X 1.000</td>
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<tr>
<td>(013) Credit for Hedging - NAIC 1 Through 5 Bonds</td>
<td>LR014 Hedged Asset Bond Schedule Column (13) Line (0199999)</td>
<td>X 1.000</td>
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<tr>
<td>(014) Credit for Hedging - NAIC 6 Bonds</td>
<td>LR014 Hedged Asset Bond Schedule Column (13) Line (0299999)</td>
<td>X 2.010</td>
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<tr>
<td>(015) Bond Reduction - Reinsurance</td>
<td>LR002 Bonds Column (2) Line (19)</td>
<td>X 1.000</td>
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<tr>
<td>(016) Bond Increase - Reinsurance</td>
<td>LR002 Bonds Column (2) Line (20)</td>
<td>X 1.000</td>
<td>=</td>
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<tr>
<td>(017) Non-Farm NAIC 1 U.S. Government Agency</td>
<td>LR002 Bonds Column (2) Line (21)</td>
<td>X 1.000</td>
<td>=</td>
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<tr>
<td>(018) Bonds Not Factor</td>
<td>LR002 Bonds Column (2) Line (21) - LR002 Bonds Column (2) Line (21)</td>
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</table>

### Mortgages

<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
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<tbody>
<tr>
<td>In Good Standing</td>
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<tr>
<td>(019) Residential Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (1)</td>
<td>X 0.575</td>
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<tr>
<td>(020) Residential Mortgages - Other</td>
<td>LR004 Mortgages Column (6) Line (2)</td>
<td>X 0.575</td>
<td>=</td>
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<tr>
<td>(021) Commercial Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (3)</td>
<td>X 0.575</td>
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<tr>
<td>(022) Total Commercial Mortgages - All Other</td>
<td>LR004 Mortgages Column (6) Line (9)</td>
<td>X 0.575</td>
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<tr>
<td>In Process of Foreclosure</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(026) Farm Mortgages</td>
<td>LR004 Mortgages Column (6) Line (10)</td>
<td>X 0.575</td>
<td>=</td>
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<tr>
<td>(027) Commercial Mortgages - Insured</td>
<td>LR004 Mortgages Column (6) Line (19)</td>
<td>X 0.575</td>
<td>=</td>
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<tr>
<td>(028) Commercial Mortgages - Other</td>
<td>LR004 Mortgages Column (6) Line (20)</td>
<td>X 0.575</td>
<td>=</td>
</tr>
</tbody>
</table>

† Denotes line items are deducted from the total rather than added.

Denotes items that must be manually entered on the filing software.
### Calculation of Tax Effect for Life and Fraternal Risk-Based Capital (Continued)

<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
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</thead>
<tbody>
<tr>
<td>(030) Residential Mortgages - Insured</td>
<td>LR004 Mortgage Column (6) Line (22)</td>
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<tr>
<td>(031) Residential Mortgages - Other</td>
<td>LR004 Mortgage Column (6) Line (23)</td>
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<tr>
<td>(032) Commercial Mortgages - Insured</td>
<td>LR004 Mortgage Column (6) Line (24)</td>
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<td>(033) Commercial Mortgages - Other</td>
<td>LR004 Mortgage Column (6) Line (25)</td>
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<tr>
<td>(034) Due &amp; Unpaid Taxes Mortgages</td>
<td>LR004 Mortgage Column (6) Line (26)</td>
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<tr>
<td>(035) Due &amp; Unpaid Taxes - Foreclosures</td>
<td>LR004 Mortgage Column (6) Line (27)</td>
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<tr>
<td>(036) Mortgage Reduction - Reinsurance</td>
<td>LR004 Mortgage Column (6) Line (29)</td>
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<td>(037) Mortgage Increase - Reinsurance</td>
<td>LR004 Mortgage Column (6) Line (30)</td>
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<td>(038) Unaffiliated Preferred Stock NAIC 1</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (1)</td>
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<td>(039) Unaffiliated Preferred Stock NAIC 2</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (2)</td>
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<td>(040) Unaffiliated Preferred Stock NAIC 3</td>
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<td>(041) Unaffiliated Preferred Stock NAIC 4</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (4)</td>
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<tr>
<td>(042) Unaffiliated Preferred Stock NAIC 5</td>
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<tr>
<td>(043) Unaffiliated Preferred Stock NAIC 6</td>
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<tr>
<td>(044) Preferred Stock Reduction - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (8)</td>
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<td>(045) Preferred Stock Increase - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (9)</td>
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<td>(046) Guaranteed Index</td>
<td>LR006 Separate Accounts Column (3) Line (1)</td>
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<td>(047) Nonindex-Book Reserve</td>
<td>LR006 Separate Accounts Column (3) Line (2)</td>
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<td>(048) Separate Accounts Nonindex-Market Reserve</td>
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<td>(050) Separate Accounts Increase - Reinsurance</td>
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<td>(051) Synthetics GICs</td>
<td>LR006 Separate Accounts Column (5) Line (5)</td>
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<td>(052) Separate Account Surplus</td>
<td>LR006 Separate Accounts Column (5) Line (5)</td>
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<tr>
<td>(053) Company Occupied Real Estate</td>
<td>LR007 Real Estate Column (3) Line (3)</td>
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<tr>
<td>(054) Foreclosed Real Estate</td>
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<td>(055) Investment Real Estate</td>
<td>LR007 Real Estate Column (3) Line (9)</td>
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<tr>
<td>(056) Real Estate Reduction - Reinsurance</td>
<td>LR007 Real Estate Column (3) Line (11)</td>
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<tr>
<td>(057) Real Estate Increase - Reinsurance</td>
<td>LR007 Real Estate Column (3) Line (12)</td>
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<tr>
<td>(058) Sub BAR Real Estate Excluding Low Income Housing Tax Credits</td>
<td>LR007 Real Estate Column (3) Line (16)</td>
<td>X</td>
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<tr>
<td>(059) Sub BAR Real Estate Excluding Low Income Housing Tax Credits</td>
<td>LR007 Real Estate Column (3) Line (16)</td>
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<tr>
<td>(060) Non-Guaranteed and All Other Low Income Housing Tax Credits</td>
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<td>(061) Sub BAR Real Estate Reduction - Reinsurance</td>
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<td>(062) Sub BAR Real Estate Increase - Reinsurance</td>
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</tbody>
</table>

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Denotes items that must be manually entered on the filing software.

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Attachment Four-B4

Capital Adequacy (E) Task Force

3/28/22

NAIC Proceedings – Spring 2022
<table>
<thead>
<tr>
<th>Source</th>
<th>Source</th>
<th>Source</th>
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<td>(063) Sub BA Bond NAIC 1</td>
<td>LR008 Other Long-Term Assets Column (5) line (2)</td>
<td>X</td>
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<td>(064) Sub BA Bond NAIC 2</td>
<td>LR008 Other Long-Term Assets Column (5) line (3)</td>
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<tr>
<td>(065) Sub BA Bond NAIC 3</td>
<td>LR008 Other Long-Term Assets Column (5) line (4)</td>
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<tr>
<td>(066) Sub BA Bond NAIC 4</td>
<td>LR008 Other Long-Term Assets Column (5) line (5)</td>
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<tr>
<td>(067) Sub BA Bond NAIC 5</td>
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<td>(068) Sub BA Bond NAIC 6</td>
<td>LR008 Other Long-Term Assets Column (5) line (7)</td>
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<td>(069) BA Bond Reduction - Reinsurance</td>
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<tr>
<td>(070) BA Bond Increase - Reinsurance</td>
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<td>(071) BA Preferred Stock NAIC 1</td>
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<tr>
<td>(072) BA Preferred Stock NAIC 2</td>
<td>LR008 Other Long-Term Assets Column (5) line (13)</td>
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<tr>
<td>(073) BA Preferred Stock NAIC 3</td>
<td>LR008 Other Long-Term Assets Column (5) line (14)</td>
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<tr>
<td>(074) BA Preferred Stock NAIC 4</td>
<td>LR008 Other Long-Term Assets Column (5) line (15)</td>
<td>X</td>
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<tr>
<td>(075) BA Preferred Stock NAIC 5</td>
<td>LR008 Other Long-Term Assets Column (5) line (16)</td>
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<tr>
<td>(076) BA Preferred Stock NAIC 6</td>
<td>LR008 Other Long-Term Assets Column (5) line (17)</td>
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<tr>
<td>(077) BA Preferred Stock Reduction-Reinsurance</td>
<td>LR008 Other Long-Term Assets Column (5) line (19)</td>
<td>X</td>
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<tr>
<td>(078) BA Preferred Stock Increase - Reinsurance</td>
<td>LR008 Other Long-Term Assets Column (5) line (20)</td>
<td>X</td>
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<td>(079) Rated Surplus Notes</td>
<td>LR008 Other Long-Term Assets Column (5) line (31)</td>
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<td>(080) Rated Capital Notes</td>
<td>LR008 Other Long-Term Assets Column (5) line (41)</td>
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<tr>
<td>(081) BA Common/Stock Affiliated</td>
<td>LR008 Other Long-Term Assets Column (5) line (50)</td>
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<tr>
<td>(082) BA Captial Loans</td>
<td>LR008 Other Long-Term Assets Column (5) line (51)</td>
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<tr>
<td>(083) Other BA Assets</td>
<td>LR008 Other Long-Term Assets Column (5) line (52.3)</td>
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<tr>
<td>(084) Other BA Assets Reduction-Reinsurance</td>
<td>LR008 Other Long-Term Assets Column (5) line (54)</td>
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<tr>
<td>(085) Other BA Assets Increase - Reinsurance</td>
<td>LR008 Other Long-Term Assets Column (5) line (55)</td>
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<tr>
<td>(086) BA Mortgages - In Good Standing</td>
<td>LR009 Schedule BA Mortgage Column (6) line (11)</td>
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<tr>
<td>(087) BA Mortgages - 90 Days Overdue</td>
<td>LR009 Schedule BA Mortgage Column (6) line (15)</td>
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<tr>
<td>(088) BA Mortgages - In Process of Foreclosure</td>
<td>LR009 Schedule BA Mortgage Column (6) line (19)</td>
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<tr>
<td>(089) Reduction - Reinsurance</td>
<td>LR009 Schedule BA Mortgage Column (6) line (21)</td>
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<tr>
<td>(090) Increase - Reinsurance</td>
<td>LR009 Schedule BA Mortgage Column (6) line (22)</td>
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<td>Miscellaneous</td>
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<tr>
<td>(091) Asset ConcentrationFactor</td>
<td>LR010 Asset Concentration Factor Column (6) line (62) +Grand Total Page</td>
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<tr>
<td>(092) Miscellaneous Assets</td>
<td>LR012 Miscellaneous Assets Column (2) line (7)</td>
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<tr>
<td>(093) Derivatives - Collateral and Exchange Traded</td>
<td>LR012 Miscellaneous Assets Column (2) line (8) + (9) + (10)</td>
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<td>(094) Derivatives</td>
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<td>(095) Derivatives NAIC2</td>
<td>LR012 Miscellaneous Assets Column (2) line (12)</td>
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<td>(096) Derivatives NAIC3</td>
<td>LR012 Miscellaneous Assets Column (2) line (13)</td>
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<tr>
<td>(097) Derivatives NAIC4</td>
<td>LR012 Miscellaneous Assets Column (2) line (14)</td>
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<tr>
<td>(098) Derivatives NAIC5</td>
<td>LR012 Miscellaneous Assets Column (2) line (15)</td>
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<tr>
<td>(099) Derivatives NAIC6</td>
<td>LR012 Miscellaneous Assets Column (2) line (16)</td>
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<tr>
<td>(100) Miscellaneous Assets Reduction-Reinsurance</td>
<td>LR012 Miscellaneous Assets Column (2) line (19)</td>
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<tr>
<td>(101) Miscellaneous Assets Increase - Reinsurance</td>
<td>LR012 Miscellaneous Assets Column (2) line (20)</td>
<td>X</td>
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</tbody>
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CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

<table>
<thead>
<tr>
<th>Source</th>
<th>(1) RBC Amount</th>
<th>(2) Tax Factor</th>
<th>(3) RBC Tax Effect</th>
</tr>
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<tbody>
<tr>
<td>(102) Replications</td>
<td>LR013 Replication (Synthetic Asset) Transactions and Mandates Converted to Corresponding Column (7) Line (2999999)</td>
<td>X</td>
<td>0.1575</td>
</tr>
<tr>
<td>(103) Reinsurance</td>
<td>LR016 Reinsurance Column (4) Line (17)</td>
<td>X</td>
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</tr>
<tr>
<td>(104) Investment Affiliates</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (6)</td>
<td>X</td>
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<tr>
<td>(105) Investment in Parent</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (10)</td>
<td>X</td>
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</tr>
<tr>
<td>(106) Other Affiliate Property and Casualty Insurers not Subject to Risk-Based Capital</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (11)</td>
<td>X</td>
<td>0.2100</td>
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<tr>
<td>(107) Other Affiliate Life Insurers not Subject to Risk-Based Capital</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (12)</td>
<td>X</td>
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</tr>
<tr>
<td>(108) Publicly Traded Insurance Affiliates</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (14)</td>
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</tr>
<tr>
<td>(109) Subtotal for C-1o Assets</td>
<td>Line (101) through (108), Recognizing the Deduction of Lines (013), (014), (015), (036), (044), (049), (056), (061), (069), (077), (084), (089), and (100) not Subject to Risk-Based Capital</td>
<td>X</td>
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<tr>
<td>(110) Off-Balance Sheet and Other Items</td>
<td>LR017 Off-Balance Sheet and Other Items Column (5) Line (27)</td>
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<tr>
<td>(111) Off-Balance Sheet Items Reduction - Reinsurance</td>
<td>LR017 Off-Balance Sheet and Other Items Column (5) Line (28)</td>
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</tr>
<tr>
<td>(112) Affiliated US Property - Casualty Insurers</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (1) Directly Owned</td>
<td>X</td>
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<tr>
<td>(113) Affiliated US Life Insurers Directly Owned</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (2)</td>
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<tr>
<td>(114) Affiliated US Property - Casualty Insurers Indirectly Owned</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (3)</td>
<td>X</td>
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<tr>
<td>(115) Affiliated US Life Insurers Indirectly Owned</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (4)</td>
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<tr>
<td>(116) Affiliated US Life Insurers - Canadian</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (5)</td>
<td>X</td>
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<tr>
<td>(117) Affiliated US Life Insurers - Canadian Directly Owned</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (6)</td>
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<tr>
<td>(118) Affiliated US Life Insurers - Canadian Indirectly Owned</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (7)</td>
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<tr>
<td>(119) Affiliated Alien Life Insurers - Canadian</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (8)</td>
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<tr>
<td>(120) Subtotal for C-0 Affiliated Common Stock Lines (110)-(111)+(112)+(113)+(114)+(115)+(116)+(117)+(118)+(119)</td>
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<tr>
<td>(121) Unaffiliated Common Stock</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17)</td>
<td>X</td>
<td>0.2100</td>
</tr>
<tr>
<td>(122) Credit for Hedging - Common Stock</td>
<td>LR018 Off-Balance Sheet Collected Column (5) Line (16)</td>
<td>X</td>
<td>0.2100</td>
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<tr>
<td>(123) Stock Reductions - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)</td>
<td>X</td>
<td>0.2100</td>
</tr>
<tr>
<td>(124) Stock Increase - Reinsurance</td>
<td>LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)</td>
<td>X</td>
<td>0.2100</td>
</tr>
<tr>
<td>(125) BA Common Stock Unaffiliated</td>
<td>LR008 Other Long-Term Assets Column (5) Line (47)</td>
<td>X</td>
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</tr>
<tr>
<td>(126) BA Common Stock Affiliated - C-1cs</td>
<td>LR008 Other Long-Term Assets Column (5) Line (48)</td>
<td>X</td>
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</tr>
<tr>
<td>(127) Common Stock Concentration Factor</td>
<td>LR008 Other Long-Term Assets Column (5) Line (49)</td>
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<tr>
<td>(128) NAIC Valuation Capital Finance Notes</td>
<td>LR008 Other Long-Term Assets Column (5) Line (51)</td>
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<tr>
<td>(129) NAIC Valuation Capital Finance Notes</td>
<td>LR008 Other Long-Term Assets Column (5) Line (52)</td>
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</tr>
<tr>
<td>(130) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subs</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (7)</td>
<td>X</td>
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<tr>
<td>(131) Affiliated Preferred Stock and Common Stock - All Other</td>
<td>LR042 Summary for Affiliated Investments Column (4) Line (13)</td>
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</tr>
<tr>
<td>(132) Total for C-1o Assets</td>
<td>Lines (121)+(122)+(123)+(124)+(125)+(126)+(127)+(128)+(129)+(130)+(131)</td>
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</tr>
<tr>
<td>(133) Disability Income Premium</td>
<td>LR019 Health/Pensions Column (2) Lines (2) through (27)</td>
<td>X</td>
<td>0.2100</td>
</tr>
</tbody>
</table>

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### CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL (CONTINUED)

<table>
<thead>
<tr>
<th>Source</th>
<th>RBC Amount</th>
<th>Tax Factor</th>
<th>RBC Tax Effect</th>
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<tbody>
<tr>
<td>(134) Long-Term Care</td>
<td>LR019 Health Premiums Column (2) Line (20) + LR023 Long-Term Care</td>
<td>X 0.2100</td>
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</tr>
<tr>
<td>(135) Individual &amp; Industrial Life Insurance C-2 Risk</td>
<td>LR025 Life Insurance Column (2) Line (28) + LR023 Long-Term Care * 0.2100 = Column (4) Line (7)</td>
<td>X 0.2100</td>
<td>-</td>
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<tr>
<td>(136a) Group &amp; Credit Life Insurance C-2 Risk</td>
<td>LR025 Life Insurance Column (2) Line (28) + LR023 Long-Term Care * 0.2100 = Column (4) Line (7)</td>
<td>X 0.2100</td>
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<tr>
<td>(136b) Longevity C-2 Risk</td>
<td>LR025-A Longevity Risk Column (2) Line (5)</td>
<td>X 0.2100</td>
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</tr>
<tr>
<td>(137) Disability and Long-Term Care Health Claims Reserves</td>
<td>LR024 Health Claims Reserve Column (6) Line (9) + Line (15)</td>
<td>X 0.2100</td>
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<tr>
<td>(138) Premium Stabilization Credit</td>
<td>LR026 Premium Stabilization Reserve Column (2) Line (10)</td>
<td>X 0.0000</td>
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</tr>
<tr>
<td>(139) Total C-2 Risk</td>
<td>LR025 Health Premiums Column (2) Line (20) + LR023 Long-Term Care * 0.2100 + LR025 Life Insurance Column (2) Line (28) + LR023 Long-Term Care * 0.2100 + LR025-A Longevity Risk Column (2) Line (5) + LR024 Health Claims Reserve Column (6) Line (9) + Line (15) + LR026 Premium Stabilization Reserve Column (2) Line (10)</td>
<td>X 0.2100</td>
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<tr>
<td>(140) Interest Rate Risk</td>
<td>LR027 Interest Rate Risk Column (3) Line (36)</td>
<td>X 0.2100</td>
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</tr>
<tr>
<td>(141) Health Credit Risk</td>
<td>LR029 Health Credit Risk Column (2) Line (7)</td>
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</tr>
<tr>
<td>(142) Market Risk</td>
<td>LR027 Interest Rate Risk Column (3) Line (37)</td>
<td>X 0.2100</td>
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</tr>
<tr>
<td>(143) Business Risk</td>
<td>LR029 Business Risk Column (2) Line (40)</td>
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<tr>
<td>(144) Health Administrative Expenses</td>
<td>LR029 Business Risk Column (2) Line (57)</td>
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<tr>
<td>(145) Total Risk Effect</td>
<td>Line (109) + (120) + (132) + (139) + (140) + (142) + (143) + (144)</td>
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### Calculation of Authorized Control Level Risk-Based Capital

**Company Name**

<table>
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<th>Source</th>
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<tbody>
<tr>
<td>Insurance Affiliates and Miscellaneous Other Amounts (C-0)</td>
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<tr>
<td>(1) Affiliated US Property-Casualty Insurers Directly Owned</td>
<td>LR042</td>
</tr>
<tr>
<td>(2) Affiliated US Life Insurers Directly Owned</td>
<td>LR042</td>
</tr>
<tr>
<td>(3) Affiliated US Health Insurers Directly and Indirectly Owned</td>
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</tr>
<tr>
<td>(4) Affiliated US Property-Casualty Insurers Indirectly Owned</td>
<td>LR042</td>
</tr>
<tr>
<td>(5) Affiliated US Life Insurers Indirectly Owned</td>
<td>LR042</td>
</tr>
<tr>
<td>(6) Affiliated Alien Life Insurers - Canadian</td>
<td>LR042</td>
</tr>
<tr>
<td>(7) Affiliated Alien Life Insurers - All Others</td>
<td>LR042</td>
</tr>
<tr>
<td>(8) Off-Balance Sheet and Other Items</td>
<td>LR042</td>
</tr>
<tr>
<td>(9) Total (C-0) - Pre-Tax</td>
<td>LR042</td>
</tr>
<tr>
<td>(10) (C-0) Tax Effect</td>
<td>LR042</td>
</tr>
<tr>
<td>(11) Net (C-0) - Post-Tax</td>
<td>LR042</td>
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</table>

**Asset Risk - Unaffiliated Common Stock and Affiliated Non-Insurance Stock (C-1cs)**

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<th>Source</th>
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<tbody>
<tr>
<td>(12) Schedule D Unaffiliated Common Stock</td>
<td>LR042</td>
</tr>
<tr>
<td>(13) Schedule BA Unaffiliated Common Stock</td>
<td>LR042</td>
</tr>
<tr>
<td>(14) Common Stock - Concentration Factor</td>
<td>LR042</td>
</tr>
<tr>
<td>(15) Affiliated Preferred Stock and Common Stock - Holding Company in Excess of Indirect Subsidiaries</td>
<td>LR042</td>
</tr>
<tr>
<td>(16) Affiliated Preferred Stock and Common Stock - All Other</td>
<td>LR042</td>
</tr>
<tr>
<td>(17) Total (C-1cs) - Pre-Tax</td>
<td>LR042</td>
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<tr>
<td>(18) (C-1cs) Tax Effect</td>
<td>LR042</td>
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<tr>
<td>(19) Net (C-1cs) - Post-Tax</td>
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**Asset Risk - All Other (C-1o)**

<table>
<thead>
<tr>
<th>Source</th>
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<tr>
<td>(20) Bonds after Size Factor</td>
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<tr>
<td>(21) Mortgages (including past due and repossessed)</td>
<td>LR042</td>
</tr>
<tr>
<td>(22) Unaffiliated Preferred Stock</td>
<td>LR042</td>
</tr>
<tr>
<td>(23) Affiliated Preferred Stock and Common Stock - Investment Subsidiaries</td>
<td>LR042</td>
</tr>
<tr>
<td>(24) Affiliated Preferred Stock and Common Stock - Parent</td>
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<tr>
<td>(25) Affiliated Preferred Stock and Common Stock - Property and Casualty Insurers not Subject to Risk-Based Capital</td>
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<tr>
<td>(26) Affiliated Preferred Stock and Common Stock - Life Insurers not Subject to Risk-Based Capital</td>
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<tr>
<td>(27) Affiliated Preferred Stock and Common Stock - All Other</td>
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</tr>
<tr>
<td>(28) Separate Accounts with Guarantees</td>
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**Notes**

- Denotes items that must be manually entered on the filing software.
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<th>Calculation of Authorized Control Level Risk-Based Capital (Continued)</th>
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<tr>
<td><strong>(30)</strong> Synthetic GICs (C-1o)</td>
<td>LR006 Separate Accounts Column (3) Line (5)</td>
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<tr>
<td><strong>(31)</strong> Synthetic Non-Operational Separate Accounts</td>
<td>LR006 Separate Accounts Column (5) Line (15)</td>
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<tr>
<td><strong>(32)</strong> Real Estate (gross of encumbrances)</td>
<td>LR007 Real Estate Column (3) Line (13)</td>
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<tr>
<td><strong>(33)</strong> Schedule BA Real Estate (gross of encumbrances)</td>
<td>LR007 Real Estate Column (5) Line (25)</td>
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<tr>
<td><strong>(34)</strong> Other Long-Term Assets</td>
<td>LR008 Other Long-Term Assets Column (5) Line (36) + LR018 Off-Balance Sheet Collateral Column (3) Line (17) + Line (18)</td>
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<tr>
<td><strong>(35)</strong> Schedule BA Mortgages</td>
<td>LR009 Schedule BA Mortgages Column (6) Line (23)</td>
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<tr>
<td><strong>(36)</strong> Concentration Factor</td>
<td>LR010 Asset Concentration Factor Column (6) Line (62) Grand Total Page</td>
</tr>
<tr>
<td><strong>(37)</strong> Miscellaneous</td>
<td>LR012 Miscellaneous Assets Column (2) Line (21)</td>
</tr>
<tr>
<td><strong>(38)</strong> Replications Transactions and Mandatory Convertible Securities</td>
<td>LR013 Replication (Synthetic Asset) Transactions and Mandatory Convertible Securities Column (7) Line (999999)</td>
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<tr>
<td><strong>(39)</strong> Reinsurance</td>
<td>LR016 Reinsurance Column (6) Line (17) Sum of Lines (21) through (39)</td>
</tr>
<tr>
<td><strong>(40)</strong> Total (C-1o) - Pre-Tax</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (109) Line (40) - Line (41)</td>
</tr>
<tr>
<td><strong>(41)</strong> (C-1o) Tax Effect</td>
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</tr>
<tr>
<td><strong>(42)</strong> Net (C-1o) - Post-Tax</td>
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<tr>
<td><strong>Insurance Risk (C-2)</strong></td>
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<tr>
<td><strong>(43)</strong> Individual &amp; Institutional Life Insurance</td>
<td>LR025 Life Insurance Column (2) Line (82)</td>
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<tr>
<td><strong>(44)</strong> Group &amp; Credit Life Insurance</td>
<td>LR025 Life Insurance Column (2) Line (82) + Line (83) + Line (84) + Line (85)</td>
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<tr>
<td><strong>(44b)</strong> Longevity Risk</td>
<td>LR025-A Longevity Risk Column (2) Line (5)</td>
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<tr>
<td><strong>(45)</strong> Total Health Insurance</td>
<td>LR024 Health Claim Reserves Column (6) Line (18)</td>
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<tr>
<td><strong>(46)</strong> Premium Stabilization Reserve Credit</td>
<td>LR026 Pension Stabilization Reserve Column (2) Line (10)</td>
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<tr>
<td><strong>(47)</strong> Total (C-2) - Pre-Tax</td>
<td>Li(45) + Li(46) + Grammat of [ Guardrail Factor * Li(45) + Li(46), Guardrail Factor * Li(45) + Li(46) ]</td>
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<tr>
<td><strong>(48)</strong> (C-2) Tax Effect</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (139) Line (47) - Line (48)</td>
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<td><strong>(49)</strong> Net (C-2) - Post-Tax</td>
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<tr>
<td><strong>Interest Rate Risk (C-3a)</strong></td>
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<tr>
<td><strong>(50)</strong> Total Interest Rate Risk - Pre-Tax</td>
<td>LR027 Interest Rate Risk Column (3) Line (36)</td>
</tr>
<tr>
<td><strong>(51)</strong> (C-3a) Tax Effect</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (140) Line (50) - Line (51)</td>
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<tr>
<td><strong>(52)</strong> Net (C-3a) - Post-Tax</td>
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<td><strong>Health Credit Risk (C-3b)</strong></td>
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</tr>
<tr>
<td><strong>(53)</strong> Total Health Credit Risk - Pre-Tax</td>
<td>LR028 Health Credit Risk Column (2) Line (7)</td>
</tr>
<tr>
<td><strong>(54)</strong> (C-3b) Tax Effect</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (141) Line (53) - Line (54)</td>
</tr>
<tr>
<td><strong>(55)</strong> Net (C-3b) - Post-Tax</td>
<td></td>
</tr>
<tr>
<td><strong>Market Risk (C-3c)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(56)</strong> Total Market Risk - Pre-Tax</td>
<td>LR027 Interest Rate Risk Column (3) Line (37)</td>
</tr>
<tr>
<td><strong>(57)</strong> (C-3c) Tax Effect</td>
<td>LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (142) Line (56) - Line (57)</td>
</tr>
<tr>
<td><strong>(58)</strong> Net (C-3c) - Post-Tax</td>
<td></td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on the filing software.
CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL (CONTINUED)

<table>
<thead>
<tr>
<th>Source</th>
<th>NAIC Company Code</th>
<th>Business Risk (C-4a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LR029 Business Risk Column 2: Lines (12) + (26) + (36)</td>
<td></td>
</tr>
<tr>
<td>(59)</td>
<td>Premium Component</td>
<td></td>
</tr>
<tr>
<td>(60)</td>
<td>Liability Component</td>
<td></td>
</tr>
<tr>
<td>(61)</td>
<td>Subtotal Business Risk (C-4a) - Pre-Tax</td>
<td></td>
</tr>
<tr>
<td>(62)</td>
<td>(C-4a) Tax Effect</td>
<td></td>
</tr>
<tr>
<td>(63)</td>
<td>Net (C-4a) - Post-Tax</td>
<td></td>
</tr>
<tr>
<td>(64)</td>
<td>Health Administrative Expense Component of Business Risk (C-4b) - Pre-Tax</td>
<td></td>
</tr>
<tr>
<td>(65)</td>
<td>(C-4b) Tax Effect</td>
<td></td>
</tr>
<tr>
<td>(66)</td>
<td>Net (C-4b) - Post-Tax</td>
<td></td>
</tr>
</tbody>
</table>

| Total Risk-Based Capital After Covariance Before Basic Operational Risk |
|-----------------------------|-----------------------------|
| C-0 + C-4a + Square Root of [(C-1o + C-3a)² + (C-1cs + C-3c)² + (C-2)² + (C-3b)² |
| + (C-4b)²] |

<table>
<thead>
<tr>
<th>Gross Basic Operational Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.03 x L(67)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Security Shortfall Calculated in Accordance With Actuarial Guideline XLVIII Multiplied by 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>LR036 XXX/XXX Reinsurance Primary Security Shortfall by Cession Column (7) Line (999999) Multiplied by 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Risk-Based Capital After Covariance (Including Basic Operational Risk and Primary Security Shortfall multiplied by 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>L(67) + L(70) + L(71)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized Control Level Risk-Based Capital (After Covariance Adjustment and Shortfall)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line (72) x 0.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tax Sensitivity Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>LR031</td>
</tr>
</tbody>
</table>

Denotes items that must be manually entered on the filing software.
Basis of Factors

The factors developed represent surplus needed to provide for excess claims over life insurance mortality risk, which is defined as adverse variance in life insurance deaths (i.e., murders, diving accidents) expected both from random fluctuations and from inaccurate pricing for future levels of claim. For a large number of trials, each insured either lives or dies based on a "roll of the dice" business while appropriately reflecting the probability of death from both normal and excess claims, offering flexibility to adjust current mortality rates for emerging experience. The present value of mortality risks included in the claims generated by this process, less expected claims, will be the amount of surplus needed under that trial. Development of the factors were volatility, level, trend, and catastrophe. The factors were developed by stochastically simulating the formula produce a level of surplus at least as much run-off of in force life insurance blocks typical of U.S. life insurers.

The capital need, expressed as needed in 95 percent of a dollar amount, is determined as the trials' greatest present value of accumulated deficiencies at the 95th percentile of the stochastic distribution of experience over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all protection years, the solved for capital ensures non-negative capital at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the net amount at risk (NAR). The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The model was developed for portfolios of 10,000, 100,000 and one million lives, and it was found that the surplus needs decreased with larger portfolios, consistent with the law of large numbers.

Specific Instructions for Application of the Formula

Lines 3, 4, 5 and 9-21 are not applicable to Fraternal Benefit Societies.

Annual statement reference is for the total net amount at risk for the category (e.g., Individual & Industrial is one category). The net amount at risk is then further broken down by size as in a tax table to reflect the decrease in risk. In larger blocks of life insurance, the breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to amounts in force is completed automatically. The calculation is as follows:

The NAR is derived for each of the factor categories using annual statement sources and company records. In force and Reserve amounts are net of reinsurance throughout.

The table below illustrates the RBC requirement calculation embedded in Line (13) for ULSG.

<table>
<thead>
<tr>
<th>Line</th>
<th>Individual &amp; Industrial ULSG</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Statement Value</td>
</tr>
<tr>
<td>12</td>
<td>Factor</td>
</tr>
<tr>
<td>13</td>
<td>RBC Requirement</td>
</tr>
</tbody>
</table>

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### Line (16) Term Life

<table>
<thead>
<tr>
<th>Block</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 500 Million</td>
<td>X 0.00175</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 4,500 Million</td>
<td>X 0.00110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00075</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Group &amp; Credit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Line (19) All Other Life

<table>
<thead>
<tr>
<th>Block</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 500 Million</td>
<td>X 0.00270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 24,500 Million</td>
<td>X 0.00075</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00050</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total All Other Life</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Line (14) Term Life In Force is derived from company records. The amount classified as Term Life needs to be consistent with the Exhibit of Life Insurance and the same block of policies as the Term reserves recorded in Line (15) which is sourced to the Analysis of Increase in Reserves During the Year – Individual Life Insurance Column 4 Line 15. The table below illustrates the RBC requirement calculation embedded in Line (16) for Term Life.
- Lines (17) and (18) All Other Life In Force and Reserves are derived from the aggregate amounts derived in lines (1) to (10) minus the ULSG amounts in lines (11) to (12) and term life amounts in lines (14) to (15). In force business not classified as ULSG or term life is assigned to all other life. The table below illustrates the RBC requirement calculation embedded in Line (19) for All Other Life.
- Lines (15) and (16) Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under are derived from company records. This category includes group contracts where the premium terms have 36 months or fewer until expiration or renewal. The in force amount classified in this category needs to be consistent with the Exhibit of Life Insurance. The reserves amount classified in this category needs to be consistent with Exhibit 5 used for Lines (11) and (12), Separate Accounts Exhibit used for Line (13), and Schedule S used for Lines (11) and (12). Federal Employees’ Group Life Insurance (FEGLI) and Servicemembers’ Group Life Insurance (SGLI) contracts are
The table below illustrates the RBC requirement calculation embedded in Line (37) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under.

<table>
<thead>
<tr>
<th>Line (37)</th>
<th>Group &amp; Credit Life with Remaining Rate Terms 36 Months and Under</th>
<th>(1) Statement Value</th>
<th>(2) Factor</th>
<th>(3) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 500 Million</td>
<td>X 0.00130 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 24,500 Million</td>
<td>X 0.00065 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00045 =</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lines (38) and (39) Group & Credit Life In Force and Reserves with Remaining Rate Terms Over 36 Months are derived from the aggregate amounts derived in lines (21) to (34) minus the Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under in lines (35) and (36). FEGLI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (40) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms Over 36 Months.

<table>
<thead>
<tr>
<th>Line (40)</th>
<th>Group &amp; Credit Life with Remaining Rate Terms Over 36 Months</th>
<th>(1) Statement Value</th>
<th>(2) Factor</th>
<th>(3) RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 500 Million</td>
<td>X 0.00180 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next 24,500 Million</td>
<td>X 0.00070 =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00045 =</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lines (41) FEGLI/SGLI In Force amounts are retrieved from the Exhibit of Life Insurance. The capital factor assigned is the same as the largest size band for group & credit life contracts with remaining rate terms 36 months and under.

<table>
<thead>
<tr>
<th>Line (41)</th>
<th>FEGLI/SGLI In Force</th>
<th>(1) Statement Value</th>
<th>(2) Factor</th>
<th>(3) RBC Requirement</th>
</tr>
</thead>
</table>

All amounts should be entered as required. The risk-based capital software will calculate the RBC requirement for individual and industrial and for group and credit.
LIFE INSURANCE - OPTION 2 - DRAFT

Basis of Factors

The factors chosen develop surplus needed to provide for excess claims over life insurance mortality risk, which is defined as adverse variance in life insurance deaths (i.e., insureds die sooner than expected) both from random fluctuations and from inaccurate pricing for future levels of mortality. The remaining lifetime of claims for a large number of lives is modeled in a block of business, while appropriately reflecting the variability of claims from both normal and excess claims. Pricing flexibility is used to adjust current mortality rates for emerging experience. The present values of mortality risks associated with the claims generated by this process, less expected claims, will be the amount of surplus needed under that trial. Development of the factors were volatility, level, trend, and catastrophe. The factors were developed by stochastically simulating the formula produce a level of surplus at least as high as the amount of in force life insurance blocks typical of U.S. life insurers.

The capital need, expressed as a percent of a dollar amount, is determined as discussed greatest present value of accumulated deficiencies at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Mortality losses are defined as the after-tax quantification of gross death benefits minus reserves released minus mortality margin present in reserves. The after-tax-statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures non-negative capital at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital need is translated to a factor expressed as a percentage of the net amount at risk (NAR). The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The model was developed for portfolios of 10,000, 100,000 and one million lives, and it was found that the surplus needs decreased with larger portfolios, consistent with the law of large numbers.

Net amount at risk was chosen as a benchmark because losses are difficult to calculate on a consistent basis from company to company.

The factors are differentiated between individual & industrial life and group & credit life, and by in force block size. Within individual & industrial life, the factors are differentiated into categories by contract type depending on the degree of pricing flexibility. Within group & credit life, the factors are differentiated into categories by the remaining length of the premium rate term by group contract. There are distinct factors for contracts that have remaining premium rate terms 36 months and under and for contracts that have remaining premium rate terms over 36 months. The Federal Employees’ Group Life Insurance (FEGLI) and Servicemembers’ Group Life Insurance (SGLI) receive a separate factor applied to the amounts in force.

Specific Instructions for Application of the Formula

Lines 4xx, 42, 5 and 9-21-41 are not applicable to Fraternal Benefit Societies.

Annual statement reference is for the total net amount at risk for the factor (e.g., Individual & Industrial (one category)). The net amount at risk is then further broken down by line 21 as a base to reflect the decrease in risk, E in a block of life insurance. This breakdown will not appear on the RBC filing software or on the printed copy, as the application of factors to amounts in force is completed automatically. The calculation is as follows:

The NAR is derived for each of the factor categories using annual statement sources and company records. In Force and Reserves amounts are net of reinsurance throughout. The In Force amounts throughout derived from company records need to be consistent with the Exhibit of Life Insurance. The Reserves amounts throughout derived from company records need to be consistent with Exhibit 5, Separate Accounts Exhibit, and Schedule S.

Pricing Flexibility for Individual Life Insurance is defined as the ability to materially adjust rates on in force contracts through changing premiums and/or non-guaranteed elements as of the valuation date and within the next 5 policy years. A material rate adjustment is defined as the ability to recover, on a present value basis, the difference in mortality provided for in the factor below for contracts with and without pricing flexibility.
Lines (11) and (12) Life Policies with Pricing Flexibility In Force and Reserves are derived from company records. Examples of products intended for this category include, but aren’t limited to, participating whole life insurance, universal life insurance without secondary guarantees, and yearly renewable term insurance where scheduled premiums may be changed. The table below illustrates the RBC requirement calculation embedded in Line (13) for Life Policies with Pricing Flexibility:

<table>
<thead>
<tr>
<th>Line</th>
<th>Individual &amp; Industrial Life Policies with Pricing Flexibility</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(11)</td>
<td>First 500 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next 250 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next 20,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over 25,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Individual & Industrial Life Policies with Pricing Flexibility: Net Amount at Risk

<table>
<thead>
<tr>
<th>Line</th>
<th>Group &amp; Credit Term Life Policies without Pricing Flexibility</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(20)</td>
<td>First 500 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next 25,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next 20,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over 25,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Group & Credit Term Life Policies without Pricing Flexibility: Net Amount at Risk

Lines (14) and (15) Term Life Policies without Pricing Flexibility In Force and Reserves are derived from company records. Examples of products intended for this category include, but aren’t limited to, level term insurance with guaranteed level premiums and yearly renewable term insurance where scheduled premiums may not be changed. The table below illustrates the RBC requirement calculation embedded in Line (16) for Term Life Policies without Pricing Flexibility:

<table>
<thead>
<tr>
<th>Line</th>
<th>Term Life Policies without Pricing Flexibility</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(16)</td>
<td>First 500 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next 25,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over 25,000 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Group & Credit Term Life Policies without Pricing Flexibility: Net Amount at Risk

Lines (17) and (18) Permanent Life Policies without Pricing Flexibility In Force and Reserves are derived from the aggregate amounts derived in lines (1) to (10) minus the amounts recorded in the other individual life categories. Examples of products intended for this category include, but aren’t limited to, universal life with secondary guarantees and non-participating whole life insurance. Policies that aren’t recorded in the other individual life categories default to this category which has the highest factors. The table below illustrates the RBC requirement calculation embedded in Line (19) for Permanent Life Policies without Pricing Flexibility:

<table>
<thead>
<tr>
<th>Line</th>
<th>Permanent Life Policies without Pricing Flexibility</th>
<th>Statement Value</th>
<th>Factor</th>
<th>RBC Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(19)</td>
<td>First 500 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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NAIC Proceedings – Spring 2022
Total Permanent Life Policies without Pricing Flexibility

Net Amount at Risk

Lines (35) and (36) Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under are derived from company records. This category includes group contracts where the premium terms have 36 months or fewer until expiration or renewal. The net in force amount classified in this category needs to be consistent with the Exhibit of Life Insurance. The reserves amount classified in this category needs to be consistent with Exhibit 5 used for Lines (28) and (29), Separate Accounts Exhibit used for Line (30), and Schedule A used for Lines (31) and (32). Federal Employees' Group Life Insurance (FEGLI) and Servicemembers' Group Life Insurance (SGLI) contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (37) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under.

<table>
<thead>
<tr>
<th>Line (37)</th>
<th>Group &amp; Credit Life with Remaining Rate Terms 36 Months and Under</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Statement Value</td>
</tr>
<tr>
<td>(2)</td>
<td>Factor</td>
</tr>
<tr>
<td>(3)</td>
<td>RBC Requirement</td>
</tr>
<tr>
<td>First 500 Million</td>
<td>X 0.00130 = 6.50</td>
</tr>
<tr>
<td>Next 24,500 Million</td>
<td>X 0.00045 = 1.10</td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00030 = 0.75</td>
</tr>
<tr>
<td>Total Group &amp; Credit Life Net Amount at Risk with Remaining Rate Terms 36 Months and Under</td>
<td></td>
</tr>
</tbody>
</table>

Lines (38) and (39) Group & Credit Life In Force and Reserves with Remaining Rate Terms Over 36 Months are derived from the aggregate amounts derived in Lines (21) to (34) minus the Group & Credit Life In Force and Reserves with Remaining Rate Terms 36 Months and Under in Lines (35) and (36). FEGLI and SGLI contracts are excluded. The table below illustrates the RBC requirement calculation embedded in Line (40) for Group & Credit Life Net Amount at Risk with Remaining Rate Terms Over 36 Months.

<table>
<thead>
<tr>
<th>Line (40)</th>
<th>Group &amp; Credit Life with Remaining Rate Terms Over 36 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Statement Value</td>
</tr>
<tr>
<td>(2)</td>
<td>Factor</td>
</tr>
<tr>
<td>(3)</td>
<td>RBC Requirement</td>
</tr>
<tr>
<td>First 500 Million</td>
<td>X 0.00180 = 9.00</td>
</tr>
<tr>
<td>Next 24,500 Million</td>
<td>X 0.00070 = 1.65</td>
</tr>
<tr>
<td>Over 25,000 Million</td>
<td>X 0.00045 = 1.10</td>
</tr>
<tr>
<td>Total Group &amp; Credit Life Net Amount at Risk with Remaining Rate Terms Over 36 Months</td>
<td></td>
</tr>
</tbody>
</table>

Line (41) FEGLI/SGLI In Force amounts are retrieved from the Exhibit of Life Insurance. The capital factor assigned is the same as the largest size band for group & credit life contracts with remaining rate terms 36 months and under.

<table>
<thead>
<tr>
<th>Line (41)</th>
<th>FEGLI/SGLI In Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Statement Value</td>
</tr>
<tr>
<td>(2)</td>
<td>Factor</td>
</tr>
<tr>
<td>X 0.00030 = 0.30</td>
<td></td>
</tr>
</tbody>
</table>

All amounts should be entered as required. The risk-based capital software will calculate the RBC requirement for individual and industrial and for group and credit.
December 21, 2021

Ms. Seong-Min Eom,
Chair, Longevity Risk (A/E) Subgroup
National Association of Insurance Commissioners

Via email: Dave Fleming (dfleming@naic.org)
Re: Longevity Risk Subgroup working agenda item on Longevity Reinsurance

Dear Seong-Min,

The American Academy of Actuaries1 (Academy) Annuity Reserves and Capital Work Group (ARCWG) recently shared with the Valuation Manual (VM)-22 (A) Subgroup an initial draft of NAIC Valuation Manual Section II and recommended VM-22 requirements associated with the ARCWG proposal on a principle-based reserving (PBR) framework for fixed annuities.2 The Academy’s C-2 Longevity Risk Work Group is providing its observations on implications this reserve proposal may have on the expansion of the scope for C-2 Longevity capital to include longevity reinsurance contracts. To summarize:

1. Longevity reinsurance is explicitly included in the scope of the ARCWG VM-22 draft;
2. Reserve aggregation, as included in the VM-22 draft, could facilitate a simple approach to including longevity reinsurance in C-2 using the same factors that currently apply to other fixed annuities; and
3. The C-2 capital approach for longevity reinsurance business written prior to the VM-22 effective date will require further study and recommendation by the Longevity Risk (E/A) Subgroup.

As you may recall, longevity reinsurance contracts were excluded from the scope of the year-end 2021 implementation of C-2 Longevity within Life Risk-Based Capital (LRBC) given the need for further discussion on appropriate capital methodology given product differences compared to payout annuities. Longevity reinsurance is explicitly included in the scope of ARCWG’s VM-22 draft. Progress on these reserve requirements may provide an opportunity to concurrently advance the discussion on C-2 capital.

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1 The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
As described in the VM-22 product definition, the reinsurer assumes the longevity risk associated with the periodic payments of the reinsured annuity contract(s). In general, the reinsurer is responsible for paying the periodic annuity payments based on actual longevity experience of the underlying population in exchange for a fixed schedule of periodic payments over the expected lifetime of the underlying annuitants. Such contracts may include net settlement provisions such that only one party makes a payment in any particular period.

The field study, which was conducted in 2018 and used to calibrate the current C-2 Longevity factors, did not include results for longevity reinsurance since there were not enough responses for companies reporting results for the product to allow for aggregated data. As a result, the Academy’s C-2 Longevity Risk Work Group is not currently able to calibrate a capital factor based on results specific to the reinsurance product. Because this reinsurance transfers the longevity risk associated with immediate and/or deferred payout annuity products that are already in scope for C-2 Longevity, it seems reasonable to postulate that the longevity risk of a longevity reinsurance contract would be consistent with the longevity risk of the underlying annuity contract prior to reinsurance.

The periodic premium payments drive important differences in reserves compared to single premium payout annuity products. On a stand-alone product basis, the VM-22 stochastic reserve for longevity reinsurance could be quite low because the present value of annuity payments under prudent estimate mortality may not materially exceed the present value of premiums. If longevity reinsurance is aggregated with other products in calculating the stochastic reserve as permitted under the VM-22 draft, the inclusion of longevity reinsurance in the aggregation could in some cases act to reduce the aggregate reserve if the longevity reinsurance premiums exceed the annuity benefits under the prudent estimate reserve assumptions. The Academy’s C-2 Longevity Risk Work Group believes this is an appropriate though potentially surprising result that should be clearly understood. Listed below is a hypothetical illustration of reserve results under aggregation.

<table>
<thead>
<tr>
<th></th>
<th>Present Value of Future Premium</th>
<th>Present Value of Future Benefits</th>
<th>Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Annuities</td>
<td>N/A</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td>Longevity Reinsurance Assumed</td>
<td>1,010</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,010</td>
<td>2,500</td>
<td>1,490</td>
</tr>
</tbody>
</table>

In this hypothetical illustration, the future longevity reinsurance premiums exceed future benefit payments, so the aggregate reserve—1,490—is less than the reserve that would have been calculated for the immediate annuities on a stand-alone basis—1,500. (The subsequent allocation of the 1,490 aggregate reserve to the contract level is not shown in this illustration.)

A simple approach to including longevity reinsurance within the scope of C-2 Longevity capital is to apply the existing capital factors to the present value of benefits for longevity reinsurance in addition to the existing reserve basis for products in scope. The ARCWG VM-22 draft as written would reflect the entire longevity reinsurance gross premium in the aggregated reserve calculation so no adjustment for premiums would be required in capital. Continuing the hypothetical illustration above, this would result in a total company basis for C-2 Longevity of 2,490:
The ARCWG VM-22 draft is written to apply prospectively to contracts issued after Jan. 1, 2024, so it does not address reserving for longevity reinsurance contracts issued before this date. The capital approach above may need to be reconsidered depending on the reserving method for these existing contracts. This retrospective issue may only apply to a small number of companies based on the low response rate for the product in the 2018 field study but will also need to be considered by the Longevity Risk Subgroup as part of the expansion of scope for C-2 Longevity.

The Academy’s C-2 Longevity Risk Work Group supports the proposal of the ARCWG, which includes an aggregate calculation of reserves. However, if aggregation of longevity reinsurance with other jointly managed annuity business is ultimately not included in the final VM-22 language (or when considering the retrospective application to contracts issued prior to Jan. 1, 2024, which may use different reserve methods), then it seems likely that a portion of the gross premium under the longevity reinsurance contracts could be excluded from the reserve calculation in order to ensure a reserve greater than zero. In that situation there would be two broad paths forward for C-2 capital:

A) **Continue to use present value of benefits as the basis for longevity reinsurance along with the same C-2 capital factor.** This approach could result in a portion of the gross reinsurance premium being excluded from both the reserve and capital calculations. This could be deemed acceptable within the context of RBC as a simple factor-based calculation for regulatory capital carried out independent of reserves. However, it would be inconsistent with a Total Asset Requirement (TAR) view of reserves and capital together achieving a consistent outcome (such as 95th percentile) across products and could result in the TAR for longevity reinsurance being overstated by the amount of any gross premium that is excluded.

B) **Consider an adjusted capital factor specific to longevity reinsurance that takes into account premium amounts not included in reserves.** It might not be possible to calibrate a single factor that would be appropriate to apply to all longevity reinsurance contracts written at different times with different premium levels and with different emerging experience. It could be possible to include a calculation of a more appropriate adjusted factor within the C-2 Longevity calculation at a company level; however, this would be more complicated than the factor times reserve approach currently used for C-2 Longevity.

Life insurance is an example of a product that also includes recurring premium payments. Under a net premium reserving methodology, a portion of the gross premium is excluded from reserves, yet no adjustment for this is required in capital. There are several key differences for longevity reinsurance that could merit consideration of the gross premium in reserves and/or capital:

- Future premium payments for longevity reinsurance are a contractual obligation that in some cases may be supported by collateral posted as security against default. Future life
insurance premiums by contrast are voluntary with a contract holder right to lapse at any
time.
• In a mortality risk event for life insurance (premature death), premium payments for a
contract cease and are not received by the insurer. By contrast, under a longevity
reinsurance risk event (extended longevity), premium payments for a contract continue in
their entirety and are netted in full against future benefit obligations.

The impact on C-2 Longevity for companies ceding risk through longevity reinsurance should
also be addressed. This could be achieved by clarifying the existing adjustment for modified
coinsurance (Modco) reserves ceded to also include reserves for which longevity risk is ceded
via longevity reinsurance contracts.

It may not be appropriate to exclude longevity risk transferred by reinsurance from scope of C-2
Longevity while including in scope payout annuity products having the same longevity risk. The
Academy’s C-2 Longevity Risk Work Group looks forward to supporting the Longevity Risk
Subgroup in completing the implementation of C-2 Longevity to include longevity reinsurance.

*****

Should you have any questions or comments regarding this letter, please contact Khloe
Greenwood, life policy analyst at the Academy (greenwood@actuary.org).

Sincerely,

Paul Navratil, MAAA, FSA
Chairperson, C-2 Longevity Risk Work Group
American Academy of Actuaries
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 16, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Chuck Hale (AL); Thomas Reedy (CA); Wanchin Chou (CT); Sean Collins (FL); Mike Yanacheak (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted the Guidance Document on Bond Factor Changes

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI believes the document will be helpful to regulators and supports its adoption with the inclusion of the reference to other changes made for yearend 2021. Mr. Yanacheak made a motion, seconded by Mr. Leung, to adopt the Working Group’s guidance document on bond factor changes (Attachment Four-C1). The motion passed unanimously.


Chris Trost (American Academy of Actuaries—Academy), chair of the Academy’s C2 Mortality Work Group, highlighted the main changes that the Academy is recommending is to expand the number of categories in the current structure which applies a factor to the net amount at risk (NAR) which decreases as the NAR increases. The Academy believes a critical element in capturing the risk is the length of the exposure period where there is not the capacity to adjust the mortality charges and because of that, he said the Academy created three categories using VM-20 as a guide with term, universal life with secondary guarantees (ULSG) and all other. The all-other category maintains the same period that the original RBC work used which is looking at the mortality risk over a five-year period because beyond that time the risk could be covered through adjustments and mortality rates. Mr. Trost said the exposure period lasts much longer for term and ULSG and the Academy used averages of 10 years for term and 20 years for ULSG. He said the Academy also added a catastrophe terrorism component and a catastrophe unknown sustained risk component. He discussed other aspects that were changed and those that were not changed as shown on page six of the recommendation (Attachment Four-C2). Ryan Fleming (Academy) presented the updated C-2 factors, other aspects of the categorization and a comparison of the recommended factors versus the current factors along with the percentage change in those factors. He discussed the C-2 factors as an overall mortality increase along with the Academy’s comparison against other capital regimes. He highlighted the Academy’s sensitivity testing which helped in identifying that the length of the mortality rate exposure period is one of the most critical variables in determining capital factors. He summarized the Academy’s recommendation and noted that the Academy does not believe that additional review of the adopted correlation factor with longevity is needed as the work on mortality was done consistently with the longevity work.

With respect to the Academy’s pandemic modeling, Ms. Hemphill noted what appeared to be one-year events and asked whether having another component to account for multi-year events was considered. Mr. Trost said the Academy was capturing a multi-year event but modeling it occurring in one year. He also noted that the Academy looked at the actual impacts of unknown sustained risks, specifically with the opioid epidemic and AIDS, and those impacts were significantly less in the insured population than the general population, but the Academy did not reflect this in its recommendation. For those sustained type risks, he said the Academy also included the assumption that the worst experience was the same at all ages which adds another level of conservatism. Ms. Hemphill expressed concern with the factor decrease for the all-other category given how non-homogenous the products are in the ability to adjust and suggested the possibility of addressing this either through revising the factors presented or adding some regulatory review process. Mr. Carmello suggested having products without the ability to adjust default the categories with higher factors and not the all-other category. Mr. Barlow said another approach could be to set the factors for the all-other category to whatever is appropriate for the product involving the most risk.

Mr. Barlow said the Academy will be working with NAIC staff on the needed structural changes so they can be exposed for comment before the end of January.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
MEMORANDUM

TO: Financial Examiners and Other State Insurance Regulators

FROM: Philip Barlow, Chair of the Life Risk-Based Capital (E) Working Group

DATE: Dec. 16, 2021

RE: Interpretation of the 2021 Life Risk-Based Capital (RBC) Results in Light of the 2021 Bond Factor Changes

Purpose and Intended Audience for this Document
This document is intended to assist financial examiners and other state insurance regulators as they review the results of 2021 RBC calculations for life insurers in light of the 2021 bond factor changes. There were also changes related to longevity risk, real estate and reinsurance that state insurance regulators may want to consider but this document is specifically addressing the bond factor changes as they have the most potential to impact the action level, including through the trend test.

More detailed information about this topic is contained in the minutes of the Life Risk-Based Capital (E) Working Group, and related documents are included on the websites for both the Working Group and the Capital Adequacy (E) Task Force. The changes to the Life RBC formula factors for bonds were adopted by the Working Group on June 11 and by the Task Force on June 30.

Executive Summary
The work to update the RBC charges applied to bonds has been ongoing for several years and reflects the efforts of many participants. The Working Group appreciates the considerable work of the American Academy of Actuaries (Academy) on this project, as well as the work done by Moody’s Analytics on behalf of the American Council of Life Insurers (ACLI). The Working Group discussed the proposals presented during numerous conference calls over the past year. The Working Group also reviewed estimates of the impact the proposals would have had on the RBC results for life insurers’ year-end 2020 filings. The Working Group concluded that both proposals presented a sound and appropriate update to the factors applied to bonds, and it ultimately adopted the proposal presented by Moody’s.
How should the effects of the change in bond factors be factored into the interpretation of RBC results?

The estimated impact of the change in bond factors the Working Group reviewed on individual companies and the life insurance industry in aggregate indicated less than a 2% increase in the authorized control level (ACL) RBC on an aggregate basis. However, a small number of companies experienced a much larger impact when the 2019 results were recalculated with the new factors. The Life RBC Trend Test (LR035) will be affected by the change in bond factors and may be an area where this change is most evident. The Trend Test calculates a margin, which is the excess of total adjusted capital (TAC) over ACL RBC, for each of the current year, prior year, and third prior year. To the extent that the current year margin is lower than the prior year or third prior year margin, regulatory action may be indicated.

For the 2021 Trend Test, the margin for 2021 is compared to the margins for 2020 and 2018. As noted, a company’s ACL RBC is expected to be increased for 2021 compared to prior years. The changes to ACL RBC due to the change in bond factors may cause some companies to trigger the Trend Test for 2021, solely because of the change in bond factors.

If state insurance regulators find that a life insurer has triggered the Trend Test, triggers an Action Level for 2021, or has a significant decline in its RBC ratio from 2020 to 2021, they could have additional discussions with the company and request additional calculations. It is likely that companies would have done some analysis of significant changes in ACL RBC, and that analysis could be shared with state insurance regulators.
Academy C-2 Mortality Work Group Recommendation

Chris Trost, MAAA, FSA
Chairperson C-2 Mortality Work Group

Ryan Fleming, MAAA, FSA
Vice Chair C-2 Mortality Work Group
American Academy of Actuaries

National Association of Insurance Commissioners (NAIC) Life Risk-Based Capital (E) Working Group (LRBCWG)—November 9, 2021

Agenda

- Review Life RBC C-2 mortality overall approach and current risk-based capital (RBC) factors
- Present recommendation on updated C-2 factors
  - Structural changes to factor categories
  - Updated factors under the recommended structure
- Appendix:
  - Methodology, assumption, and risk distribution comparisons
  - Validation, peer review, limitations
Life RBC C-2 Mortality Overall Approach (1 of 2)

- Mortality risk is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience.
- C-2 requirement covers mortality risk up to the 95th percentile covering adverse experience in excess of the amount covered in statutory reserves.
- C-2 requirement includes mortality risks related to:
  - Volatility Risk—natural statistical deviations in experienced mortality
  - Level Risk—error in experience mortality assumption
  - Trend Risk—adverse mortality trend
  - Catastrophe Risks
    - Large temporary mortality increase from a severe event such as a pandemic or terrorism
    - Sustained mortality increase from an unknown risk

Life RBC C-2 Mortality Overall Approach (2 of 2)

- Evaluate mortality risks using stochastic simulation of projected statutory losses.
- Discount after-tax cash flows (at 2.765% after-tax discount rate [3.5% pre-tax]).
- Express capital requirement using a factor-based approach applied to Net Amount at Risk (NAR) and convert to pre-tax.
C-2 Life Mortality Risk-Based Capital

<table>
<thead>
<tr>
<th>Current Pre-Tax RBC Factors</th>
<th>Per $1000 of NAR</th>
<th>Individual &amp; Industrial Life</th>
<th>Group &amp; Credit Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>First $500M</td>
<td>2.23</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>Next $4.5B</td>
<td>1.46</td>
<td>1.16</td>
<td></td>
</tr>
<tr>
<td>Next $20B</td>
<td>1.17</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>&gt;$25B</td>
<td>0.87</td>
<td>0.78</td>
<td></td>
</tr>
</tbody>
</table>

- The C-2 component of RBC represents **17-18%** of total life industry risk-based capital

What Changed and Didn’t Change from the Original Work*

**What Changed**
- Expanded categories to three product categories for individual life and two categories for remaining rate terms for group life
- Addition of a catastrophe terrorism component
- Addition of a catastrophe unknown sustained risk component, replaces severe adverse HIV scenarios in original work
- Lower experience mortality rates
- Lower discount rates (2.765% after-tax versus 6% in original work)
- Inforce assumptions reflecting current U.S. life insurers (demographic, product, lapses, etc.) and group specific assumptions
- Mortality risk assumptions calibrated to latest research and studies
- New model developed in Excel VBA; stochastic capabilities are much greater today than the early 1990’s

**What Didn’t Change**
- Statistical safety level – 95th percentile over 5 years for individual life products with inforce pricing flexibility
- Capital is determined for losses in excess of reserve mortality – 5% margin in statutory reserve mortality is consistent with one standard deviation

* See the Appendix for a detailed comparison of the current and original work
Pre-Tax C-2 Factor Recommendation versus Current RBC

<table>
<thead>
<tr>
<th>Risk Component</th>
<th>Large Inforce Size &gt;$25B NAR</th>
<th>Small Inforce Size ≤$500M NAR</th>
<th>Key Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Scenarios</td>
<td>↓ 45%</td>
<td>↓ 25%</td>
<td>Removal of discrete HIV scenarios</td>
</tr>
<tr>
<td>Level</td>
<td>↓ 25%</td>
<td>↑ 5%</td>
<td>Lower experience mortality rates, reducing risk with large credible blocks</td>
</tr>
<tr>
<td>Trend</td>
<td>↑ 20%</td>
<td>↑ 10%</td>
<td>Greater range of mortality trends and differences by age/sex cohort</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Risk increases with longer exposure periods</td>
</tr>
<tr>
<td>Catastrophe</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
<td>Similar pandemic severity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Addition of 9/11-type terrorism event (+1%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Addition of unknown sustained risk event (+4-9%)</td>
</tr>
<tr>
<td>Capital Quantification Method</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
<td>Update to greatest present value of accumulated deficiencies (GPVAD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Loss quantified as death benefits minus reserves released</td>
</tr>
<tr>
<td>Volatility</td>
<td>↑ 0%</td>
<td>↓ 5%</td>
<td>Similar results as the original model</td>
</tr>
<tr>
<td>Length of Risk Exposure Period</td>
<td>↑ varies</td>
<td>↑ varies</td>
<td>Factors increase based on the length of the current mortality rate risk exposure period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This is a critical variable for differentiating mortality risk</td>
</tr>
</tbody>
</table>

Lower Experience Mortality Rates

- The new model uses a distribution of rating classes using 2017 CSO tables
- 2017 Commissioners Standard Ordinary (CSO) mortality rates are significantly lower (50%-90%) than “88% of the 1975-80 Basic Table” used previously due to decades of mortality improvement in the U.S.
- An example at a typical age highlights the significant decrease

<table>
<thead>
<tr>
<th>Comparison of Experience Mortality Rates, Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rates Per 1,000 Age 45, Male</td>
</tr>
<tr>
<td>Table</td>
</tr>
<tr>
<td>88% of 1975-80 Basic Table</td>
</tr>
<tr>
<td>2017 CSO Unloaded Composite</td>
</tr>
<tr>
<td>% Difference</td>
</tr>
</tbody>
</table>

- Similar % decreases also occur at different gender, ages and underwriting classes
- Experience mortality manifests through the level risk component
C-2 Factor Attribution by Mortality Risk
Individual Life - 5-Year Projection Period Example

- Risks for large inforce blocks are spread proportionately between volatility/level, trend, and catastrophe
- Smaller inforce blocks are subject to higher volatility and level risks, which results in higher factors versus larger blocks

C-2 Factor Attribution by Mortality Risk
Group Life - 5-Year Projection Period Example

- Risks for large inforce blocks are spread proportionately between volatility/level, trend, and catastrophe
- Smaller inforce blocks are subject to higher volatility and level risks, which results in higher factors versus larger blocks
Expanded Categories to Three Products for Individual Life and Two Categories for Remaining Rate Terms for Group Life

**Original 1990s Work**
- 1993 factors used a 5-year risk exposure period for all individual life business and a 3-year risk exposure period for group life because it assumed that management actions would occur to reset current mortality rates to reflect emerging experience.

**Current Work**
- For individual life, management action to reset current mortality rates may be limited or non-existent for products that offer longer term mortality rate guarantees (e.g., Universal Life with Secondary Guarantees (ULSG), Level Term).
- For group life, there are varying lengths of premium rate terms in the marketplace.
- Factors aligned with the remaining risk exposure period of current mortality rates on an inforce block is appropriate. This risk differentiation can be accomplished by varying factors by product for individual life and by remaining premium term for group life.
- The recommendation is to expand factors into additional categories to reflect the current mortality rate risk exposure period over the remaining lifetime of an inforce block of business.
  - For individual life insurance, the recommendation is to differentiate into three product categories with definitions consistent with the annual statement – analysis of operations by line of business – individual life insurance and VM-20.
  - For group life insurance, the recommendation is to differentiate into two categories by remaining length of the rate term based on company records by group contract.
Two New Catastrophe Components

- A terrorism component was developed based on industry experience from the September 11, 2001 terrorist attacks.
  - Component assumes a 5% annual probability of an extra 0.05 deaths per 1,000.
- As shared at the September 11, 2020 LRBCWG meeting, a new catastrophe component was developed for a sustained mortality increase from an unknown risk, which serves as a replacement for the adverse HIV scenarios in the original work.
  - Component is intended to cover unknown risks that could materialize in the insured population.
  - The component assumes a 2.5% annual probability of a 5% sustained severe mortality increase.
  - If the event occurs, it is sustained for the remainder of the projection period up to a maximum period of 10 years.
  - Without this component the recommended factors would be about 0.1 lower.
- The recommendation is to include these two new catastrophe components.

Recommended Updated C-2 Factors

<table>
<thead>
<tr>
<th>Per $1000 of NAR</th>
<th>Individual &amp; Industrial Life</th>
<th>Group &amp; Credit Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Tax Life RBC C-2 Factors</td>
<td></td>
</tr>
<tr>
<td>Universal Life with Secondary Guarantees</td>
<td>Term Life</td>
<td>All Other Life</td>
</tr>
<tr>
<td>First $500M (Small)</td>
<td>3.90</td>
<td>2.70</td>
</tr>
<tr>
<td>Next $24.5B (Medium)</td>
<td>1.65</td>
<td>1.10</td>
</tr>
<tr>
<td>&gt;$25B (Large)</td>
<td>1.10</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Individual Life: New categorization would be determined based on the categories specified in the annual statement analysis of operations by line of business and consistent with VM-20.
- ULSG: factors are the highest due to the longest current mortality rate guarantees and are based on a 20-year risk exposure period for a mature inforce block.
- Term Life: factors are based on a typical 10-year risk exposure period for a mature inforce block. The industry is concentrated in 10, 20 and 30-year level term.
- All Other Life: factors are based on a 5-year risk exposure period and assume inforce pricing may be adjusted following adverse mortality experience due to the presence of non-guaranteed elements. Examples are universal life products without secondary guarantees and participating whole life products.

Group Life: New categorization would be determined based on company records for the remaining premium rate terms by group contract.
- One category is for remaining premium rate terms greater than 3 years and is represented by a 5-year exposure period.
- The other category is remaining premium rate terms 3 years and under and is represented by a 3-year exposure period.
Recommendation on Updated C-2 Factors

- Size bands were reviewed, and the recommendation is to combine the current middle two categories ($500M-$5B and $5B-$25B) into one category ($500M-$25B).
- The recommendation is to continue categorizing industrial life with individual life and credit life with group life.
- The recommendation is to continue with the 50% credit given for group premium stabilization reserves.

* As of 2019 annual statement reporting.

Recommendation vs Current RBC
Individual & Industrial Life Impacts

- Overall individual life industry impact would be a modest decrease with industry exposure by NAR concentrated in Term business amongst large insurers.
- Factors increase for ULSG.
- Factors decrease for products with inforce pricing flexibility (i.e., All Other category).
- Small ULSG and Term carriers would experience an increase on retained business; however, reinsurance is typically used to transfer/mitigate the mortality risk.
## Recommendation vs Current RBC

### Group & Credit Life Impacts

- **C-2 is reduced by up to 50% of premium stabilization reserves**

Overall group industry impact would be a significant decrease in C-2 capital.

Factors decrease for all but one category: small size for longer rate terms which stays about the same.

Group life factors decreased due to the decades-long decline in experience mortality rates, and the exposure periods remain shorter term as compared to individual life.

C-2 is reduced by up to 50% of premium stabilization reserves.

### Pre-Tax Life RBC C-2 Factors

<table>
<thead>
<tr>
<th>Per $1000 of NAR</th>
<th>Group &amp; Credit Life</th>
<th>Change vs Current RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current RBC</td>
<td>Remaining Rate Terms Over 3 Years</td>
<td>Remaining Rate Terms 3 Years and Under</td>
</tr>
<tr>
<td>First $500M</td>
<td>1.75</td>
<td>1.30</td>
</tr>
<tr>
<td>Remaining Rate Terms Over 3 Years</td>
<td>+3%</td>
<td>-26%</td>
</tr>
<tr>
<td>Next $4.5B</td>
<td>1.16</td>
<td>0.70</td>
</tr>
<tr>
<td>Remaining Rate Terms 3 Years and Under</td>
<td>-40%</td>
<td>-61%</td>
</tr>
<tr>
<td>Next $20B</td>
<td>0.87</td>
<td>0.45</td>
</tr>
<tr>
<td>Remaining Rate Terms Over 3 Years</td>
<td>-20%</td>
<td>-48%</td>
</tr>
<tr>
<td>&gt;$25B</td>
<td>0.76</td>
<td>0.30</td>
</tr>
<tr>
<td>Remaining Rate Terms 3 Years and Under</td>
<td>-41%</td>
<td>-61%</td>
</tr>
</tbody>
</table>

## C-2 Factors as an Overall Mortality Increase and Observations Versus Other Capital Regimes

### Overall Mortality Increase

<table>
<thead>
<tr>
<th>Inforce Block Size</th>
<th>Individual &amp; Industrial Life – 5-year</th>
<th>Group &amp; Credit Life – 5-year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>+22%</td>
<td>+31%</td>
</tr>
<tr>
<td>Medium</td>
<td>+10%</td>
<td>+14%</td>
</tr>
<tr>
<td>Large</td>
<td>+8%</td>
<td>+10%</td>
</tr>
</tbody>
</table>

- Table translates factors to an overall mortality percentage increase for a 5-year risk exposure period.
- Percentage increases are similar for other risk exposure periods with cumulative magnitudes being greater for longer periods.
  - For example, a 10% increase for 10 years is more severe than a 10% increase for 5 years.
- Factors were reviewed against other capital regimes, including Canada, International Capital Standards (ICS), Solvency II and rating agency.
  - Mortality risk drivers are consistent.
  - Confirmed magnitudes are reasonable for the 95th percentile.
Sensitivity Testing:
Other Attributes that Increase Mortality Risk

- The model was extensively sensitivity tested, and the following attributes increase mortality risk for companies concentrated in these areas.
- The C-2 Mortality Work Group doesn’t recommend differentiating RBC factors by these attributes; however, they may be useful to regulators when reviewing potentially weakly capitalized companies.
- **Older Attained Ages**: capital needs per unit of net amount at risk increase for attained ages 65 and older due to increasing mortality rates.
- **Substandard/Classified Underwriting Classes**: capital needs are higher due to higher mortality rates on unhealthier/riskier lives.

Summary of Recommendations

- The Academy C-2 Life Mortality Work Group recommends the factors shown on Slide 14 which reflect:
  1. Expanding factors into additional categories to reflect the current mortality rate risk exposure period over the remaining lifetime of an inforce block of business
     - For individual life insurance, the recommendation is to differentiate into three product categories with definitions consistent with the annual statement – analysis of operations by line of business – individual life insurance and VM-20
     - For group life insurance, the recommendation is to differentiate into two categories by the remaining length of the premium term based on company records by group contract
  2. Including the two new catastrophe components for 1) terrorism (expressed as a 5% annual probability of an extra 0.05 deaths per 1,000) and 2) the risk of a sustained mortality increase from an unknown event (expressed as a 2.5% annual probability of a 5% sustained mortality increase)
  3. Combining the current middle two size categories into one category
  4. Continue categorizing industrial life with individual life and credit life with group life
  5. Continue with the 50% credit given for group life premium stabilization reserves
- The work group opines that additional review of the adopted correlation factor with longevity C-2 is not necessary as the Life C-2 modeling was completed consistently with longevity.
Proposed Timeline

- A proposed timeline for a year-end 2022 implementation
  - By end of Q4 2021: expose recommended final factors
  - By end of Q1 2022: structural changes are adopted
  - By end of Q2 2022: updated factors are adopted
  - Year-end 2022: factors are implemented for year-end 2022 annual statements

Questions?

Additional Questions, contact:

Khloe Greenwood, Life Policy Analyst
greenwood@actuary.org

Chris Trost, Chairperson C-2 Mortality Work Group

Ryan Fleming, Vice Chair C-2 Mortality Work Group
### Appendix: Method and Assumption Comparison

<table>
<thead>
<tr>
<th>Item</th>
<th>Original Work</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Method</td>
<td>Monte Carlo Model – Present Value (PV) of Death Benefits</td>
<td>Monte Carlo Model – PV of Statutory Losses</td>
</tr>
<tr>
<td></td>
<td>• Loss defined as death benefits minus reserves released</td>
<td></td>
</tr>
<tr>
<td>Capital Quantification</td>
<td>PV(95%) – 105%*PV(Expected)</td>
<td>GPVAD(95%)</td>
</tr>
<tr>
<td></td>
<td>• 5% margin/load assumed in reserve mortality</td>
<td>• Greatest present value of accumulated deficiencies (GPVAD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5% margin/load assumed in reserve mortality</td>
</tr>
<tr>
<td>Length of Exposure Period</td>
<td>5 years (3 years for Group)</td>
<td>5, 10, and 20 years for Individual Life</td>
</tr>
<tr>
<td></td>
<td>• Assumed exposure past 5 years could be offset through management actions (raise premium, adjust non-guaranteed elements, etc.)</td>
<td>3 and 5 years for Group Life</td>
</tr>
<tr>
<td>Discount rate</td>
<td>6% after-tax</td>
<td>2.765% after-tax [3.5% pre-tax]</td>
</tr>
<tr>
<td>Experience Mortality</td>
<td>88% of 1975-1980 Male Basic Table</td>
<td>2017 Unloaded Commissioners’ Standard Ordinary Table (CSO) for Individual Life</td>
</tr>
<tr>
<td></td>
<td>• 15Y Select &amp; Ultimate Structure</td>
<td>• Gender distinct – Male/Female</td>
</tr>
<tr>
<td></td>
<td>• Male/Female not explicitly modelled</td>
<td>5 underwriting classes (3 non-smoker/2 smoker)</td>
</tr>
<tr>
<td></td>
<td>• Underwriting adjustments applied based on generation</td>
<td>SOA 2016 Group Life Experience Study for Group Life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gender distinct – Male/Female</td>
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<tr>
<td>Mortality Improvement</td>
<td>Unknown source</td>
<td>2017 Improvement Scale for VM-20</td>
</tr>
<tr>
<td></td>
<td>• 1.00%</td>
<td>• Varies by gender and age</td>
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</table>

### Appendix: Risk Distribution Approach Comparison

<table>
<thead>
<tr>
<th>Risk</th>
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<th>Recommendation</th>
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<tbody>
<tr>
<td>Volatility</td>
<td>Binomial(Policies, q)</td>
<td>Binomial(Policies, q)</td>
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<tr>
<td>Level</td>
<td>Implicit from Discrete Scenarios:</td>
<td>LR~N(0, σlev&lt;sup&gt;2&lt;/sup&gt; + σMVol&lt;sup&gt;2&lt;/sup&gt;)</td>
</tr>
<tr>
<td></td>
<td>• 7 Competitive Pressures scenarios – risk of overoptimistic pricing assumptions</td>
<td>• Two independent components:</td>
</tr>
<tr>
<td></td>
<td>• 15 AIDS scenarios – early 90's estimates of the impact of AIDS on insured mortality (could fit in level, trend, or catastrophe)</td>
<td>• Credibility/statistical sampling volatility (σlev)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• True mortality volatility (σMVol)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continuous normal distribution</td>
</tr>
<tr>
<td>Trend</td>
<td>Discrete Distribution</td>
<td>[MI&lt;sub&gt;1&lt;/sub&gt;, MI&lt;sub&gt;2&lt;/sub&gt;, ..., MI&lt;sub&gt;15&lt;/sub&gt;]</td>
</tr>
<tr>
<td></td>
<td>• 7 scenarios adjust mortality improvement assumption</td>
<td>Correlated normally distributed random variables</td>
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<tr>
<td>Catastrophe</td>
<td>Discrete Distribution</td>
<td>3 Discrete Distributions</td>
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<tr>
<td></td>
<td>• Pandemic</td>
<td>• Pandemic – calibrated from multiple sources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Terrorism – 5% probability of additional 0.05 / 3K</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unknown Risk – 2.5% probability of a sustained 5% increase</td>
</tr>
</tbody>
</table>
Appendix: Model Validation, Peer Review, Limitations

- **Validation:** Model assumptions were developed by the work group through reviewing current mortality research and studies applicable to the U.S. life insurance industry. The assumptions were discussed, reviewed and agreed upon through the work group’s bi-weekly calls. Model results and sensitivities were also reviewed extensively by the work group. The work group also provided several updates to the NAIC Life Risk-Based Capital Working Group throughout the project and feedback was obtained from regulators.

- **Peer Review:** The model was independently peer reviewed by a member of the work group. The peer review confirmed that the calculations performed by the model were reasonable for the intended purpose and were being applied as intended.

- **Limitations:** The model is intended to stochastically project through Monte Carlo simulation the run-off of inforce life insurance blocks typical of U.S. life insurers in order to develop capital factors for use in the NAIC RBC formula for C-2 life insurance mortality risk. Other uses outside of this intended purpose may not be appropriate. Product features in the model were developed at a very basic level and consider differences in base statutory reserves, lapses, post level term mortality experience, face amounts and attained ages. The model is not designed to replicate detailed product and inforce block characteristics unique to individual companies. In particular, ULSG products were not directly modeled. The work group concluded based on the modeling that the capital factors are insensitive to product differences for a given risk exposure period. The recommendation to differentiate based on product is an indirect way to get at the length of mortality rate guarantee, utilizes the current reporting structure of the annual statements, and is aligned with principles based reserving differentiation.

Appendix:
Prior Work Group Presentations to Life RBC

- **September 2020**
- **December 2019**
- **June 2019**
- **April 2019**
- **August 2018**
- **August 2017**
Credit mitigation vs. capital relief

- Life reinsurance transactions with licensed or accredited reinsurers generally do not require a collateral mechanism to provide credit for reinsurance (CFR).

- Separate and distinct from CFR, the Life RBC Manual instructions reference certain collateral mechanisms (e.g., funds withheld or trusteeed collateral), which, if present, allow the Cedant to avoid an overstatement of RBC charges that would otherwise be applied for credit exposure to reinsurance counterparties. The Life RBC formula addresses uncollateralized credit exposure to reinsurers, whether admitted/accredited or unauthorized, and offers RBC credit only for certain listed collateral mechanisms.

- While the subject provision of the Life RBC Manual allows an RBC credit for certain non-CFR collateral mechanisms, certain other credit risk mitigation (comfort) arrangements developed by large custodial institutions are not similarly treated, resulting in significant inefficiencies in certain life reinsurance transactions.
Growing demand for ‘comfort trusts’

- In many life reinsurance transactions, where the parties negotiate and agree to collateral arrangements for commercial reasons, they are forced to use trusteed assets in order to achieve the desired RBC credit, even where a trust is not needed to satisfy CFR requirements; such “comfort trusts” are common in a variety of life reinsurance transactions, including block acquisitions, embedded value and reserve financings and pension risk transfers.
  - J.P. Morgan is aware of numerous transactions that involve over $50 billion of assets held in Comfort Trusts.

- Other collateral mechanisms can provide the same level of security to Cedants with lower costs and greater flexibility.
Custody Control Accounts

- The Finance industry widely supports and leverages custodial control accounts ("Custody Control Accounts") where segregated collateralization under third-party control is required (e.g. pledges to FHLBs, Segregated Initial Margin, variation margin for 40 Act clients, etc.).
  - In the same way, a Custodian can hold assets pledged by the Reinsurer for the benefit of the Cedant in connection with a reinsurance transaction.

- The intent of the Custody Control Account is to provide the same protections to the Cedant as would be provided by a trust arrangement. Both Comfort Trusts and Custody Control Accounts can be structured to:
  - Segregate assets to cover claims and other amounts payable under the subject reinsurance agreement
  - Establish a senior claim of the Cedant over the account assets in the event of a Reinsurer insolvency or receivership
  - Permit the Cedant to take control of the assets in the event of specified breaches of the reinsurance agreement
  - Allow the Cedant to monitor the composition of assets in the account
  - Restrict Reinsurer withdrawal and replacement of assets from the account based on agreed conditions

- However, a Custody Control Account offers the same operational control as a trust arrangement, at a reduced cost due to increased scale and automation:
  - Custodial arrangements represent the majority of collateralized assets held by Custodian banks.
  - Custody Control Accounts provide a greater level of automation and straight-through-processing, resulting in lower costs (up to $100K per annum, per account) for all parties (insurers and Custodians).
  - Custody Control Accounts and Comfort Trusts both offer the following services:
    - Priced Position Reporting
    - Monitoring of specific withdrawal and replacement conditions based on objective criteria
    - Detailed transaction reporting
    - Administration and servicing of assets
  - Today, Clients have a limited number of banks that are able to provide Comfort Trusts with the same capabilities and at the same price as a custody arrangement. By allowing Custody Control Accounts to receive the same RBC treatment as Comfort Trusts, insurers would be able to select among a larger group of providers.

J.P.Morgan
Proposed changes to RBC instruction

From Risk-Based Capital Forecasting & Instructions – Life and Fraternal, 2019

REINSURANCE
LR016 (p. 53 of the 2019 Edition)

There is a risk associated with recoverability of amounts from reinsurers. The risk is deemed comparable to that represented by bonds between risk classes 1 and 2 and is assigned a pre-tax factor of 0.78 percent. To avoid an overstatement of risk-based capital, the formula gives a 0.78 percent pre-tax credit for reinsurance with non-authorized and certified companies, for reinsurance among affiliated companies, for reinsurance with funds withheld or reinsurance with authorized reinsurers that is supported by equivalent trusteed or custodied collateral that meets the requirements of the types stipulated in paragraph 18 of Appendix A-785 (Credit for Reinsurance), where there have been regular bona fide withdrawals from such trusteed or custodied collateral to pay claims or recover payments of claims during the calendar year covered by the RBC report, and for reinsurance involving policy loans. Withdrawals from trusteed or custodied collateral that are less than the amounts due the ceding company shall be deemed to not be bona fide withdrawals. For purposes of these instructions, “custodied collateral” shall mean assets held pursuant to a custodial arrangement with a qualified U.S. financial institution (as defined in Appendix A-785 (Credit for Reinsurance)) pursuant to which the underlying assets are segregated from other assets of the reinsurer and are subject to the exclusive control of, and available to, the ceding company in the event of the reinsurer’s failure to pay under, and otherwise pursuant to the terms of, the subject reinsurance agreement.
Custody Control Account

Key Features

Custody
- Pledgor instructs assets to be placed into custody account free of payment
- Asset servicing on securities that are registered in J.P. Morgan’s nominee name
- Automated income transfer capability, back to main custody account in respect of any income earned on depository eligible assets can be provided

Control
- SWIFT message release automation for collateral release AND substitutions. Support for different arrangements (e.g., Single/Joint Authentication)
- Secured Party can assume control of account upon Notice of Exclusive Control instruction to the Custodian (NOEC)

Reporting
- Consolidated custody reporting available to both client and secured party
- View and schedule customized or pre-defined reports
- Intra-day and end-of-day reporting via SWIFT

Legal & Operational Highlights

Legal Documents Required
- Global Custody Agreement: Bilateral agreement for custodial services between Pledgor and Custodian
- Account Control Agreement: Tri-party agreement between Pledgor, Secured Party and Custodian

Legal & Operational Framework
- Custody Bank acts as Custodian (not as Trustee)
- Custodian has subordinated lien over assets in the control account (though may retain a first priority lien for fees and expenses)
- Assets are segregated in a control account in the Pledgor’s name FBO the Secured Party
- The Secured Party can assume control of the account at any time upon the satisfaction of conditions as stipulated in the underlying bilateral agreement w/ the Pledgor (e.g. an event of default as notified and exclusively determined by the Secured Party) and following Custodian’s receipt of a Notice of Exclusive Control (NOEC). Custodian has a reasonable time to act on the instruction and does not validate the event of default.
- Custodian is indemnified for following instructions
- Custodian acts upon instructions by Pledgor to deliver assets into the control account
- Parties have flexibility to decide on the control model – i.e., whether release and/or substitution of assets requires single party or dual (Pledgor and Secured Party) instructions
- The Account Control Agreement supplements a Global Custody Agreement and is not a standalone agreement.
The chart below summarizes key comparisons between: (1) a trust account established by a reinsurer to provide an asset or reduction from liability to a ceding company for reinsurance ceded (a “Credit for Reinsurance Trust”); (2) a trust account established by a reinsurer in connection with a reinsurance agreement that is not necessary to provide an asset or reduction from liability for reinsurance but rather provides credit protections to the ceding company (a “Comfort Trust”); and (3) a custodial account established by a reinsurer to provide credit protections to a ceding company in connection with a reinsurance agreement (a “Comfort Custodial Account”). With respect to a Comfort Custodial Account, the chart contemplates the structure proposed by JPMorgan in connection with its proposed changes to the RBC Manual.

<table>
<thead>
<tr>
<th>Nature of Reinsurer</th>
<th>Credit for Reinsurance Trust</th>
<th>Comfort Trust</th>
<th>Comfort Custodial Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurer is not licensed or accredited in Cedant’s domiciliary jurisdiction.</td>
<td>Reinsurer is licensed or accredited in the Cedant’s domiciliary jurisdiction.</td>
<td>Reinsurer is licensed or accredited in the Cedant’s domiciliary jurisdiction.</td>
<td></td>
</tr>
</tbody>
</table>

| Effect on Credit for Reinsurance | Collateral in trust provides a reduction for liability (statutory credit for reinsurance) where Reinsurer is not licensed or accredited. | No effect on Credit for Reinsurance as collateral is not required in order for the Cedant to receive statutory reserve credit. | No effect on Credit for Reinsurance as collateral is not required in order for the Cedant to receive statutory reserve credit. |

<p>| Cedant Reinsurance Counterparty Credit Exposure RBC Charges and Credits | An RBC credit is applied to offset the RBC charge for reinsurance counterparty credit exposure because such exposure has been mitigated through the trust mechanism. | An RBC credit is applied to offset the RBC charge for reinsurance counterparty credit exposure because such exposure has been mitigated through the trust mechanism. | Although credit exposure would be reduced under a Comfort Custodial Account similar to both a Credit for Reinsurance Trust or Comfort Trust, the current RBC instructions mandate a reinsurance counterparty credit charge with no offsetting credit because of the form of the legal agreement governing the collateralization arrangement. Under JPMorgan’s proposed revisions to the RBC Instructions, the RBC charges and credits across all three of these arrangements would be harmonized. Custodial Account Equivalent with a trust. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Credit for Reinsurance Trust</th>
<th>Comfort Trust</th>
<th>Comfort Custodial Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>Assets deposited in trust with a third-party trustee by the Reinsurer for the benefit of the Cedant.</td>
<td>Assets deposited in trust with a third-party trustee by the Reinsurer for the benefit of the Cedant.</td>
<td>Assets deposited in custodial account established by the Reinsurer with a third-party account bank subject to the first priority lien and exclusive control of the Cedant.</td>
</tr>
<tr>
<td><strong>Asset Classes</strong></td>
<td>Assets permitted to be deposited in trust are specified by the applicable statute. Frequently limited to cash, U.S. Treasuries or Agencies and SVO Listed Securities.</td>
<td>Asset classes are subject to the RBC instructions, and additionally include foreign securities, equity interests and interests in investment companies.</td>
<td>Asset classes would be subject to the RBC instructions, and additionally include foreign securities, equity interests and interests in investment companies.</td>
</tr>
<tr>
<td><strong>Valuation</strong></td>
<td>Cedant is only allowed to receive credit for reinsurance based on the market value of assets of the Trust Account.</td>
<td>Valuation is based on the contractual agreement between the parties. Frequently comfort trust agreements and related reinsurance agreements provide that the asset balance required is based on book value of assets unless one or more specified credit events have occurred, in which case market values are required.</td>
<td>Similar to a Comfort Trust, parties would agree to method of valuation of account assets.</td>
</tr>
<tr>
<td><strong>Duties of Trustee/Bank</strong></td>
<td>Trustee is a directed trustee, required to hold assets and act in accordance with the instructions of the parties, as set forth in the Trust Agreement.</td>
<td>Trustee is a directed trustee, required to hold assets and act in accordance with the instructions of the parties, as set forth in the Trust Agreement.</td>
<td>Bank would be required to hold assets and act in accordance with the instructions of the parties, as set forth in the Account Control Agreement.</td>
</tr>
<tr>
<td><strong>Title of Assets</strong></td>
<td>Title of assets is transferred to the trustee of the trust.</td>
<td>Title of assets is transferred to the trustee of the trust.</td>
<td>Title of assets is maintained by the Reinsurer, but subject to a lien in favor of the Ceding Company, which lien is perfected through exclusive control over the assets pursuant to an Account Control Agreement.</td>
</tr>
<tr>
<td>Withdrawal Conditions</td>
<td>Credit for Reinsurance Trust</td>
<td>Comfort Trust</td>
<td>Comfort Custodial Account</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------</td>
<td>---------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>No conditions are allowed for the withdrawal of assets by the Ceding Company.</td>
<td>Reason and nature for withdrawal by the Ceding Company are agreed to by the parties and is typically based on specified defaults of the Reinsurer.</td>
<td>Reason and nature for withdrawal by the Ceding Company are agreed to by the parties and is typically based on specified defaults of the Reinsurer.</td>
<td>Withdrawals by Reinsurer may be allowed based on both market value or book value tests; if such tests are met, the Reinsurer can request the trustee to release such excess.</td>
</tr>
<tr>
<td>Withdrawal of assets by the Reinsurer is generally not allowed except to the extent that the market value of assets exceeds 102% of the reserves ceded under the reinsurance agreement, in which case the Reinsurer can request the trustee to release such excess.</td>
<td>Withdrawals by Reinsurer can be allowed based on both market value or book value tests; if such tests are met, the Reinsurer can request the trustee to release such excess.</td>
<td>Withdrawals by Reinsurer may be allowed based on both market value or book value tests; if such tests are met, the Reinsurer can request the Bank to release such excess and the corresponding lien.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substitution of Assets</th>
<th>Credit for Reinsurance Trust</th>
<th>Comfort Trust</th>
<th>Comfort Custodial Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substitution of assets are only allowed to the extent that the market value of replacement assets exceeds the market value of the replaced assets.</td>
<td>Restrictions on substitutions are agreed between the parties and are typically based on book value and market value of relevant assets.</td>
<td>Restrictions on substitutions are agreed between the parties and are typically based on book value and market value of relevant assets.</td>
<td>Restrictions on substitutions are agreed between the parties and are typically based on book value and market value of relevant assets.</td>
</tr>
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January 24, 2022
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force  [ ] Health RBC (E) Working Group  [ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup  [ ] Investment RBC (E) Working Group  [ ] Operational Risk (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup  [ ] P/C RBC (E) Working Group  [ ] Longevity Risk (A/E) Subgroup

DATE: ____________________________  FOR NAIC USE ONLY

CONTACT PERSON: ____________________________  Year: __________

TELEPHONE: ____________________________

EMAIL ADDRESS: ____________________________

ON BEHALF OF: ____________________________

NAME: ____________________________

TITLE: ____________________________

AFFILIATION: ____________________________

ADDRESS: ____________________________

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[ ] Health RBC Blanks  [ ] Property/Casualty RBC Blanks  [ ] Life and Fraternal RBC Instructions
[ ] Health RBC Instructions  [ ] Property/Casualty RBC Instructions  [ ] Life and Fraternal RBC Blanks
[ ] OTHER ____________________________

DESCRIPTION OF CHANGE(S)

In reference to SAPWG referral 2020-#36 (8/13/2018) and VOSTF referral 2020-#38 (9/21/2018); Attribute bond risk-based capital (RBC) factors to bond mutual funds that have applied for Regulatory Treatment Analysis Service (RTAS) and have received a National Association of Insurance Commissioners (NAIC) designation from the Securities Valuation Office (SVO), based on a look-through calculation of the credit risk for the fund’s underlying bonds, using a weighted average rating factor methodology (WARF) in conjunction with a qualitative review of the fund’s pertinent U.S. Securities and Exchange Commission (SEC) registered investment documents. Proposed factor changes:

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<thead>
<tr>
<th>Designation</th>
<th>Factor</th>
<th>Current (SVO review unavailable)</th>
<th>New (With SVO review)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>0.300</td>
<td></td>
</tr>
<tr>
<td>NA</td>
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<tr>
<td>1.A</td>
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<td>1.C</td>
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</table>
Background

Until recently, all mutual funds, bond or equity-oriented, were classified as “common stock,” unless they met specific eligibility criteria for inclusion on the now-discontinued Money Market Mutual Fund List or Bond Mutual Fund List. The Bond Mutual Fund List eligibility criteria were narrow in scope, only permitting bond-like treatment of a mutual fund if it invested solely in U.S. Government securities with the fund maintaining the highest credit quality rating given by an NAIC Credit Rating Provider (CRP). Since the discontinuation of these lists, the SVO has positioned a new list known as the NAIC Fixed Income-Like SEC Registered Funds List to allow for the evaluation and inclusion of mutual funds that predominantly invest in individual bond securities.

NAIC staff previously questioned the equity-like treatment for bond mutual funds as part of the Statutory Accounting Principles (E) Working Group’s (SAPWG) investment classification project. As a part of this project, NAIC staff determined that the inclusion of “mutual funds” within the “common stock” definition was overly broad. Consequently, the SAPWG adopted a proposal to add a column on Schedule D, Part 2, Section 2 (subsequently implemented by Blanks (E) Working Group) that would permit funds designated by the SVO (and only funds designated by the SVO) to be reported on that schedule. Eligibility for such reporting would require an NAIC designation that could, in turn, align with an RBC factor to be determined by the Capital Adequacy (E) Task Force. This action effectively recognized that with appropriate review of underlying holdings, more appropriate risk-based capital treatment can be achieved through the designation process, without changing the reporting schedule or accounting for such investments. This adoption led to a referral from SAPWG (2020–#36) for RBC consideration.

Concurrently, the Valuation of Securities (E) Task Force (VOSTF) directed NAIC staff to develop a comprehensive proposal to ensure consistent treatment for investments in funds that predominantly hold bond portfolios, across all schedules. Significant efforts were made to align fund guidance and evaluation treatment in the P&P Manual. The adopted language created the new, aforementioned NAIC Fixed Income-Like SEC Registered Funds List of the P&P Manual, which expanded the existing evaluation framework to permit review and designation for all funds issued by an investment company whose offering is registered with and regulated by the SEC and whose published investment objective is to invest almost exclusively in bonds. The VOSTF’s procedure permits the sponsor of a fund or an insurer to request an SVO assessment of a fund to determine if it meets requirements imposed by the Task Force for more appropriate treatment. If the fund is eligible, the SVO adds the name of the fund to the relevant list with a preliminary NAIC designation. This adoption led to a referral from VOSTF (2020–#38) that the Capital Adequacy (E) Task Force (CAPAD) consider formally integrating the comprehensive instructions for mutual funds adopted for the P&P Manual into the NAIC RBC framework, by attributing bond RBC factors to any bond fund meeting the P&P Manual criteria, and achieving an NAIC designation through the SVO’s evaluation process.

Both of these preceding events and changes have effectively positioned bond mutual funds to be accurately evaluated, designated, and reported with RBC charges that are reflective of the bond securities within the fund.

Regulation

Bond mutual funds (investment companies) are registered with and regulated by the SEC and have published investment objectives to invest in bonds. Strict regulation has enabled bond mutual funds to reliably deliver bond exposure to investors for over 85 years, through unprecedented market events, such as the interest rate shock in the 1970s that saw the U.S. Federal Funds’ rate go above 14%, and also, when interest rates were cut to near 0%, during the global financial crisis and the years that followed. As of year-end 2020, there is over $5.2 trillion in total net assets entrusted to the bond mutual fund investment structure (ICI Investment Company Fact Book 2021).

1 Purposes and Procedures Manual of the NAIC Investment Analysis Office: Part Three – SVO Procedures and Methodology for Production of NAIC Designation (2019); “A bond mutual fund is eligible for inclusion on the Bond List if the fund meets the following conditions: The fund shall invest 100% of its total assets in the U.S. Government securities listed in the section below, class 1 bonds that are issued or guaranteed as to payment of principal and interest by agencies and instrumentalities of the U.S. Government, including loan-backed bonds and collateralized mortgage obligations, and collateralized repurchase agreements comprised of those obligations at all times.”

2 SAPWG – Ref #2013-36 – SSAP No. 30 – Common Stock – Key Elements: The inclusion of “mutual funds” within the “common stock” definition is overly broad and allows inclusion of all “investment company” investments, and the characteristics of some of these investments may warrant separate accounting and reporting consideration (e.g., look-through). Per the SEC, an “investment company” is a company (corporation, business trust, partnership, or limited liability company) that issues securities and is primarily engaged in the business of investing in securities.
Mutual funds are stringently regulated under the Investment Company Act of 1940 (the “1940 Act”) and the Securities Act of 1933. These laws impose extensive obligations on the mutual fund and its investment adviser. As an SEC-regulated investment company, a mutual fund must invest its portfolio assets in accordance with the investment strategies outlined in its prospectus and other governing fund documents. The fund prospectus is an SEC-regulated legal document, updated annually, to inform current and prospective investors of the risks, fees, and investment strategy of the fund. It is not permissible for a bond mutual fund to change its investment strategy in any fundamental way that does not require the fund to at least notify its shareholders of the change, and in most cases, a mutual fund’s fundamental investment strategies cannot be altered without shareholder approval.

Additionally, Section 17(f) of the ‘40 Act imposes strict regulations that require the portfolio securities (purchased on behalf of the investors) to be held by an independent custodian, segregated from the fund sponsor’s own assets. Section 17(f) also requires the net assets of the fund to be physically segregated from assets of other funds, and from the assets of the investment adviser (or any other person/entity), and provides for, among other things, periodic examinations of the assets by an independent public accountant. Finally, the SEC requires mutual fund custodians to protect a fund’s assets by segregating them from their own assets. Fund custodians must have authorized instructions from the fund’s authorized representative, designated by an officer of the fund, to deliver securities or cash from the fund.

Structure

Mutual funds should be treated (for RBC purposes) in accordance with their underlying portfolio holdings because those portfolio securities drive the value and risks of the mutual fund. A shareholder in a mutual fund has a proportionate interest in, and exposure to, the underlying portfolio of securities held by the mutual fund. Bond mutual funds exist to pool the interests of many shareholders for the purpose of investing in fixed-income securities and pass through the cash flows and investment returns generated by its bond portfolio. Because the mutual fund must honor investor redemption requests at the Net Asset Value (NAV) per share, that is, at the actual value of the investor’s proportionate interest in the mutual fund’s underlying bond portfolio, the NAV is a highly accurate reflection of the fund’s underlying portfolio. The fund is simply a conduit for the performance of the underlying portfolio securities, as the federal securities laws make clear – under Rule 22c-1 of the ‘40 Act, shares of an open-end mutual fund generally may only be bought or sold at the fund’s net asset value, which is the value of its underlying portfolio securities less fund liabilities and expenses as determined under Rule 2a-4 of the ‘40 Act. Consequently, the risks of investing in a mutual fund are a reflection of the securities constituting its portfolio. In the case of a bond mutual fund, the risks and interests represented are that of the individual bonds held.

An examination of what this structure means for insurers

A bond mutual fund is not an operating company engaged in a trade or business that issues common stock and does not share inherent characteristics of common stock. The securities that the bond mutual fund holds represent the economic value of the fund. In other words, a bond fund investor has no rights in the underlying securities owned, with respect to: 1) ownership of the companies; 2) voting rights in those companies, and; 3) sharing in the company profits or losses. Any contention that a bond mutual fund should be treated as an equity from a RBC standpoint is inconsistent with these rights and the debt exposures conveyed through the ‘40 Act structure.

As previously stated, a bond mutual fund shareholder has a proportionate interest in the underlying securities (bonds), as reflected in the current NAV per share for the fund, but only directly owns shares of the mutual fund. The shareholder does not directly own the bonds, and therefore, does not have a direct creditor relationship with the issuer. Instead, the bond mutual fund, as a registered investment company, is the direct owner of the individual bonds, and carries the creditor relationship with the issuers. Within this legal structure, the fund itself (as creditor) does not default, in the traditional sense, with respect to its relationship with the shareholder. Rather, each individually owned bond within the portfolio carries risk of default to its creditor (i.e., the bond mutual fund). For this structural reason, default risks occur “within the fund” at the same statistical occurrence rate as in any other debtor/creditor ownership structure for the bond securities (e.g., an insurer owning the bond directly). Any default occurrence is immediately recognized in the fund’s NAV, just as any other institutional investor would recognize the same default on their balance sheet. Therefore, credit risk of a bond mutual fund can be represented as a product of the weighted average credit risk of the individual bonds owned by the fund, and probabilities of default hold true for each underlying security. As with direct bond ownership, bond funds have interest rate, inflation, and credit risk associated with the underlying bonds owned by the fund, reflected in the daily NAV.

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1Section 3(a)(1)(C) of the Investment Company Act defines an investment company as an issuer that is engaged or proposes to engage in the business of investing, reinvesting, owning, holding or trading in securities, and owns or proposes to acquire “investment securities”

2Management companies usually are structured as corporations or trusts. A management company’s board of directors (or trustees) oversees the management of the company. See Section 2(a)(12) of the Investment Company Act. A management company’s investment adviser (which is typically a separate entity, registered with the Commission) manages the company’s portfolio securities for a fee. See Section 2(a)(20) of the Investment Company Act.
We can further examine this structure by defining the prospective constituents. Within the bond mutual fund legal structure, the fund is the investment “company”, and the registered investment adviser of the fund serves as the portfolio manager, investing for economic benefit for the “company”. This economic benefit is then proportionally passed-through the registered investment company (i.e., mutual fund) to the shareholder (e.g., insurer), in exchange for a fee, in the form of an expense ratio. Similarly, an insurance “company” may directly own a portfolio of hundreds or thousands of bonds that are managed by an internal team of investment management professionals that it compensates for these services, for the economic benefit of their general account and policy holders. Finally, an insurance “company” may access these bonds through a separately managed account (SMA) of individual bonds, managed on behalf of the “company” by a professional asset management firm. Once again, the investment adviser is acting in a fiduciary capacity for the insurer for the economic benefit of the “company” and its owners, in exchange for a management fee.

<table>
<thead>
<tr>
<th>Structure</th>
<th>Portfolio holdings</th>
<th>Bond Owner</th>
<th>Portfolio Adviser</th>
<th>Economic Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutual Fund</td>
<td>100 Bonds</td>
<td>Mutual Fund</td>
<td>Fund Sponsor</td>
<td>Insurer General Account</td>
</tr>
<tr>
<td>Separately Managed Account</td>
<td>100 Bonds</td>
<td>Insurer</td>
<td>Investment Firm</td>
<td>Insurer General Account</td>
</tr>
<tr>
<td>Direct ownership</td>
<td>100 Bonds</td>
<td>Insurer Employee</td>
<td>Insurer General Account</td>
<td></td>
</tr>
</tbody>
</table>

In all three arrangements, regardless of structure, there is a portfolio of bonds, a company that owns those bonds, portfolio adviser, and economic benefit passed on to the general account. Bonds held directly, or through other types of investment vehicles, hold the same types of securities. Therefore, portfolios of securities held in registered open-end management investment companies under the ‘40 Act should receive similar RBC treatment, in order to promote consistent, accurate application of capital treatment for structural ownership arrangements that produce the same economic value and risks.

An examination of credit rating downgrades

Based on structure, it should also be noted that there are no significant differences with respect to individual bond downgrades and the options available to manage such downgrades. This includes passively managed mutual funds that track a fixed income benchmark. When an issuer downgrade occurs, the downgrade is uniformly occurring within the bond market for any creditor, whereby a negative change in the rating of the bond security has occurred. A downgrade happens when a credit rating agency analyst feels that the future prospect for the security has weakened from the original recommendation, usually due to a material and fundamental change in the company's operations, future outlook, or industry, but does not indicate a guarantee of default. In each structure described, the owner has similar options.

While a passively managed mutual fund’s objective is to track and deliver indexed returns, it is not legally obligated to sell a bond that has been downgraded out of scope of the index, at the time of the announced downgrade event, or even at the time in which the tracked benchmark provider removes the bond from the index, on the last day of the month of occurrence. Instead, the mutual fund, just like the individual institutional owner or SMA, has options to mitigate its risk and manage its portfolio for the benefit of the shareholder. In all ownership structures, the owner may: 1) sell the bond; or 2) hold the bond despite the implied increase of risk.

Also, a downgrade does not necessarily equate to illiquidity and can result in either a discounted sale price option for the owner (immediately recognized in the NAV of a mutual fund), or in some instances, an increased value and sale price (recognized increase to mutual fund NAV) in the bond market, due to the market’s perception of a higher yield from the issuer that may not necessarily represent increased default risks to the prospective buyer. A mutual fund provider may leverage its scale and strong broker/dealer relationships to trade this security at a specific time (or over time) that will give the fund best execution and economic value.

Additionally, downgrades occur annually for a relatively small portion of the total U.S. bond market, and have represented less than 1% of issuance, on average, from 2007 to 2020. Of these downgrades, the majority remained within investment grade quality, with only 0.1% falling below investment grade. At the same time, a bond mutual fund only holds a fraction of bond market issues, and therefore may only own a fraction of a fraction of downgraded bonds that could in any manner impact a decision to sell the bond from the portfolio. As was previously discussed, these decisions to potentially mitigate portfolio risk are no different across ownership structures and immaterial in the decision to apply a certain set of risk-based capital factors.

*Calculated based on, Bloomberg Finance L.P., Moody’s, S&P, Fitch, and SIFMA market data.
Validity of evaluation methodology

The recommendation to apply bond factors to bond mutual funds, based on an SVO quantitative and qualitative review, is based on a NAIC approach successfully conducted for almost 30 years (see previous citation of eligible bond mutual funds that invest 100% of their total assets in the U.S. Government securities). The approach is consistent with past NAIC practice, easy to implement, and considers the role of the VOSTF in identifying investment risks and the practical approach expressed in the administration of the RBC framework, which is based on default characteristics of corporate bonds, but applied to many other instruments, with risk and default characteristics unlike those of corporate bonds. This method for evaluating risk, and application of bond factors as a proxy to achieve appropriate levels of risk-based capital for these investments, has proven over decades that it is built on sound policy and should also be readily be applied to bond mutual funds.

Current SVO procedures permit the sponsor of a fund, or an insurer, to request a SVO assessment of a fund to determine if the fund is within scope of the comprehensive instructions for mutual funds, adopted in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). If, and only if, the fund is eligible, the SVO conducts an analysis, and adds the name of the fund to the relevant list, with a preliminary NAIC designation. Therefore, any bond mutual funds not submitted through the established SVO framework would continue to be covered by SSAP No. 30 and remain ineligible for NAIC designation and/or corresponding bond RBC factors. This rigorous process includes evaluation upon initial submission to the SVO and an ongoing process that has the ability to adapt ratings if a fund’s composition or investment approach changes. For any rated fund the analysis would be conducted by the SVO twice each year; once during the fund provider’s mandatory annual review and again when an insurer files notice of its ownership of the fund.

The SVO’s well-developed analysis framework (successfully implemented for bond ETFs since 2004) includes a comprehensive look-through to all securities held in the investment in order to assess the inherent risks borne by the fund. This calculation of the credit risk for the fund’s underlying investment portfolio uses a weighted average rating factor methodology (WARF). The WARF factor for each portfolio security (issue/security specific) is determined by first translating its NAIC CRP changes. For any rated fund the analysis would be conducted by the SVO twice each year; once during the fund provider’s mandatory annual review and again when an insurer files notice of its ownership of the fund.

The SVO’s well-developed analysis framework (successfully implemented for bond ETFs since 2004) includes a comprehensive look-through to all securities held in the investment in order to assess the inherent risks borne by the fund. This calculation of the credit risk for the fund’s underlying investment portfolio uses a weighted average rating factor methodology (WARF). The WARF factor for each portfolio security (issue/security specific) is determined by first translating its NAIC CRP rating into an NAIC Designation. For bond securities that are unrated but have an NAIC Designation, the Designation is used. The WARF factor for that NAIC Designation is then market value-weighted. The weighted factor for each investment is summed to determine the fund’s credit rating, which is then translated into the equivalent NAIC Designation.

The analysis is detailed in nature and accurately identifies similar risks of credit quality and interest rate sensitivity, associated with the underlying bonds, but also scrutinizes the rare instances where funds have more of a heterogeneous investment profile or dispersion of risk. The analysis is built on three key pillars:

- An extensive quantitative look-through analysis that is built on sound mathematical principles, in which a fund cannot “hide” lower-quality bonds behind those with stronger credit quality. Instead, the risks of any lower-quality bonds result in a higher NAIC designation and corresponding RBC charge. This total charge for a given dollar of investment is often higher than if the same dollar was invested with proportionate weighting in each individual bond within the portfolio. As an example, Vanguard’s designated bond ETFs consistently give insurers diversified exposure to “higher” credit quality, relative to the applied NAIC designation, corresponding RBC factor, and total capital charge. (Data can be provided upon request. The same principle will hold true for similarly structured ‘40 Act mutual funds.).

- A qualitative review of the fund, considering the fund’s objectives and investment constraints, as outlined in the SEC-regulated prospectus; thus, the SVO review considers the full range of the fund’s possible future bond investments, not just the present.

- Ongoing regulatory oversight of the mutual funds used in insurers’ portfolios, which remains a critical safeguard. If an insurance company buys a preliminarily designated listed fund, it must file that fund with the SVO for an additional analysis and official validation of the previously analyzed credit risks in order to receive an official NAIC designation. This new analysis takes into account any credit quality changes in a fund, including previously discussed downgrades, which may or may not have been sold from the fund. Only after this additional analysis does the SVO assign an official NAIC designation and enter the security into the NAIC systems for fixed-income like treatment.

Validity and summary of bond factor application

A mutual fund is a reflection of the composition of individual bonds within the fund’s portfolio. Every bond mutual fund will have its own unique number and variety of holdings, credit quality exposure, and therefore risk associated with the fund. Due to the endless variety of holdings and credit exposure that a fund can contain, a single, one-time analysis cannot be conducted at a mutual fund industry level to standardize new RBC factors to be applied across various “buckets” of bond mutual funds. Therefore, the approach to look-through each submitted bond mutual fund, using the WARF methodology, and apply as a proxy a bond designation, is the only appropriate analysis that can be conducted to accurately apply an RBC factor aligned with the risk of each unique portfolio.
As previously described, mutual funds are pass-through entities that pass through the cash flows and investment experience generated by the portfolio. If the fund only holds debt, the investor will only experience debt-like cash flows through the fund, generated by the principal and interest of the individual bonds held by the fund. Additionally, the risks of the bond fund are a reflection of the aggregate risks of each underlying bond component of the portfolio. As an investor in those bonds, a mutual fund bears those risks proportionate to its exposure in the security in the same manner that an insurer would bear the risk proportionate to their investment exposure in a specific individual bond held.

Within the context of RBC and how bond factors are attributed on a basis of a debtor’s ability to meet obligations to a creditor, the mutual fund “company” itself does not default in its relationship with the shareholder, because there is no creditor/debtor relationship with the shareholder. Therefore, standardized default rates of funds cannot be analyzed. Similarly, an insurer who owns a portfolio of bonds does not default, but rather, individual bonds within the insurer’s portfolio have default probabilities based on the credit quality of the issuer and the risk to not meet obligations. The same economic experience exists for both investing entities, and each creditor has the same legal protections and opportunity for economic recovery. However, in the event a decision is made to trade the bond in default, a bond mutual fund provides a structural advantage to most other institutions, due to scale and broker/dealer relationships that include dedicated coverage. Because of these advantages, bond mutual funds can more effectively trade these bonds at an opportune time, thus creating efficiencies of value in comparison to other owners of the issuance in default.

As the owner of the individual bonds, the mutual fund has a direct creditor relationship with the bond issuer and is subject to default at a statistical rate inherent in the creditworthiness of the issuer. In this case, the mutual fund directly bears the risk of issuer default and the financial impact in a manner proportionate to each bond. This is the same creditor relationship and risk that an individual insurer experiences when it directly owns individual bonds with varying credit qualities, at varying amounts, within their individually managed portfolio or SMA. Therefore, RBC for the individual insurance company is an aggregate of the weighting the insurer has to each individual bond and its credit quality. Similarly, when the SVO analyzes a mutual fund they look at the individual weighting to each bond and its credit quality to produce a weighted average, just as you mathematically can with an individual insurer’s portfolio. (Data can be provided upon request.)

**Impact**

Impact should be considered secondary to applying charges that are appropriate to the risk of the investment and the validity of such factors, as previously described. Utilization of bond RBC factors will be aligned with the CAPAD policy that insurers are capitalized at a minimally acceptable level and aligned and implemented through an SVO methodology that accurately assesses the underlying credit risk. With accurate application of valid RBC factors, impact will be appropriate.

Bond mutual funds offer a number of benefits to insurers, including the ability to redeem shares with the fund, daily valuation of the portfolio at NAV, immediate low-cost diversification, and professional investment management. By pooling together the assets of thousands or millions of investors, mutual funds achieve greater scale and efficiency than virtually any investor, including many insurers, could hope to obtain individually. Importantly, the biggest beneficiaries of a broader inclusion of bond mutual funds for bond RBC application would be small and mid-size insurers. In our experience, these companies often have challenges constructing diversified bond portfolios without incurring high costs because of the comparatively limited scale of their portfolios. Allowing for expansion of bond factor application to SVO evaluated bond mutual funds would accurately reflect the inherent risk in the portfolio and remove an inconsistent barrier to these low-cost options provided by top institutional money managers. These managers can help insurers increase the probability of meeting their portfolio goals while simultaneously reducing risk through greater diversification.

For those insurers that currently invest in bond mutual funds, but receive an equity-like factor, future impact to RBC cannot be accurately measured, because there is an unknown variable in the number of bond mutual fund asset managers that will apply for RTAS in order to receive an NAIC designation with a corresponding bond factor. However, given the knowledge and resources required to submit a mutual fund for such treatment, it can reasonably be hypothesized that a limited number of mutual funds will apply for the SVO review process and receive bond factors, leading to a minimal effect across these held bond mutual funds and on insurer RBC. Below, is a historical three-year summary of the small amount invested in bond mutual funds that would have asset manager “eligibility” to apply for review and bond factor treatment.

<table>
<thead>
<tr>
<th>Approximate bond mutual fund admitted assets (SMM)</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life companies</td>
<td>$565</td>
<td>$1,200</td>
<td>$725</td>
<td>$964</td>
</tr>
<tr>
<td>Non-life companies</td>
<td>$3,735</td>
<td>$3,100</td>
<td>$4,275</td>
<td>$4,836</td>
</tr>
<tr>
<td>Total</td>
<td>$4,300</td>
<td>$4,300</td>
<td>$5,000</td>
<td>$5,800</td>
</tr>
</tbody>
</table>
These invested funds would be eligible for bond factor RBC only if they submit for, and undergo, the SVO evaluation process, leading to an official NAIC designation listing. The above figures equate to less than 1/10 of 1% of insurers’ net admitted assets, according to statutory filings. Given the incredibly small allocation to bond funds within insurer portfolios, even in the most extreme assumed instance, where RBC would reduce from a 30% common stock charge to the lowest NAIC designation and charge (0.39% or 0.30%) for all current holdings, there would be very little impact to investment RBC, which is only one contributing factor to a company’s overall RBC.

**Administrative Changes**

@ NAIC RBC Group

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**Additional Staff Comments:**

** This section must be completed on all forms.  
 Revised 2-2019
Property and Casualty Risk-Based Capital (E) Working Group  
Virtual Meeting (in lieu of meeting at the 2022 Spring National Meeting)  
March 23, 2022

The Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 23, 2022. The following Working Group members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Charles Hale (AL); Wanchin Chou, Qing He, Amy Waldhauser, and George Bradner (CT); Robert Ridenour and Virginia Christy (FL); Judy Mottar (IL); Leatrice Geckler (NM); Halina Smosna and HauMichael Ying (NY); Will Davis (SC); Miriam Fisk and Monica Avila (TX); and Adrian Jaramillo and Michael Erdman (WI). Also participating were: Chris Erwin and Leo Liu (AR); Rolf Kaumann (CO); Adrienne Lupo (DE); Patrick P. Lo (HI); Tish Becker (KS); Vanessa Sullivan (ME); Julie Lederer (MO); Justin Schrader and Gordon Hay (NE); Trey Hancock (TN); and Steve Drutz (WA).

1. **Adopted Catastrophe Risk (E) Subgroup Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021, Minutes**

   Mr. Chou said the Catastrophe Risk (E) Subgroup met Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021. During these meetings, the Subgroup took the following action: 1) adopted proposal 2021-15-CR (Adding KCC Models), which the Subgroup exposed for a 30-day public comment period ending Nov. 26, 2021; 2) adopted proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only), which the Subgroup exposed for a 60-day public comment period ending Feb. 13; 3) heard an update from the Catastrophe Model Technical Review Ad Hoc Group. The update included the discussion of the survey questions created by the members within the group, which were based on *Actuarial Standard of Practice (ASOP) No. 38—Catastrophe Modeling (for All Practice Areas)*; 4) discussed three different kinds of catastrophe models that deviate from the vendor models. The Subgroup will focus on discussing the vendor catastrophe models with adjustments or different weight first; 5) discussed the issue of double counting in the R5 component. The Subgroup asked the interested parties to review the current methodology and provide comments in the upcoming meetings; 6) discussed the possibility of adding flood peril in the Rcat component. Industry asked the Subgroup to consider the materiality issue with respect to whether the flood peril is warranted, given the exposure of the industry; and 7) heard a presentation from Milliman on the private flood market.

   Mr. Chou made a motion, seconded by Mr. Davis, to adopt the Subgroup’s Feb. 22, 2022 (Attachment Five-A1); Jan. 25, 2022 (Attachment Five-A2); and Dec. 16, 2021 (Attachment Five-A3) minutes. The motion passed unanimously.

2. **Adopted the Report of the Catastrophe Risk (E) Subgroup**

   Ms. Smosna said the Subgroup met March 22, 2022, and took the following action: 1) adopted its Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021, minutes; 2) discussed its 2022 working agenda items; 3) discussed the insured loss threshold for wildfire peril; 4) exposed proposal MOD 2021-17-CR (Wildfire Information-Only Reporting Exemption) for a 14-day public comment period ending April 5; 6) discussed the independent model review instruction in the Rcat component; and 7) discussed the issue of double counting in the R5 component.

   Mr. Chou made a motion, seconded by Mr. Hale, to adopt the report (Attachment Five-A) of the Catastrophe Risk (E) Subgroup. The motion passed unanimously.

Mr. Chou said the purpose of this proposal is to include the Karen Clark & Company (KCC) model as one of the approved third-party commercial vendor catastrophe models. The Subgroup received one supporting letter, which encouraged the Subgroup to keep the approval list current with market usage.

Mr. Chou made a motion, seconded by Mr. Ridenour, to adopt proposal 2021-15-CR (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Eight). The motion passed unanimously.

4. **Adopted Proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only)**

Mr. Chou said the purpose of this proposal is to include wildfire peril in the Rcat component for informational purposes filing until all the concerns are addressed before incorporated into the risk-based capital (RBC) calculation. He stated that the Subgroup received three comment letters during the exposure period. However, Mr. Chou indicated that the Subgroup agreed to take time to evaluate the impact and allow more time for the modelers to enhance their modeling approach with this new peril.

Mr. Chou made a motion, seconded by Mr. Ridenour, to adopt proposal 2021-17-CR (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Nine). The motion passed unanimously.

5. **Adopted Proposal 2021-14-P (R3 Factor Adjustment)**

Mr. Botsko said this proposal intends to eliminate the double-counting effect of the operational risk charge on the component. He said NAIC staff performed an analysis to determine the impact on the RBC action levels by reducing the 2% reinsurance recoverable RBC charge for all reinsurance designation equivalents. The result indicated that the impact is insignificant, as there are only three companies with total adjusted capital (TAC) between zero to 75 million that will change the RBC results from action level to no action. He also stated that the Working Group received no comments during the exposure period.

Mr. Chou made a motion, seconded by Mr. Davis, to adopt proposal 2021-14-P (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Ten). The motion passed unanimously.

6. **Exposed Proposal 2022-01-P (Removing Trend Test for Informational Purposes Only Footnote)**

Mr. Botsko said since the trend test has been adopted by every state, the purpose of this proposal is to remove the trend test for information-only wordings in the PR033 footnote.

The Subgroup agreed to expose proposal 2022-01-P for a 30-day public comment period ending April 22.

7. **Discussed its Working Agenda**

Mr. Botsko summarized the changes of Working Group’s 2022 working agenda, which included the following substantial changes: 1) adding the exposure and/or adoption dates to the items of “evaluate other catastrophe risks for possible inclusion in the charge” and “evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses”; 2) changing the expected completion dates for “evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments,” “continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as
appropriate,” “evaluate if changes should be made to the P/C formula to better assess companies in runoff,” and “evaluate the Underwriting Risk Line 1 Factors in the P/C formula” items; 3) removing the “modify instruction to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories” and “evaluate R3 Adjustment for Operational Risk Charge” items; 4) adding the adoption date to the “implement wildfire peril in the Rcat component (for informational purposes only)” item; and 5) adding “evaluate the possibility of modifying exemption criteria for different cat perils in the PR027 interrogatories,” “evaluate the possibility of enhancing the independent model instructions,” and “remove the trend test footnote in PR033” items under the new items section.

Without hearing any comments from state insurance regulators and industry, Mr. Botsko said the working agenda will be forwarded to the Capital Adequacy (E) Task Force for consideration.

8. **Heard Updates on Current P/C RBC Projects from the Academy**

Allan Kaufman (American Academy of Actuaries—Academy) said the Academy’s Property/Casualty (P/C) Risk-Based Capital Committee provided a report describing the calibration of indicated Line 4 premium and reserve risk factors, which was one of the three reports that the Academy described to the Working Group in 2019. He stated that currently, the Academy has four ongoing projects. First is the second of the three reports, which is the line 7 and line 8 of premium and reserve risk, respectively. Mr. Kaufman said he anticipates that this report would be shared with the Working Group for discussion during the next quarter. Second is the third of the three reports, which is the line 14 (loss and premium concentration factors) of premium and reserve risks. He said he anticipates that this report will be provided to the Working Group by end of 2022. He also stated that the last two projects, which are an update to the factors used to avoid overlap between the line 4 premium risk factor and the separate hurricane and earthquake charges in Rcat and the development of a revised approach of line 1 factor, will be presented to the Working Group by the end of the next quarter and by the end of 2022 or early 2023, respectively.

9. **Discussed Other Matters**

Mr. Botsko said a response letter to request for input regarding the definition of run-off companies was forwarded to the Restructuring Mechanisms (E) Subgroup in April 2021. The Subgroup planned to schedule a meeting in April to discuss this issue. Mr. Botsko encouraged all the interested parties to participate at the meeting and provide thoughts to the Working Group during the upcoming meeting.

Lastly, Mr. Botsko was pleased to announce that Mr. Chou will be serving as Working Group vice chair.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met March 22, 2022. The following Subgroup members participated: Wanchin Chou, Chair, George Bradner, and Qing He (CT); Halina Smosna, Chair, Gloria Huberman, HauMichael Ying (NY); Laura Clements and Giovanna Muzzarelli (CA); Jane Nelson (FL); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Tom Botsko (OH); Andrew Schallhorn (OK); and Miriam Fisk, Monica Avila, and Rebecca Armon (TX). Also participating were: Adrienne Lupo (DE); Brock Bubar (ME); and Julie Lederer (MO).

1. **Adopted its Feb. 22, 2022; Jan. 25, 2022; and Dec. 16, 2021, Minutes**

Mr. Chou said the Subgroup met Feb. 22, 2022; Jan. 25, 2022, and Dec. 16, 2021. During these meetings, the Subgroup took the following action: 1) adopted proposal 2021-15-CR (Adding KCC Models), which the Subgroup exposed for a 30-day public comment period ending Nov. 26, 2021; 2) adopted proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only), which the Subgroup exposed for a 60-day public comment period ending Feb. 13, 2022; 3) received an update from the Catastrophe Model Technical Review Ad Hoc Group. The update included the discussion of the survey questions created by the members within the group, which were based on **Actuarial Standard of Practice (ASOP) No. 38—Catastrophe Modeling (for All Practice Areas)**; 4) discussed three different kinds of catastrophe models that deviate from the vendor models. The Subgroup will focus on discussing the vendor catastrophe models with adjustments or different weight first; 5) discussed the issue of double counting in the R5 component. The Subgroup asked the interested parties to review the current methodology and provide comments in the upcoming meetings; 6) discussed the possibility of adding flood peril in the Rcat component. Industry asked the Subgroup to consider the materiality issue with respect to whether the flood peril is warranted, given the exposure of the industry; and 7) heard a presentation from Milliman on the private flood market.

Mr. Botsko made a motion, seconded by Ms. Clements, to adopt the Subgroup’s Feb. 22, 2022 (Attachment Five-A1); Jan. 25, 2022 (Attachment Five-A2); and Dec. 16, 2021 (Attachment Five-A3) minutes. The motion passed unanimously.

2. **Discussed its Working Agenda**

Ms. Smosna summarized the changes of the 2022 working agenda, which included the following substantial changes: 1) adding the exposure and adoption dates to the “evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the cat model losses” item; 2) removing the “modify instruction to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories” item; 3) adding the adoption date to the “implement wildfire peril in the Rcat component (for informational purposes only)” item; and 4) adding “evaluate the possibility of modifying exemption criteria for different cat perils in the PR027 interrogatories” and “evaluate the possibility of enhancing the independent model instructions” items under the new items section. Without hearing any comments from state insurance regulators and industry, Ms. Smosna said the working agenda will be forwarded to the Property and Casualty Risk-Based Capital (E) Working Group for consideration.
3. **Discussed the Insured Loss Threshold for Wildfire Peril**

Ms. Smosna asked the Subgroup to consider using the same threshold of 25 million or greater estimated insurer losses for wildfire peril as the earthquake and hurricane perils. She said any received comments regarding this item will be discussed during the Subgroup’s next meeting on April 19.

4. **Exposed Proposal MOD 2021-17-CR (Wildfire Information-Only Reporting Exemption)**

Scott Williamson (Reinsurance Association of America—RAA) said this modification applies only to those smaller companies, where the modeling requirements would impose a cost and compliance burden that represent an outsized cost relative to the incremental benefit of providing the modeled data for information-only purposes. He stated that this exemption option is intended only to apply to the information-only reporting for wildfire, while the Subgroup continues to evaluate materiality and model maturity. It would no longer be available when the wildfire peril is added to the Rcat component unless the companies qualify under the exemptions listed in PR027 Interrogatory items C(7), C(8), or C(9).

The Subgroup agreed to expose proposal MOD 2021-17-CR for a 14-day public comment period ending April 5.

5. **Discussed the Independent Model Review Instruction in the Rcat Component**

Mr. Chou said some written comments related the instructions to review an internal model were received from the Missouri Department of Commerce and Insurance (DCI) earlier (Attachment Five-A4). Ms. Lederer said the DCI asked the Subgroup to look into the following items in the internal model review instructions: 1) consider rewording item 3 to make the Subgroup’s intention clear; 2) consider reviewing the comparison of internal model estimates to actual results for historical events; and 3) experiencing difficulty in receiving written documentation from the group-wide supervisor. She also stated that the DCI did not engage an outside consultant to review the model as this model is highly confidential. It was quite a heavy lift for reviewing based on the Rcat instructions. Ms. Lederer also said the DCI is not aware of any other companies that applied for permission to use their internal models in other states.

Mr. Chou urged the interested parties to review the current PR027 internal model instructions and provide comments or wordings to the NAIC staff in next three weeks. He said any received information will be discussed during the Subgroup’s next meeting on April 19.

6. **Discussed the Issue of Double Counting in the R5 Component**

Ms. Smosna said the NAIC did not receive any comments on this item since the Subgroup’s last meeting on Feb. 22. She said the wildfire peril will follow the same process as the other perils to adjust the R5 component based on the PR100’s data collection. The Subgroup agreed unanimously.

7. **Discussed Other Matters**

Mr. Chou said that the AIR Worldwide, Risk Management Solutions (RMS), and Karen Clark & Company (KCC) are the only third-party commercial vendor wildfire models agreed to be used by the Subgroup. He stated that the Subgroup only agreed on using the CoreLogic model for earthquake and hurricane peril and ARA HurLoss and Florida Public Model (FPHLM) for hurricane peril only. These clarifications will be reflected in the 2022 Risk-Based Capital (RBC) PR027 instructions.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 22, 2022. The following Subgroup members participated: Wanchin Chou, Co-Chair, and Qing He (CT); Halina Smosna, Co-Chair, Gloria Huberman, and HauMichael Ying (NY); Robert Ridenour, Vice Chair, and Jane Nelson (FL); Laura Clements, Lynne Wehmueller, and Giovanni Muzzarelli (CA); Judy Mottar (IL); Anna Krylova (NM); Tom Botsko (OH); Andrew Schallhorn (OK); and Miriam Fisk and Rebecca Armon (TX). Also participating was: Julie Lederer (MO).

1. Consider Adoption of Proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only)

Mr. Chou said the Subgroup identified wildfire as one of the major drivers of U.S. insured losses during the previous meeting. He also stated that a referral letter from the Climate and Resiliency (EX) Task Force was received on March 15, 2021, to recommend that the Subgroup consider: 1) expanding the current catastrophe framework to include other perils such as wildfire, flood, and/or convective storms that may experience a greater tail risk under projected climate-related trends; and 2) implementing two perils in the risk-based capital (RBC) framework by year-end 2022 if possible. He said a response was sent by the Subgroup on April 26, 2021, indicating that the catastrophe models are complicated; the Subgroup will need time to review and gain a better understanding so the costs and benefits for using the models are justified. He also said a proposal to include wildfire peril in the Rcat component for informational purposes only was developed and exposed for a 60-day public comment period ending Feb. 13. He stated that the Subgroup received three comment letters during the exposure period; some minor editorial changes in the proposal were made based on the received comment letters to clarify that this proposal is for informational purposes only and no timeline has been set for the RBC implementation until the needed enhancements and statistical impacts are implemented. In addition, the exemption interrogatory clearly indicated that the exemption rules to address the minimal wildfire exposure are consistent with the earthquake and hurricane perils.

Matthew Wulf (Swiss Re) recommended that the Subgroup consider extending the informational purposes only period to allow companies the time to responsibly incorporate either a vendor or internal model fully into pricing, risk selection, and capital management processes. Matthew Vece (American Property Casualty Insurance Association—APCIA) also supported an extended, multi-year period for informational-only filings until all the concerns are addressed before incorporated into RBC for solvency purposes, as wildfire models are still in the new stage of development, and the models are more prone to yielding inconsistent results, especially in the tail of the distribution. Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC) and Scott Williamson (Reinsurance Association of America—RAA) said they submitted a comment letter on Feb. 13. Mr. Rodgers suggested that the filing only be required for companies that currently employ the approved models. He also stated that the comment letter clearly indicates that both NAMIC and the RAA do not think wildfire models are ready to be relied upon for solvency purposes; exploring other opportunities to address this peril during the for informational purposes only period is worth consideration. Mr. Botsko recommended that the Subgroup move the proposal forward, as the Subgroup agreed to take time to evaluate the impact and allow more time for the modelers to enhance their modeling approach with this new peril. Mr. Williamson asked the Subgroup to consider adopting the proposal with a carve out for companies that do not currently employ the model. Ms. Smosna asked for clarity around the term “employ” and whether Mr. Williamson means “license” models or “use” models, because many companies use models through their broker relationships and do not actually license the models. Mr. Williamson stated that he intended the term “employ” to refer to companies that license the models. Ms.
Smosna expressed concern that that might leave out too large a universe of companies from the informational-only process. Mr. Chou said the Subgroup will continue working with the RAA to resolve the exemption issues in the near future. He also encouraged all the interested parties to keep reviewing the comments and continue discussing the outstanding issues in the upcoming meetings.

Having no further comments, Mr. Botsko made a motion, seconded by Mr. Ridenour, to adopt proposal 2021-17-CR (see NAIC Proceedings – Spring 2022, Capital Adequacy (E) Task Force, Attachment Nine). The motion passed unanimously.

2. **Discussed the Independent Model Review Instructions in Rcat**

   Mr. Chou said during the previous discussion, the Subgroup identified three different kinds of catastrophe models that deviate from the vendor models: 1) internal catastrophe models; 2) vendor catastrophe models with adjustments or different weight; and 3) derivative models based on the vendor models. He stated that the Subgroup will focus on discussing the vendor catastrophe models with adjustments or different weight first. He said he believes the PR002 Attestation and PR027 Catastrophe Risk pages will require further modification to better accommodate this type of model. Ms. Lederer said the Missouri Department of Commerce and Insurance (DCI) has used the RBC instructions to review an internal catastrophe model. She said she would like to offer some comments to the Rcat instructions in the upcoming meeting. Mr. Chou also asked the industry to review the instructions and provide comments at the Spring National Meeting.

3. **Discussed the Issue of Double Counting in the R5 Component**

   Ms. Smosna said the wildfire peril will follow the same process as the other perils to adjust the R5 component based on the PR100s data collection. She said any received comments regarding this item will be discussed in the upcoming meeting.

4. **Heard a Presentation Regarding the Private Flood Market**

   Nancy Watkins (Milliman) provided a presentation on: 1) flood market background; 2) the need for flood catastrophe models; 3) flood and catastrophe model regulation; and 4) flood model evaluation (Attachment Five-A1a). Mr. Chou said currently, the Subgroup just started the discussion on: 1) the materiality of the flood peril; and 2) the RBC financial solvency regulations. He stated that Ms. Watkins will be invited back for another presentation if the Subgroup decides to further study this peril.

   Lastly, Mr. Chou said the Subgroup will continue discussing all the outstanding issues at the Spring National Meeting.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
U.S. Private Flood Market

NAIC Catastrophe Risk (E) Subgroup

February 22, 2022

Nancy Watkins, FCAS, MAAA
Principal & Consulting Actuary, Milliman

Agenda

- Flood market background
- The need for flood catastrophe models
- Flood and catastrophe model regulation
- Flood model evaluation
Flood market background

Flood risk is increasing...

“The rain broke records set just 11 days before by Tropical Storm Henri, underscoring warnings from climate scientists of a new normal on a warmed planet. Hotter air holds more water and allows storms to gather strength more quickly and grow ever larger.”

New York Times, September 7, 2021

“The United States is expected to experience as much sea level rise by the year 2050 as it witnessed in the previous hundred years... sea levels along the coastline will rise an additional 10-12 inches by 2050 with specific amounts varying regionally, mainly due to land height changes.”

National Oceanic and Administration Association, February 15, 2022
...but the U.S. flood insurance market is underserved

- Current U.S. residential flood insurance market
  - Estimated 4% of SFHs have flood insurance (2021)
  - NFIP: $3.6B total premium on 4.8M policies (2019)
  - Private insurers reported $735M in Private Flood DWP (2020) vs. $577M in DWP (2019)
  - About one-third of Private Flood DWP is estimated to be residential
  - 175 private carriers writing flood insurance (2020) vs. 152 in 2019
  - Potential U.S. residential flood insurance market is between $37B and $47B of DWP
- For comparison purposes, 2020 HO DWP was $110B

What makes an insurance market sustainable?

- **Availability**
  - Insurer can manage and measure the risk
  - Insurer can charge premiums that represent the cost of risk transfer

- **Affordability**
  - Policyholders are able to pay the premium

- **Reliability**
  - Insurer will be able to pay claims
  - System will be stable over the long term

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Flood risk is local
Varies greatly over short distances and requires granular rating
Flood risk is catastrophic
Requires advanced catastrophe models for risk measurement and management

Milliman

National Flood Insurance Program
Supplementing historical experience with advanced catastrophe models

FEMA is updating the NFIP risk rating methodology through the implementation of a new pricing methodology called Risk Rating 2.0. The methodology leverages industry best practices and cutting-edge technology to enable FEMA to deliver rates that are actuarily sound, equitable, easier to understand and better reflect a property's flood risk.

Risk Rating 2.0 was implemented for new policies in October 2021 and will apply to renewal policies in April 2022. As part of the rate development process, FEMA supplemented NFIP's historical loss experience with commercial catastrophe models for inland flood and storm surge.

Description of RR 2.0 methodology and data sources: https://www.fema.gov/flood-insurance/risk-rating
Flood models are necessary for climate-readiness

Under a high climate scenario, an estimated 750k single-family properties in the US will face major repricing by 2050
Catastrophe model treatment varies widely among states

- Prohibition of the use of catastrophe models for some or all purposes in establishing rates
- Silent on the use of catastrophe models
- Questionnaires and case-by-case model validation
- Regulations piggybacking on other state reviews
- Statewide body for scientific and technical review of catastrophe models
How different states treat catastrophe models

- **Florida**: Models used in rate filings must be accepted by the Florida Commission on Loss Projection Methodology, which conducts extensive reviews of hurricane and flood models.

- **South Carolina**: Models must be approved by South Carolina, historically have followed Florida’s lead.

- **Hawaii**: Models must be accepted but historically have not been reviewed frequently, resulting in the requirement to use old models.

- **California**: Not allowed for setting overall rate levels (except for Earthquake and Fire Following Earthquake). Allowed for setting rate relativities, granular territory definitions, underwriting/firing.

- **New York**: Does not allow catastrophe models.

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**Flood model evaluation**
Evaluation of emerging models
Specific actuarial techniques

- Calibration versus out-of-sample validation
- Reasonability checking
  - Is the aggregate AAL believable?
  - How often does it produce unreasonable location level AALs?
  - Does it produce logical relationships with risk?
  - Does it produce discontinuities?
- Does it reflect important variables that alter vulnerability?
- Does it include all important sub-perils?
- How does it compare to other models (if available)?
- Give special consideration to outliers

Example: Annual Average Loss (AAL) by model
Average AAL impacts the rate level

Wide disparities exist across different models for inland flood

Storm surge also shows sizeable variation of AALs across models
Example: Inspection of individual risks
Which modeled AALs are most reasonable?

<table>
<thead>
<tr>
<th>Model</th>
<th>Beach house</th>
<th>Inland property</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model A</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Model B</td>
<td>$30</td>
<td>$3</td>
</tr>
<tr>
<td>Model C</td>
<td>$20,000</td>
<td>$30</td>
</tr>
</tbody>
</table>

Example: Correlation among models
Higher agreement in relative risk for storm surge than inland flood

<table>
<thead>
<tr>
<th>Inland flood (4 counties)</th>
<th>Storm surge (2 counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model A</td>
<td>Model B</td>
</tr>
<tr>
<td>1.00</td>
<td>0.26</td>
</tr>
<tr>
<td>1.00</td>
<td>0.30</td>
</tr>
<tr>
<td>1.00</td>
<td>0.34</td>
</tr>
<tr>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

None of the models are highly correlated for inland flood
Significantly higher correlation among storm surge AALs
Example: Spatial analysis of inland flood

- Model A shows limited high AALs
- Model B shows high AALs farther away from rivers
- Model C shows more high-AAL locations, generally very close to rivers
- Model D shows high AALs the farthest away from rivers

Proposal for catastrophe model clearinghouse

- Multi-disciplinary panel to develop standards, select expert reviewers, and manage model review process
- Third-party experts chosen by panel to perform confidential reviews
  - Consistent professional review team for all models for a given peril
  - Expert team would depend on nature of model but could include engineers, scientists, technologists, actuaries, claims experts, other professionals
- Voluntary participation by states who wish to rely on expert model review
  - Retention of state-level control of ultimate determination of acceptability
  - States may add filing-specific questions regarding model usage
- Potential clearinghouse deliverables
  - Standardized modeler disclosures
  - Market basket output for state level regulatory analysis, comparison
  - Third-party expert reports reviewing model compliance with standards, suitability for specific purposes
Vision for sustainable private flood insurance market

Available, affordable, reliable insurance

Agents and insurers actively competing to provide variety of options for consumers

Higher participation / take-up rates across all flood zones

Affordable risk-based premiums for the greatest number of households

Continuous improvements in data, modeling and risk communication

Ability to anticipate, measure and plan for future climate scenarios

Reduced reliance on disaster assistance + faster rebound post-event

Thank you

Nancy Watkins
nancy.watkins@milliman.com
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Jan. 25, 2022. The following Subgroup members participated: Wanchin Chou, Chair, and Qing He (CT); Robert Ridenour, Vice Chair, and Jane Nelson (FL); Laura Clements and Giovanni Muzzarelli (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova and Leatrice Geckler (NM); Halina Smosna and Gloria Huberman (NY); Tom Botsko and Dale Bruggeman (OH); Andrew Schallhorn (OK); Will Davis (SC); and Miriam Fisk, Rebecca Armon, and Monica Avila (TX).

1. **Discussed the Possibility of Adding Flood Peril in the Rcat Component**

Mr. Chou said the Subgroup received a referral letter from the Climate and Resiliency (EX) Task Force in March 2022, which recommended that the Subgroup consider expanding the current catastrophe framework to include other perils such as wildfire, flood, and/or convection storms that may experience a greater risk under projected climate-related trends. He also said a response from the Subgroup stated that it was focusing on developing the risk charge for the wildfire perils at that time due to limited resources. He said last year, the Subgroup completed: 1) reviewing three different wildfire vendor models; and 2) adopting the Karen Clark & Company (KCC) earthquake and hurricane models. As the wildfire instructions and risk-based capital (RBC) structure is currently exposed for comments, he believes now is a good time to start reviewing the next peril; i.e., flood. He stated that the flood model review ad hoc group will be established next month to start the review process. He said he anticipates that the process will be similar to the wildfire model review process, which will include six different phases: 1) introduction to flood models; 2) in-depth technical reviews; 3) impact studies (model comparison); 4) developing RBC risk charge; 5) exposing the flood peril RBC structure and instructions for information purposes only; and 6) modifying the structure and instructions based on the comments and feedback. He urged all the interested parties to contact NAIC staff if they are interested in joining the ad hoc group. Scott Williamson (Reinsurance Association of America—RAA) encouraged the Subgroup to consider the materiality issue with respect to whether the flood peril is warranted, given the exposure of the industry. He also asked NAIC staff to perform a materiality analysis to determine if it makes sense to proceed further. Mr. Botsko recommended that the Subgroup consider conducting a company survey to determine if the exposure of not only the flood but also the convective storms are significant enough to study further. Ralph Blanchard (Travelers) said he is concerned that adding flood peril may have issues on removing the double counting in the R5 component, as flood can be caused by multiple perils. Nancy Watkins (Milliman) recommended that the Subgroup consider reviewing the Alabama Department of Insurance (DOI) Private Flood Insurance Survey as a good starting point.

2. **Discussed the Independent Model Review Instructions in Rcat**

Mr. Chou said last year, the Subgroup discussed three different kinds of catastrophe models that deviate from the vendor models: 1) internal catastrophe models; 2) vendor catastrophe models with adjustments or different weight; and 3) derivative models based on the vendor models. He stated that the industry provided some valuable information during the discussion, such as recommending that Subgroup: 1) consider developing a basic approval process if the Subgroup decides to rely on models in order to ensure the use of models are consistent and comparable across companies; and 2) review the RBC instructions, as it clearly indicated that a company should use the same data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. He said he believes adding this charge of reviewing the PR002 and PR027 instructions and blanks to the ad hoc group is worth considering, as both items are related to the model review process. He also
stated that this is just a continued improvement of the RBC instructions and blanks; this is a high priority for the Subgroup, and it will be reflected in the Subgroup’s working agenda soon. Matthew T. Wulf (Swiss Re) said Swiss Re and its domiciliary state will continue working with the Subgroup on this item in the future. Mr. Blanchard said Travelers will continue supporting the idea of treating adjustments to the vendor models differently from the totally separate models.

3. Discussed the Issue of Double Counting in the R5 Component

Mr. Chou said the current RBC formula PR100 through PR122 require insurers to provide actual catastrophe losses incurred separately by Annual Statement Line of Business for each of the last 10 accident years. The purpose of requiring the reporting of actual catastrophe losses is to avoid double counting catastrophe losses in the formula. Mr. Chou stated that the catastrophe risk element of the RBC formula is based on the results of catastrophe models run by the insurer. The existing R5 industry factors are derived from industry total loss data, which includes actual catastrophe losses, so it is necessary to study these actual catastrophe losses to avoid the double counting that would otherwise take place. Mr. Chou asked the industry to review the current methodology and provide comments in the next meeting.

4. Discussed Other Matters

Mr. Chou said proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only) was exposed for a 60-day public comment period ending Feb. 13. He encouraged all the interested parties to review the materials and submit comments for discussion in the upcoming meeting.

Lastly, Mr. Chou said he is pleased to announce the appointment of Ms. Smosna as co-chair of the Subgroup. He said he will work closely with Ms. Smosna to ensure the Subgroup completes all its charges successfully in the future.

Mr. Chou said the Subgroup will continue discussing all the outstanding issues in the meeting next month.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.

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The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Dec. 16, 2021. The following Subgroup members participated: Wanchin Chou, Chair, and Amy Waldhauer (CT); Laura Clements and Giovanni Muzzarelli (CA); Judy Mottar (IL); Gordon Hay (NE); Halina Smosna (NY); Tom Botsko and Dale Bruggeman (OH); Andrew Schallhorn (OK); Will Davis (SC); and Miriam Fisk and Monica Avila (TX).


Mr. Chou said the Florida Commission on Hurricane Loss Projection Methodology (FCHLPM) reviewed and verified the Karen Clark & Company (KCC) hurricane model on June 19, 2019, and June 4, 2021. The Subgroup believed the KCC models seem to qualify under the same standards as the other modeling firms have for earthquakes and hurricanes. Mr. Chou said a proposal was created to include the KCC earthquake and hurricane models as one of the NAIC approved third-party commercial vendor models to calculate the catastrophe risk charge, which was exposed for a 30-day public comment period. He also stated that the Subgroup received one comment letter during the exposure period. Glen Daraskevich (KCC) said the KCC supports the proposed update to the list of NAIC-approved catastrophe models and appreciates the Subgroup’s goal of keeping the list current with market usage.


2. **Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group**

Mr. Chou said the ad hoc group met Dec. 6 to discuss the survey questions created by the members within the group, which was based on Actuarial Standard of Practice (ASOP) No. 38—Catastrophe Modeling (for All Practice Areas). He said the survey results indicated that the ad hoc group gained a better understanding on different aspects of different models during a series of question and answer sections.

Ms. Smosna stated that the ad hoc group reviewed the technical documentation provided by three vendors: Risk Management Solutions (RMS), AIR, and KCC. Also, the ad hoc group posed questions to each noted vendor and had several follow up discussions with them separately. Ms. Smosna said the ad hoc group also acknowledged that although these are the best tools available to assess wildfire risk, limitations exist. A notable limitation across all three vendors includes the data vintage. In addition, Ms. Smosna indicated that the ad hoc group noted that although the key vendors are subject matter experts (SMEs), this does not negate the fact that wildfire models are in their infancy. Moreover, she said the ad hoc group comfortably stated that the vendors are experts and have dedicated huge resources to wildfire modeling; but going further and being able to state that the level of capital required for wildfire exposure is adequate based upon the modeling is a conclusion that cannot be validated by the ad hoc group. She concluded that at this point, the ad hoc group members only have a basic understanding of each vendor model and are reasonably familiar with the major model components and how those components interrelate.

Mr. Chou said the issue of the wildfire-prone areas was also discussed during the meeting. He stated that identifying the potential wildfire-prone areas will provide better determination of exemption from the wildfire charge. In addition, he provided a brief overview on the wildfire structure to the ad hoc group. He said the
structure will be included in the 2022 risk-based capital (RBC) formula just for informational purposes only. He also stated that the structure will not go live until all the outstanding issues are resolved. Lastly, he said the ad hoc group will not meet until the Subgroup starts reviewing the next peril.

3. **Exposed Proposal 2021-17-CR (Adding Wildfire Peril for Informational Purposes Only)**

Mr. Chou said while the Subgroup reviewed the possibility of expanding the current catastrophe framework to include other perils that may experience a greater tail risk under projected climate-related trends, the wildfire has been identified as one of the major drivers of the U.S. insured losses. He suggested that setting up a proposal to include wildfire peril in the Rcat component for informational purposes only to address this risk is necessary. He also indicated that the wildfire peril will not be included in the RBC calculation until all the outstanding issues are resolved. Lastly, he urged all the interested parties to review the proposal and provide comments during the exposure period.

Mr. Botsko expressed the Subgroup’s appreciation to the ad hoc group for its efforts in reviewing the wildfire models. Ralph Blanchard (Travelers) proposed to include Florida in the wildfire-prone areas. Steve Broadie (American Property Casualty Insurance Association—APCIA), Scott Williamson (Reinsurance Association of America—RAA), and Matthew Wulf (Swiss Re) requested to extend the 30-day exposure to 60 days due to the holiday season and the need for more time to review.

The Subgroup agreed to expose proposal 2021-17-CR for a 60-day public comment period ending Feb. 13.

Mr. Chou said the Subgroup will continue discussing all the outstanding issues in the meeting next month.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
Hi Wanchin and Eva,

We note that agenda item 2 of Tuesday’s call is on the RCAT independent model review instructions. Since the Missouri Department of Commerce and Insurance (DCI) has used these instructions to review an internal catastrophe model, we would like to offer the subgroup our comments.

**Background on the DCI’s review**

On April 7, 2017, the Catastrophe Risk Subgroup granted permission for Swiss Re to use its internal model for year-end 2017 RCAT reporting. For subsequent year-ends, this permission came from the Missouri DCI.

In order to grant Swiss Re initial permission for year-end 2018 reporting, the DCI performed an in-depth review of the company’s model, centered around the seven requirements in the RCAT instructions. We relied on written information from the company, phone calls with the company, and in-person meetings with the company and the group-wide supervisor. Our review was informative and valuable. It was also extremely time-consuming for the DCI (and, I assume, for the company as well). Performing a thorough review based on the requirements in the RCAT instructions could be difficult for small insurance departments with limited technical staff.

As mentioned above, the DCI performed an in-depth review in 2018. For subsequent year-ends, our review has been much more high-level and has focused on any follow-up items from the previous year. While the RCAT instructions indicate that ongoing review should happen through the exam process, this may be too infrequent in some cases, especially since the company could be asked to re-file prior RBC reports if the regulator identifies a concern. Companies large enough to use their own model are probably only examined every five years. The DCI would prefer to perform an annual review and remain updated on any changes to the model. This seems particularly important as more perils are added to the RCAT charge.

**Our comments on the seven items in the RCAT instructions**

Taken as a whole, the seven requested items in the RCAT instructions seem reasonable. Gathering information on these items allowed for a thorough review and made the DCI comfortable granting permission for Swiss Re to use its model.

We offer the following comments on several of the items:

1. **Regarding item 3:**
   a. We do not know what it means to validate a peril or for perils to include both U.S. and global exposures. We raised these concerns in 2017 before the instructions were finalized. In order to attempt to comply with this item, we interpreted it as we saw reasonable. Namely, we checked that:
      i. If the insurer has exposure to the perils covered by the RBC catastrophe risk charge (earthquake and hurricane), those perils are contemplated in the RBC charge, and
      ii. The insurer is including both U.S. and non-U.S. exposures in the RBC charge.
   b. Whether or not our interpretation is correct, we recommend rewording this item to make the subgroup’s intention clear.

2. **Regarding item 6:**
   a. It appears that complying with this item is challenging for several reasons:
i. If an insurer has been relying on its internal model for many years, it may not maintain a license for a vendor model.

ii. If an insurer aggregates losses, instead of exposures, across accounts, it may not be able to produce a portfolio of exposures for input into a vendor model.

iii. It can be difficult, if not impossible, to identify drivers of differences between an internal model and a vendor model. First, the models are extremely complex, relying on numerous modules and impacted by various assumptions within those modules. Second, vendor model licenses often prohibit “back engineering” of the model’s parameterizations, so the company may not have full insight into the model’s assumptions.

b. Given these difficulties, would it be possible to add alternative methods of comparison to the RCAT instructions? We have found it helpful to review a comparison of internal model estimates to actual results for historical events.

3. Regarding item 7: We experienced difficulty in receiving written documentation from the group-wide supervisor.

Thank you for allowing us to share our experiences with the RCAT instructions.

Sincerely,

Julie

Julie Lederer, FCAS, MAAA
Property and Casualty Actuary
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Sign up for DCI news
The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met March 22, 2022. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Carrie Mears (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung and Debbie Doggett (MO); Lindsay Crawford (NE); Bill Carmello and Bob Kasinow (NY); Dale Bruggeman and Tom Botsko (OH); Mike Boerner (TX); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Adopted its Feb. 28 Minutes

The Working Group met Feb. 28. During this meeting, the Working Group took the following action: 1) discussed overall charges and the Financial Condition (E) Committee’s direction; 2) heard a preliminary investment overview and member perspectives; and 3) received comments from an initial request related to RBC treatment for asset-backed securities (ABS).

Mr. Spudeck made a motion, seconded by Mr. Chou, to adopt the Working Group’s Feb. 28 minutes (Attachment Six-A). The motion passed unanimously.

2. Discussed Comments Received

   a. American Council of Life Insurers

Paul Graham (American Council of Life Insurers—ACLI) presented the ACLI’s comment letter (Attachment Six-B). He noted the significant complexity involved in developing RBC for ABS. He noted the determination of associated risks (i.e., loss given default, timing, and others) will be different from commercial bonds. He said collateralized loan obligations (CLOs) might be able to be mapped to current bond factors using what has been learned from commercial mortgage-backed securities (CMBS) and residential mortgage-backed securities (RMBS) modeling. He suggested addressing CLOs first with other ABS to follow. He noted that RBC has historically followed the rule of rough justice and underscored the fact that the purpose of RBC is to identify weakly capitalized companies. He noted the ACLI’s suggestion that a technical resource group could be formed to help get the project started, defining scope, risks to study, and how this work fits within the RBC framework.

   b. Bridgeway Analytics

Amnon Levy (Bridgeway Analytics) presented Bridgeway Analytics’ comments (Attachment Six-C). He indicated support for the comments by Mr. Graham and the ACLI on a phased approach, allowing for coordination with the related review of nationally recognized statistical rating organizations (NRSROs) use in Securities Valuation Office (SVO) designations and acknowledging the complexity of the issues involved. He highlighted the need for the framework to be consistent with its use and measurement of differentiated risk measures, including that of a single credit investment (e.g., a rating and thus designation), and a portfolio loss concept that considers diversification and concentration (e.g., c1 factors). With respect to the RBC framework and providing state insurance regulators better tools to identify weakly capitalized companies and align investment incentives, he highlighted the need for ongoing monitoring of tail risks that can change materially from year to year with varying risk factors and to a varying degree across RMBS, CMBS, CLOs, and other structured assets. He also noted risks that are not captured by ratings, and thus NAIC designations. He said the approach should be sensitive to volatility.
and cyclical fluctuations. He stated that the data on ratings, and thus NAIC designations, that are fundamental to C-1 RBC are particularly sparse for structured assets. By and large, NRSRO methodologies were modified substantially after the financial crisis, with few credit events since. With data on collateral experience generally more robust than tranche experience, Mr. Levy said Bridgeway Analytics believes reliance on model-based approaches can better capture nuanced and varying characteristics across structured asset segments.

c. Risk & Regulatory Consulting

Ed Toy (Risk & Regulatory Consulting—RRC) presented RRC's comments (Attachment Six-D). He said the RBC framework was originally intended as a regulatory tool to be able to see weakly capitalized companies, and the framework was not intended to be granular or very detailed. However, he stated that investment vehicles owned by insurers have grown more varied and investment practices more complex. With this consideration, he said some degree of increased detail may be warranted to avoid regulatory arbitrage. He said a big step was already completed with the increased granularity of NAIC bond designations, as that eliminated the inappropriate incentive to race to the bottom with investments with BBB-minus designations and the disincentive to lean towards BBB-plus bonds.

Mr. Toy stated support for the review of the RBC framework to ensure that complex assets have RBC charges that are commensurate with the risk. He said structured securities are one of the investments where additional attention may be appropriate, but he encouraged the Working Group to think holistically and consider the broader themes mentioned by Mr. Graham. Mr. Toy stated that there are different kinds of risk and that tail risk is potentially different for different assets. While tail risk includes differences in volatility for default risk, he said the major issue is differences in loss severity. He stated that higher-level classes of structured securities are not perceived to be a material area of concern, and the primary issue is with subordinate classes. As such, understanding the industry exposure to subordinate classes of structured securities and how the characteristics of these investments compare with other asset classes that are also potentially concerning may be beneficial. Mr. Toy provided examples of collateral loans, which have a flat RBC factor for life entities and construction mortgage loans as two asset classes that have also had significant growth. Looking at asset classes with high tail risk, he also inquired about the assessment of asset classes that have materially less tail risk, such as government bonds. He said focusing on particular asset classes with specific risks without having a holistic discussion may create imbalances in the formula.

Mr. Toy stated that understanding the focus of tail risk is also a key element. If the focus is loss severity, then the question that should be addressed is how loss severity translates into a risk of loss to surplus, which is the main issue for RBC. He stated that if an insurer owns an investment at significant discount to par, then the risk of loss to surplus may be different from another insurer that owns the same investment at par.

Mr. Toy said the overall discussion should begin with representatives of the American Academy of Actuaries (Academy), and if there is a need to focus on specific areas, then engaging a consulting actuary may make sense.

Mr. Toy also addressed the specific question of residuals, which is a subcategory of structured securities. He stated that as classes are the bottom supporting tranche in a capital structure, then treatment as equity makes sense. With regard to Mr. Toy's question regarding the reporting of residuals, Mr. Bruggeman said there are two proposals being considered for adoption at the Blanks (E) Working Group. These proposals will require classification of residuals on Schedule BA and asset valuation reserve (AVR) based on underlying characteristics. The proposals mirror existing underlying classifications as fixed income, common stock, real estate, mortgage loans, and other. Mr. Toy commented that more granular classifications, particularly for the common stock category, may be warranted, providing an example of differences between publicly traded and private common...
stock investments. He stated having the same factor for the various stock or equity backed assets highlights the point of focusing on underlying risks.

d. **FLOIR**

Mr. Spudeck presented comments (Attachment Six-E) from the Florida Office of Insurance Regulation (FLOIR). He said with the progression and innovation towards more complicated investments, this is an opportunity to dig into the use of NAIC designations, as well as the classification of assets. He stated that the focus should be on the risk to surplus and ultimately the risk to policyholders or the insurer’s capital position. He stated that this project is likely going to be a long process but one that is overdue. Mr. Spudeck stated that it may appropriate to start with current asset exposures, but he said current exposures should not drive the work as that prevents considering issues or exposures that are currently being designed or developed until they have permeated the industry. He said waiting for items to be widespread makes it more difficult for the regulatory community to craft a nimble, agile, and efficient response to get the asset class reflected to where it should have been in the first place.

3. **Adopted its Working Agenda**

Mr. Barlow presented the Working Group’s working agenda and said it includes items referred from the Financial Condition (E) Committee and prior referrals to the Capital Adequacy (E) Task Force that focused on investments. He said the referrals from the Committee, as they include timelines, are recommended to be addressed first. However, to be consistent with many of the comments made, he said he recommends a holistic review as an overall approach.

Mr. Drutz made a motion, seconded by Mr. Botsko, to adopt the Working Group’s working agenda (Attachment Six-F).

4. **Discussed its Next Steps**

Mr. Barlow said the Working Group will begin with a review of the projects requested from the Committee. He stated support for a holistic review and supported Mr. Spudeck’s comment to review the role of NAIC designations and how assets are classified as part of this process. He said it would be key to identify the risks of asset classes and the impact on the solvency of insurance companies. He stated support for a process that allows consideration of new assets as they come into insurance company portfolios. He said it would be ideal if the revised process would prevent application of RBC factors based on an NAIC designation or asset classification that is ultimately not appropriate for the asset’s risk. He echoed the comments from Mr. Graham that it will not be possible to be perfect, but the goal is to have reasonable charges that are not too high or too low based on the risk of the asset. He stated that the process will be complicated, and that the assessment needs to consider the overall impact to the financial statements, reserves, and overall capital and surplus of insurance companies to be in line with the goal of RBC to identify weakly capitalized companies, or to identify actions that move companies towards being weakly capitalized.

Mr. Tsang asked about the percentage of these complex assets currently owned by insurance companies. Mr. Barlow stated that the Working Group does not have an exact number, but he will further inquire with the Capital Markets Bureau. He stated that reporting consistency is one of the challenges, as reporting is inconsistent, and it is not always clear that the reported asset is a structured or complex security. He stated that these investments are often mixed in with other corporate bonds in the reporting structure.
Mr. Tsang asked whether it was feasible to apply a factor to these securities and whether some form of simulation analysis to evaluate the risk of these assets would be more appropriate. He said a structured security is not like a corporate bond, and it will be difficult to determine an appropriate factor when there are many variants among the different types of structures. Mr. Barlow stated that this is a good point, but his preference would be to try to determine a methodology to apply a factor. He said this process could result with use of current factors or could result with the creation of a whole new set of factors, but he would like to see if that is possible before moving to something more complicated, particularly as the magnitude of these investments is still uncertain. He said developing a complicated methodology for a limited number of assets would not be relevant in identifying weakly capitalized companies. Mr. Therriault said they will work to develop an assessment of exposure. He said the structured security group would also be well positioned to model these types of transactions and assess risks.

Mr. Tsang stated that another working group is also monitoring these structured securities for cash-flow testing. He asked whether the actions of that group, particularly if it puts a cap on structured assets for cash-flow testing, would affect the consideration of this Working Group. He stated that he would not want a revised factor from this Working Group and an updated actuarial guideline from another group to impede each other. Mr. Barlow stated that it is important to coordinate with the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, and the work that is being done to the reserves and how it might ultimately affect the solvency of an insurance company. He said this Working Group has representatives from a variety of groups to make sure that the right people are involved and that the discussions include all relevant information.

Mr. Barlow said the next steps would be the development of recommendations with suggestions on moving forward. As to whether it would be beneficial to have small subgroups focusing on specific areas, he said he would like to begin working at the full Working Group level, and if projects became too cumbersome, then perhaps small groups could be considered. Mr. Carmello, Ms. Mears, and Mr. Boerner all stated agreement with keeping the discussion initially within the full Working Group in developing recommendations. Mr. Barlow said specific agendas for key topics will be developed to allow progress through a project plan. He said he does not think the Working Group is at the point where a consultant would be beneficial, so he recommends putting that consideration aside for the time being. He said as the Working Group moves forward, there may be a better understanding of the services and assistance a consultant could provide. Mr. Wanchin agreed with future consideration of a consultant after the Working Group can define the scope of the project and determine the experts who can help achieve specific goals. Mr. Spudeck agreed, noting that it would be more efficient to first determine the information needed prior to engaging a consultant. John DuBois (MassMutual) suggested that framing the project by determining the size of the different asset classes may assist the next discussion. Mr. Barlow said the Working Group should expect meetings to be scheduled after the Spring National Meeting with specific agendas and goals noted for each meeting.

5. Discussed Other Matters

James Braue (United Health Group) asked whether this Working Group would also be considering parallel treatment to the AVR for the asset classes that are being considered for revised RBC. Mr. Barlow stated that this would occur on the life side.

Julie Gann (NAIC) said the Blanks Working Group (E) is scheduled to meet March 29, and two proposals up for adoption related to residual reporting on Schedule BA and AVR are available on the Working Group’s website.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.
The RBC Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Task Force met Feb. 28, 2022. The following Working Group members participated: Philip Barlow, Chair (DC); Thomas Reedy (CA); Wanchin Chou (CT); Ray Spudeck (FL); Carrie Mears (IA); Vincent Tsang (IL); Fred Andersen (MN); William Leung and Debbie Doggett (MO); Lindsay Crawford (NE); Bill Carmello (NY); Tom Botsko (OH); Mike Boerner and Rachel Hemphill (TX); Steve Drutz and Tim Hays (WA); and Amy Malm (WI).

1. Discussed its Formation, its Charges, and Financial Condition (E) Committee Direction

Mr. Barlow introduced the call and referred to a memorandum from Mr. Botsko, chair of the Capital Adequacy (E) Task Force, to the Financial Condition (E) Committee requesting the formation of the Working Group. Mr. Botsko stated that the formation of the Working Group was primarily for the evaluation of investments and risk from an RBC perspective, and the Committee was supportive of the formation. Mr. Barlow summarized the Working Group’s initial charges: 1) identifying and acknowledging uses of RBC beyond the purpose of the Risk-Based Capital (RBC) for Insurers Model Act (§312); 2) assessing the impact of potential changes in contributing to the identification of weakly capitalized companies; and 3) documenting the modifications made over time to the formulas. He stated that during an initial Jan. 12 joint call of the Working Group with the Committee, the Committee provided direction on two projects: 1) consider a second phase of the bond factors; and 2) review residual tranches for RBC. He stated that the requested work of the Committee could be completed with the scope of the Working Group charges, and he identified that the Working Group will likely have extensive coordination with the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, as well as other groups, while completing a comprehensive review of the investment component of the RBC calculation.

2. Discussed Desired Outcomes

Ms. Mears, chair of the Valuation of Securities (E) Task Force and vice chair of the Statutory Accounting Principles (E) Working Group, provided viewpoints on behalf of both groups, as Dale Bruggeman (OH), chair of the Statutory Accounting Principles (E) Working Group, was unable to attend. She stated that the bond project of the Statutory Accounting Principles (E) Working Group came about as state insurance regulators identified a shift in insurer portfolios from traditional bond holdings to more structured products. She identified that the accounting framework did not contemplate the type of collateral that could be held under these innovative products. She stated that the bond project initially began with a focus on equity investments that could be securitized, resulting in movement from Schedule BA: Other Invested Assets to Schedule D-1: Long-Term Bonds, but the project ultimately became a holistic review of Schedule D-1 and the principal concepts in classifying investments as bonds. She stated that the desire to have similar focuses on these types of investments at the Task Force and the RBC Investment Risk and Evaluation (E) Working Group to ensure that the ratings and capital framework continues to be appropriate for these types of investments.

Ms. Mears noted that a specific concern from a Statutory Accounting Principles (E) Working Group perspective occurs when an insurer holds an “entire stack” from a securitization, which is basically akin to continued holdings of the entire pool or portfolio of underlying collateral, and this concern is more prevalent when the collateral is equity-based. She provided an example of a collateralized fund obligation (CFO) where equity funds were held on Schedule BA with a 30% RBC charge but then went through a securitization process in which higher-level tranches were moved to Schedule D-1, resulting in much less RBC charges, and the remaining residual tranches were...
retained on Schedule BA. In this scenario, the economics and overall risk are not different from the insurer holding the entire investment on Schedule BA, but with the securitization and the ability to divide the holdings between Schedule D-1 and BA, the insurer RBC position is significantly different. Ms. Mears noted that an original proposal as part of the bond project tried to address this issue; however, it was quickly identified that this dynamic is not an accounting issue but pertains to risk assessment and ultimately RBC concepts. As such, there is a desire for the Working Group to address this as part of the residual tranche review. Ms. Mears stated that this residual review would be applicable to all securitizations but would be most impactful to CFO investments. She stated that the risk assessment may also be easier for residuals of a collateralized loan obligation (CLO), which have underlying collateral that is rated and may be more difficult for other structures that have underlying collateral that is not rated or does not fit within the existing RBC framework. She proposed moving forward with structural changes in the calculation, with subsequent edits to reflect the determined factors.

Ms. Mears then presented comments from the Valuation of Securities (E) Task Force, noting that there is a clear connection for some investments between the reported designations and resulting RBC factors. She stated that the Task Force has a project this year to undertake a review on how it uses credit rating providers (CRPs) and assess the types of risks that are encompassed within ratings from the various CRPs to ensure an understanding of the differences between CRPs. She stated that understanding the risks that are reflected in the CRP ratings, which translate to NAIC designations, will correspond to the Working Group in understanding the factors that should be considered in response to those designations. She stated that extensive collaboration of the impacted groups is paramount in ensuring that an appropriate overall statutory framework encompassing accounting, designations, and RBC is in place for all investments, but particularly for securitizations.

Mr. Barlow stated that the comments of Ms. Mears align with his perceptions for the Working Group. He stated that the Working Group should first focus on setting RBC charges that correlate with the risk insurers are undertaking and ensure that the risk the RBC is addressing is commonly understood. He said he believes this is in line with the Ms. Mears’ comments on understanding what is represented with CRP ratings and NAIC designations. He stated that he has been adherent to the concept that RBC is intended to identify weakly capitalized companies, and that has driven historical work of the Life Risk-Based Capital (E) Working Group; however, the work of the RBC Investment Risk and Evaluation (E) Working Group will not necessarily be focused on the work to identify weakly capitalized companies. Instead, the Working Group is likely going to be focusing on a more granular breakdown of investment risk. Although not focusing on weakly capitalized companies, this approach will add clarity and guidance for the other purposes in which RBC is used by insurance companies in making investment decisions. Mr. Barlow stated that the intent is to make RBC a non-factor in determining insurer investment decisions, as each investment will have a charge aligned with the investment risk. He stated that there are differences in the life, property/casualty (P/C), and health formulas, and the Working Group should assess whether the work being completed should be identical in all three formulas or if circumstances exist that support different formulas. He noted that representatives from the various RBC groups are participating in the Working Group, so this assessment will be completed as part of the process.

Mr. Barlow stated that he would like the Working Group to work holistically with its projects and ultimately have a broad methodology that will also address new assets and can be regularly updated with asset factors. He stated that the historical use of the RBC formula attempted to pull information from the financial statements; therefore, two identical companies would have similar RBC. This approach did not allow subjectivity into the RBC formula. Mr. Barlow stated that with changes in investments, two companies could seemingly look the same, but the underlying components of the investments could be different, and the RBC formula may have not been adjusted to reflect this dynamic. He stated that it would be ideal to be as objective as possible with the identification of investment risk, so that with sufficient information in the financial statement, investments can be categorized to ensure appropriate treatment for RBC formula purposes. He also stated that having a clear understanding of the designations, as well as the risk they represent, will also assist in calculating RBC factors that recognize the way
the assets are rated. Although this may not be a short-term result, it would be a goal for the Working Group, particularly with the path of developing a framework that will be appropriate in categorizing new assets and investment structures. Mr. Barlow stated that the RBC groups have historically been reactive to the decisions from other groups in the reporting of investments, and he would suggest developing a framework that can address current and future investments.

Mr. Botsko, representing the chair of the Capital Adequacy (E) Task Force and the Property and Casualty Risk-Based Capital (E) Working Group, affirmed the comments of Mr. Barlow, noting that the groups need to work together in determining an appropriate framework that allows for correct RBC charges. He stated that working together will allow a more efficient outcome for industry. Mr. Drutz, representing the chair of the Health Risk-Based Capital (E) Working Group, confirmed the comments of both Mr. Barlow and Mr. Botsko. Ms. Mears also agreed and encouraged participation of industry and state insurance regulators across the different groups. Mr. Barlow agreed and stated that the RBC Investment Risk and Evaluation (E) Working Group should assist with the coordination effort between the different groups.

Mr. Barlow stated that an exposure on Jan. 12 by the Financial Condition (E) Committee directed comments to the Working Group. The deadline for those comments is Feb. 28, and a specific call will occur to consider the comments from that exposure.

3. Received a Presentation on the High-Level Overview of Investment Development

Charles Therriault (NAIC) presented a summary of structured finance securities on behalf of NAIC Investment Analysis Office (IAO) staff. In principle, securitization is a simple concept involving the legal isolations of assets in a bankruptcy remote entity for the purpose of either collateralizing or generating cash flows sufficient to issue a debt security from the bankruptcy remote entity. However, since its inception in the late 1960s, securitization has evolved to become a tool to finance or monetize just about any asset imaginable.

Mr. Therriault stated that there is a very broad range of structured finance securities that may or may not be divided into different classes called tranches. The only real common theme is the legal isolation of assets in a bankruptcy remote entity. Beyond that, structured finance securities have no uniformity as to the nature of the assets, cash flow generation, classes or tranches, payments to the investor, or method of repaying the principal at maturity. The structures include asset backed securities (ABS), mortgage-backed securities, residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS), collateralized debt obligations (CDOs), collateralized loan obligations (CLOs), insurance-linked risk transfer securities, future flow securitizations, credit tenant lease financing, ground lease financing, military housing administration fee securitization, and whole business securitization, along with many other names. Mr. Therriault stated that the underlying assets can be any asset such as mortgages, credit card receivables, commercial loans, home equity loans, student loans, equipment and property leases, movie revenues, royalty payments, aircraft landing slots, toll roads, or oil reserves, as just about any cash-producing vehicle or situation can be securitized.

Mr. Therriault stated that ratings play an important role in structured finance, as most of these securities are filing exempt (FE), meaning ratings are used to assign an NAIC designation. There is no universal standard for assessing their risk or any consistency in the methodologies across credit rating agencies to provide a uniform credit rating or risk assessment. The performance of structured finance has also varied across the asset class and types. The IAO raised the issue regarding the reliance upon CRP ratings and the lack of oversight as to the analytical basis for those ratings to the Valuation of Securities (E) Task Force in its Nov. 29, 2021, memo. The greater risk assessment variation rewards risk-taking without the commensurate RBC. Mr. Therriault stated that there can be potentially significant distortions of an insurer’s RBC ratio if the underlying rating used to set an NAIC designation is not derived in a manner that is comparable to or consistent with the risk assessment used in determining those RBC
factors. Ratings are not interchangeable, and IAO staff believe the NAIC’s use of them in its regulatory processes needs to reflect those differences efficiently and effectively.

4. Discussed Investment Reporting Perspectives

Ms. Mears stated that the Statutory Accounting Principles (E) Working Group and the Valuation of Securities (E) Task Force, as part of the bond project and investment analysis, will be making reporting changes. As such, if there are data points or analysis requests from the RBC Investment Risk and Evaluation (E) Working Group, those can be considered as part of the reporting changes being considered under the bond project. Ms. Mears inquired about the RBC structural change deadlines, stating a preference to have the structural changes in place as soon as possible for residual tranches so the framework is in place for potential factor changes. Mr. Barlow stated that structural changes need to be exposed by the end of January and adopted by the end of April. For instructional changes, which includes changing factors in the existing structure, those changes need to be exposed by April 30 and adopted by June 30. Mr. Barlow stated that in the past, the Life Risk-Based Capital (E) Working Group has incorporated structural changes in advance of factor changes to allow the deadlines to be met. He stated a presumption that such an approach has also been followed by the other RBC working groups. He stated that the intent for a more objective approach may consider differences in the schedule—i.e., grouping items together—or capture more identifiers for assets, allowing RBC to use the identifiers to better apply factors. He stated that this may be more feasible than increasing the schedules in the annual statement. Ms. Mears noted that these comments are helpful and beneficial, as the reporting changes are considered as part of the bond project. She stated that significant reporting revisions are anticipated, particularly to Schedule D-1 as part of the bond project.

Ralph Blanchard (Travelers) stated that he has historically looked to determine bond default rates by classification, and it was difficult to do so, as the reporting schedules have changed frequently over the years. He requested that the new structure be designed so it can be retained over time so that future analysis on bond classifications would be easier to complete. He stated that this detail was not in the investment schedule but supplemental data, but the format has changed over the years, so it was difficult to track. Julie Gann (NAIC) stated that she is not familiar with the location in the financial statements that captured bond defaults, but she said she would research this information and see what has changed from a historical perspective.

5. Discussed Other Matters

Mr. Barlow identified that Ms. Gann developed a chart of the pending investment-related referrals previously provided to the Capital Adequacy (E) Task Force or RBC working groups. He stated that some of the referrals were deferred for the bond factor proposal. Included within the chart are the two projects directed by the Financial Condition (E) Committee, which includes Phase II of the bond factors and residual interests. Mr. Barlow stated that these two projects will be addressed first, noting that they can be worked on concurrently. Next, the other projects on the chart would be prioritized by the Working Group, and additional investment-related referrals may be added to this list of projects. Mr. Barlow stated that the work on Phase II of the bond factors will begin first with a consideration of the comments received. He stated the intent to work holistically, so all projects should be reviewed with consideration of how assets are reported and how RBC factors are applied under the financial statement framework.

Having no further business, the RBC Investment Risk and Evaluation (E) Working Group adjourned.

Att RBCIREWG 2-28-22 Minutes.docx
March 4, 2022

Philip Barlow, Chair
Risk-Based Capital Investment Risk and Evaluation (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Re: Phase II Bond RBC Initiative for Structured Securities

Dear Philip:

ACLI appreciates the opportunity to provide comments on the NAIC’s project to review the Risk-based Capital (RBC) treatment of Asset-backed Securities (ABS), including collateralized loan obligations (CLOs), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk. We note that these are preliminary comments on the project, rather than specific comments on any of the technical aspects of the RBC treatment of Asset-backed Securities.

Overview

ACLI agrees with the NAIC that review of the RBC treatment of structured securities is an important follow-up to the work done to develop new RBC factors for bonds. The Phase 1 bond factors were based on the review of default and loss experience of corporate bonds based on their rating, which might not be appropriate for structured securities.

We suggest that, due to the complexity of this project, it would be helpful once an initial path forward (e.g., defining project plan, scope, and writing RFP, if necessary) is decided, or also as part of those discussions, to assemble a representative working group of regulators, NAIC staff, and industry subject matter experts to help address technical elements, with full transparency for all interested parties. It also seems to reason that a significant amount of this technical work would need vetting more broadly at certain stages of development.

Our comments start with a possible outline of a project plan and then we provide our initial responses to the RFC questions.
Suggested Outline of Project Plan

From a timing perspective, ACLI envisions that the project can be covered in two phases. Work on the two phases can be accomplished either sequentially or in parallel, with longer implementation for the second phase as it’s more involved with more steps.

Phase 1

- Develop a modeling approach or other approach for CLOs and map to current C1 bond factors, potentially leveraging the existing NAIC modeling infrastructure for RMBS and CMBS; review rating agency methodologies.
- Apply a “no arbitrage” principle and evaluate equalization of RBC on the underlying (if available) and the securitization tranches through calibration and by allowing residual tranches to have a variable RBC based on measurable investment risk.
- The implementation plan for Phase 1 could be developed by year-end 2022 and may be less likely to need the assistance of a consultant.

Phase 2

- Assess mapping adequacy and consistency across modeled categories (RMBS, CMBS and CLOs).
- Implement refinements to modeling approaches to ensure appropriate assessment of tail risk.
- Develop a practical approach to map other ABS to current bond factors following the established principles from Phase 1 where the collateral has an assigned RBC. Define alternative approaches, e.g., bottoms-up underwriting, where collateral does not have a well-established RBC.
- Phase 2 is more complex – will likely take 2-3 years. Phase 2 likely requires hiring a consultant that could be engaged from time to time but is not a condition to implement partial solutions.

Project Timeframe

ACLI agrees that this project is a high priority. As noted above, the RBC charges for certain ABS structures, such as CLOs, may be completed relatively expediently, while other structures may take multiple years to complete. While we would expect that the RBC charges would be implemented as they are completed, care should be taken to determine the impact to industry before setting a specific implementation date.

Responses to Specific RFC Questions

Methodologies for capturing the risk (including tail risk) that exists with such assets (e.g., ratings-determined bond factors, a modeling process akin to the current CMBS/RMBS approach, or other proposals).

It is too early to suggest an exact methodology and this needs to be studied further. Structured securities do require a methodology that models collateral outcomes against the capital structure and cashflow waterfall of the security to derive loss projections for each tranche that are representative of the underlying collateral.

Risk modeling approaches for structured securities (beyond RMBS/CMBS) should be evaluated on the basis that they capture the tail risk of a skewed or heavy-tailed loss distribution (e.g., statistical approaches such as Conditional Tail Expectation (“CTE”) / TVaR / Expected Shortfall, scenario/stress testing, etc.).
How a consultant or consulting actuary could be used by the NAIC to determine the appropriate charge based upon certain data.

As exemplified during the Phase 1 RBC discussions, a consultant with capital markets expertise can add considerable value. Structured securities are significantly more complex than corporate bonds, reinforcing the need for this expertise. Once the scope of the project has been determined, the consultant could:

- Survey existing regulatory frameworks
- Provide initial modeling and calibration
- If needed, provide ongoing modeling and calibration

Given the technical complexity of structured securities, the ACLI recommends that the consultant coordinate closely with NAIC Structured Securities and Capital Markets Bureau to ensure a robust implementation of the developed recommendations.

The need for review outside of Life RBC (Health, P&C).

Since most insurance investments in structured securities reside in life insurance portfolios, the ACLI supports the initial focus being limited to Life RBC; however, it would be wise for the other two Working Groups to be kept apprised of the work done.

Whether residual tranches in ABS structures can be evaluated in conjunction with and under similar methodologies as the debt tranches.

The full structure, inclusive of all tranches, should be evaluated on a consistent methodological basis. For example, if the NAIC modeled all of the debt tranches of a particular CLO, the cashflow accruing to the residual is simply the difference between the cashflow accruing to the underlying collateral and the cashflow accruing to the sum of the debt tranches.

Specific proposals for addressing RBC treatment of residual tranches to reduce arbitrage incentives.

As a general principle, the level of capital held for all securitized tranches including the residual should generally be consistent with the capital held for the underlying collateral (where specific NAIC capital methodologies are available for such underlying collateral), recognizing retained exposures, diversification within the collateral pool and other relevant attributes, inclusive of any structural enhancements that improve economic outcomes for investors. Modeling of the full waterfall structure would permit the NAIC to perform ongoing checks to ensure that capital arbitrage incentives are minimized.

The ACLI looks forward to working with the NAIC on this project.

Sincerely,

Paul S. Graham, III, FSA, MAAA

cc: Commissioner Scott White, Chair, Financial Condition (E) Committee
Amnon Levy
Chief Executive Officer, Bridgeway Analytics
Amnon.Levy@BridgewayAnalytics.com
www.BridgewayAnalytics.com

February 28, 2022
Mr. Philip Barlow
Chair
NAIC Risk-Based Capital Investment Risk and Evaluation Working Group
Sent via email: JBarr@naic.org

RE: RBC treatment of asset backed securities

Dear Philip:

Bridgeway Analytics appreciates the opportunity to provide comments on RBC treatment of asset backed securities. Bridgeway Analytics encourages the NAIC and regulators to explore potential differentiated capital charges across credit segments, and in particular the treatment of structured assets, particularly for Life RBC. When redesigning the 2021 c1 factors, the reports I provided to the NAIC Life Risk-Based Capital Working Group on behalf of the ACLI highlighted the material differentiated risks, including tail risks, across asset classes that are not differentiated by NRSRO ratings alone and thus NAIC designations.1,2

With the 2021 reports providing details regarding our views on data and methodologies, our comments in this letter are more general. There are a wide range of approaches that can revise the RBC framework to provide regulators with tools to better identify weakly capitalized companies, and better align investment incentives. With that context, we feel it is critical for the RBC framework to have the following characteristics:

- Parsimony, scalability, and consistency, allowing for a holistic articulation of portfolio tail risk that aspires to be level-set across asset classes and over time. To the extent practical, the framework should be consistent with its use and measurement of differentiated risk measures, including that of a single credit investment (e.g., a rating and thus designation), tail loss of a single credit investment (which impacts loss given default), and a portfolio loss concept that considers diversification and concentration (e.g., c1 factors).
- Ongoing governance and monitoring of tail risks, that can change materially from year to year with varying risk factors and to a varying degree across RMBS, CMBS, CLO and other structured assets. Risks, that are not captured by ratings, and thus NAIC designations, alone.
- Data on ratings and thus NAIC designations, that are fundamental to c1 RBC, are particularly sparse for structured assets. By and large, NRSRO methodologies were modified substantially after the financial crisis, with few credit events since. With data on collateral experience generally more robust than tranche experience, we feel reliance on model-based approaches can better capture nuanced and varying characteristics across structured asset segments; characteristics that can have material implications for portfolio tail risks.

We raise these points to hopefully provide a level of transparency for the complexity and efforts that will be needed to address these important issues, as compared to, say, revising the c1 factors in 2021.

We appreciate the opportunity to comment on this exposure.

Sincerely,
Amnon Levy

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1 Assessment of the Proposed Revisions to the RBC C1 Bond Factors Prepared for the NAIC and ACLI
2 Revisions to the RBC C1 Bond Factors Prepared for the NAIC and ACLI
https://content.naic.org/sites/default/files/inline-files/2021%20Revisions%20to%20the%20RBC%20C%20Bond%20Factors%205%2D24.pdf
Memo

To: Scott White, Chair, Financial Condition (E) Committee
Cc: Tom Botsko, Chair, Capital Adequacy (E) Task Force
    Phil Barlow, Chair, Investment Risk and Evaluation (E) Working Group
From: Tricia Matson, Partner and Edward Toy, Director
Date: February 25, 2022
Subject: RRC comments for the exposure related to certain Complex Assets before the Investment Risk and Evaluation Working Group

Background

The Financial Condition (E) Committee (E Committee) exposed for comment a set of questions regarding the appropriate Risk-Based Capital (RBC) treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk (Complex Assets). RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the E Committee members.

RRC Comments

- We have the following general comments:
  - We applaud these efforts. We agree that the RBC framework should be reviewed to ensure that Complex Assets have RBC charges that are commensurate with the risk, in particular highly structured assets that may not have significant risk at moderately adverse levels but have a very significant potential for loss in tail scenarios.
  - We believe that it is important for the RBC recognize that different asset classes have different characteristics, in particular in terms of loss severity after a default occurs, but also in the pattern of defaults. For example, the loss severity and pattern of default loss can vary significantly among corporate bonds versus government bonds versus structured securities (RMBS, CMBS and ABS), as well as investments not on Schedule D such as mortgage loans. We believe that the regulators should carefully consider the issue of tail risk and how that should be treated across all asset classes.

- We have the following specific comments on individual items exposed:
  - Regarding methodologies for capturing the risk (including tail risk): Different measures of tail risk could be appropriately reflected in different RBC factors while continuing the current process for assigning NAIC Designations. However, given that the exposure is focused on loss severity, this should recognize that bonds that are held at a discount to par also have a different profile from the perspective of risk of loss to surplus. There is also a question of timing of that loss after a default event occurs, which may require a methodology that projects losses over a relatively long time horizon after the occurrence of the event. Use of a conditional tail expectation (which takes an average over the full tail events) rather than Value

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at Risk (which looks at a specific point in the tail) may be more appropriate for Complex Assets since, for example, some may not have significant risk charges at a 95th percentile, but would have significant risk charges if the average of the highest 10% of risks were evaluated since it would capture deeper tail risk.

- Regarding use of a consultant: Since capturing tail risk may require more robust modeling approaches such as CTE, it could be helpful to the NAIC to engage a consulting actuary.

- Regarding the need for review outside of Life RBC (Health, P&C): If the E Committee decides that Risk-Based Capital factors should be adjusted to reflect different kinds of tail risk, we believe this should be applicable to the relevant assets and there should not be differences based on insurer type. Asset risk is specific to the asset. That is not to say that investment practices are not different across insurer types, but that is more appropriately adjusted for in the way that the overall RBC formulae work.

- Whether residual tranches in ABS structures can be evaluated in conjunction with and under similar methodologies as the debt tranches: Guidance for residual tranches of all Structured Securities was recently clarified to have those reported on Schedule BA, and not on Schedule D. This reflects appropriately on the fact that these are in a first loss position, much the same as an equity holding, in the capital structure, and are generally not considered securities that can be rated by the Nationally Recognized Statistical Rating Organizations (NRSROs). While they may have some characteristics akin to a debt security, they are more appropriately treated as equity-like and we believe they should take the RBC factor of similar assets that are reported on Schedule BA.

- Specific proposals for addressing RBC treatment of residual tranches to reduce arbitrage incentives: A substantive question is what the actual exposure is across the insurance industry. There are a number of factors that may be worth considering, not just for residual tranches of structured securities (assuming they will be treated as equity) but also other investments that receive equity treatment. Before considering a specific proposal, we recommend addressing a key principle, namely what are the actual exposures and what are the different characteristics of those exposures. The profile of residual tranches differs from publicly traded common stock, which differs from investments in private funds.

Thank you for the opportunity to provide comments on this important initiative. We can be reached at tricia.matson@riskreg.com/(860) 305-0701 and edward.toy@riskreg.com/(917)561-5605 if you or other E Committee members have any questions.
To: Risk-Based Capital Investment Risk and Evaluation (E) Working Group

From: Ray Spudeck

c: Jane Barr, NAIC

Date: February 18, 2022

Re: Response to Request for Comments on RBC project for Certain Asset Back Securities

The Office has been closely following this issue and has been actively involved in the discussion. In response to your request, we would like to reiterate and reinforce some of the thinking we have already expressed.

We continue to believe that the risk, especially tail risk, of this growing class of asset structures cannot be realistically captured in traditional ratings and have been in support of a modeling-based approach as has been adopted for CMBS. These securities share many of the same features that led the NAIC to move to modeling for CMBS, but in many cases are more complex and intricate.

Clearly, outside expertise will be needed to guide the regulatory community toward the “best” answers. Whether it is an actuarial expertise, investment expertise or some combination of the two is an open question. As to whether to publish an NAIC RFP for an outside vendor, or accept the offer of the ACLI to pay for the consultants, using the previous approach, we feel the important concern is to ensure that we are getting the right expertise in a group who is responsive to regulator concerns and issues.

We do believe that while, in the current market, this issue is likely to be more critical in the Life sector, as we are building this structure with a forward looking lens, the other groups (P&C, and Health) should be involved as they may well have to address these as the market evolves and grows.

Lastly, with regard to the residual tranches, we continue to be of the opinion that the ability of the methodologies used for debt tranches to fully capture the unique risks that can be associated with the residual tranches is an open question that will require more detailed research and analysis.
Further, as to specific proposals for addressing these residual tranches, while getting the “right” RBC charge for them is of course essential, we also think that the ability to provide transparency to the regulator as to who is holding these and in what amounts is equally important. And this transparency should be easily identifiable.
### Carryover Items – RBC IR & E

<table>
<thead>
<tr>
<th>#</th>
<th>Owner</th>
<th>Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
<th>Source</th>
<th>Comments</th>
<th>Date Added to Agenda</th>
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<tbody>
<tr>
<td>8</td>
<td>RBC IRE</td>
<td>2</td>
<td>2022 or Later</td>
<td>Supplementary Investment Risks Interrogatories (SIRI)</td>
<td>Referred from CADTF Referral from Blackrock and IL DOL</td>
<td>The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review all investment referrals.</td>
<td>1/12/2022</td>
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<tr>
<td>9</td>
<td>RBC IRE</td>
<td>2</td>
<td>2022 or Later</td>
<td>NAIC Designation for Schedule D, Part 2 Section 2 - Common Stocks</td>
<td>Referred from CADTF Referral from SAPWG 8/13/2018</td>
<td>10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>10/11/2018</td>
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<tr>
<td>10</td>
<td>RBC IRE</td>
<td>2</td>
<td>2022 or Later</td>
<td>Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.</td>
<td>Referred from CADTF Referral from SAPWG</td>
<td>10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>1/12/2022</td>
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<td>11</td>
<td>RBC IRE</td>
<td>2</td>
<td>2022 or Later</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referred from CADTF Referral from VOSTF 9/21/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day Comment period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>11/16/2018</td>
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### Ongoing Items – RBC IR&E

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### New Items - RBC IR & E

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<th>Working Agenda Item</th>
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</thead>
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<tr>
<td>12</td>
<td>2023 or later</td>
<td>Evaluate the appropriate RBC treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (FSOs), or other similar securities carrying similar types of tail risk (Complex Assets).</td>
<td>Request from E Committee, SAPWG, VOSTF</td>
<td>Per the request of E Committee comments were solicited asking if these types of assets should be considered a part of the RBC framework.</td>
<td>1/12/2022</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>2025 or later</td>
<td>Evaluate and develop an approach to map other ABS to current bond factors following the established principles from Phase I where the collateral has an assigned RBC. This project will likely require an outside consultant and the timeline could exceed 2-3 years.</td>
<td>Request from E Committee</td>
<td>Per the request of E Committee comments were solicited requesting the need for outside review.</td>
<td>1/12/2022</td>
<td></td>
</tr>
</tbody>
</table>
Capital Adequacy (E) Task Force

RBC Proposal Form

[ ] Capital Adequacy (E) Task Force [ ] Health RBC (E) Working Group [ ] Life RBC (E) Working Group
[ ] Catastrophe Risk (E) Subgroup [ ] Investment RBC (E) Working Group [ ] SMI RBC (E) Subgroup
[ ] C3 Phase II/ AG43 (E/A) Subgroup [ ] P/C RBC (E) Working Group [ ] Stress Testing (E) Subgroup

DATE: 10/25/2021

FOR NAIC USE ONLY

Agenda Item # 2021-18-H-MOD

ON BEHALF OF: Health RBC (E) Working Group

NAME: Steve Drutz
TITLE: Chief Financial Analyst/Chair
AFFILIATION: WA Office of Insurance Commissioner
ADDRESS: 5000 Capitol Blvd SE
Tumwater, WA 98501

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[ ] Health RBC Blanks [ x ] Health RBC Instructions [ ] Other ___________________
[ ] Life and Fraternal RBC Blanks [ ] Life and Fraternal RBC Instructions
[ ] Property/Casualty RBC Blanks [ ] Property/Casualty RBC Instructions

DESCRIPTION OF CHANGE(S)

Incorporate benchmarking guidelines for the Working Group to follow in updating the investment income adjustment in the underwriting risk factors for Comprehensive Medical, Medicare Supplement, and Dental & Vision lines.

REASON OR JUSTIFICATION FOR CHANGE **

The reason for the change is to clearly identify the frequency and parameters to use in adjusting the underwriting risk factors for investment income in the Comprehensive Medical, Medicare Supplement, and Dental & Vision lines.

Additional Staff Comments:

11-4-21 cgb The WG exposed for 30-day public comment period ending on Dec. 3, 2021.
12-16-21 cgb One comment letter received.
12-16-21 cgb The Working Group adopted the proposal.
01-28-22 cgb The Working Group re-exposed with alternative language for 15 days. Comments due back on 02-14-22. The purpose of the alternative language is to add further clarity.
02-14-22 cgb No comments received.
02-25-22 cgb The WG re-adopted the proposal as modified with the alternative language to be used in place of the originally proposed language.

** This section must be completed on all forms.
UNDERWRITING RISK - L(1) THROUGH L(21)
XR013

Line (12) Underwriting Risk Claims Ratio. For Columns (1) through (5), Line (11) / Line (6). If either Line (6) or Line (11) is zero or negative, Line (12) is zero.

Line (13) Underwriting Risk Factor. A weighted average factor based on the amount reported in Line (6), Underwriting Risk Revenue. The factors for Column (1) through (3) have incorporated an investment income yield of 0.5%.

<table>
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<tr>
<th>Product</th>
<th>$0 – $3 Million</th>
<th>$3 – $25 Million</th>
<th>Over $25 Million</th>
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<tbody>
<tr>
<td>Comprehensive Medical &amp; Hospital</td>
<td>0.1493</td>
<td>0.1493</td>
<td>0.0893</td>
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<tr>
<td>Medicare Supplement</td>
<td>0.1043</td>
<td>0.0663</td>
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<tr>
<td>Dental &amp; Vision</td>
<td>0.1195</td>
<td>0.0755</td>
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<td>Stand-Alone Medicare Part D Coverage</td>
<td>0.251</td>
<td>0.251</td>
<td>0.151</td>
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<tr>
<td>Other Health</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
</tr>
<tr>
<td>Other Non-Health</td>
<td>0.130</td>
<td>0.130</td>
<td>0.130</td>
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</table>

The investment income yield was incorporated into the Comprehensive Medical & Hospital, Medicare Supplement and Dental & Vision lines of business. The purpose was to incorporate an offset to reduce the underwriting risk factor for investment income earned by the insurer. The Working Group incorporated a 0.5% income yield that was based on the yield of a 6-month US Treasury Bond. Each year, the Working Group will identify the yield of the 6-month Treasury bond (U.S. Department of the Treasury) on each Monday through the month of January and determine if further modifications to the 0.5% adjustment are needed. Any adjustments will be rounded up to the nearest 0.5%.

Line (14) Base Underwriting Risk RBC. Line (6) x Line (12) x Line (13).
The proposed change would add the KCC as one of the approved third party commercial vendor catastrophe models.

**REASON OR JUSTIFICATION FOR CHANGE**

To keep the consistency with other third party commercial vendors for earthquake and hurricane catastrophe models. KCC has got the approval from the Florida Commission on hurricane loss projection methodology on 6/19/2019 and 6/4/2021.

**Additional Staff Comments:**

10/27/21 – The Subgroup agreed to expose this proposal for a 30-day public comment period ending Nov. 26.
12/16/21 – The Subgroup adopted this proposal during the Dec. 16, 2021, virtual meeting.
CALCULATION OF CATASTROPHE RISK CHARGE RCAT
PR027

The projected losses can be modeled using the following NAIC approved third party commercial vendor catastrophe models: AIR, EQECAT-CoreLogic, RMS, KCC, the ARA HurLoss Model, or the Florida Public Model for hurricane, as well as catastrophe models that are internally developed by the insurer or that are the result of adjustments made by the insurer to vendor models to represent the own view of catastrophe risk (hereinafter “own models”).

However, an insurer seeking to use an own model must first obtain written permission to do so by the domestic or lead state insurance regulator. In the situation where the model output is used to determine the catastrophe risk capital requirement for a single entity, the regulator granting permission to use the own model is the domestic state. In the situation where the model output is used to determine the catastrophe risk capital requirement for a group, the grantor is the lead state regulator. In the situation where the insurer seeking permission is a non-U.S. insurer, the grantor shall be the lead state regulator. Under all scenarios, the regulator that is granting permission should inform other domestic states that have a catastrophe risk exposure and share the results of the review.

To obtain permission to use the own model, the insurer must provide the domestic or lead state insurance regulator with written evidence of each of the following:

1. The use of the own model is reasonable considering the nature, scale, and complexity of the insurer’s catastrophe risk;
2. The own model is used for catastrophe risk management, capital assessment, and the capital allocation process and the model has been used for at least the last 3 years;
3. The perils included in the RBC Catastrophe Risk Charge have been validated by the insurer and that these perils include both US and global exposures, where applicable;
4. The own model has been developed using reasonable data and assumptions and that model results used in determining the RBC Catastrophe Risk Charge reflect exposure data that is no older than six months;
5. The insurer has individuals with experience in developing, testing and validating internal models or engages third parties with such experience. The insurer must provide supporting model documentation and a copy of the latest validation report and the insurer is solely responsible for the relevant cost. For each peril included in the RBC Catastrophe Risk Charge, the validation report should attest that the projected losses are a reasonable quantification of the exposure of the reporting entity. The validation report must provide a description of the scope, content, results and limitations of the validation, the individual qualifications of validation team and the date of the validation. Both the model documentation and the model validation report must be provided at a minimum once every five years, or whenever the lead or domestic state calls an examination; whenever there is a material change in the model; or whenever there is a material change in the insurer’s exposure to catastrophe exposure.
6. The results of the own model should be compared with the results produced by at least one of the following models: AIR, EQECAT-CoreLogic, RMS, KCC, ARA HurLoss, or the Florida Public Model. The insurer must provide the comparison and an explanation of the drivers of differences between the results produced by the internal model vs. results produced by the selected prescribed model.
7. If the own model has been approved or accepted by the non-U.S. group-wide supervisor for use in the determination of regulatory capital, the insurer must submit evidence, if available, from the non-US group-wide supervisor of the most recent approval/acceptance including the description of scope, content, results and limitations of the approval/acceptance process and dates of any planned future approval/acceptance, if known. The name and the contact information of a contact person at the non-US group-wide supervisor should also be provided for questions on the approval/acceptance process.

If the lead or domestic state determines that permission to use the own model cannot be granted, the insurer shall be required to determine the RBC Catastrophe Risk Charge through the use of one of the third party commercial vendor models (AIR, EQECAT-CoreLogic, RMS, KCC, ARA HurLoss (hurricane only)), or the Florida Public Model for hurricane, as advised by the lead state or domestic state.
If the lead or domestic state determines that permission to use the own model can be granted to determine the RBC Catastrophe Risk Charge, the model will be subject to additional review through the ongoing examination process. If, as a result of the examination, the lead or domestic state determines that permission to use the own model should be revoked, the insurer may be required to resubmit the risk-based capital filing and any past filings so impacted where own model was used, as directed by the lead state or domestic state.

If the insurer obtains permission to use the own model, it cannot revert back to using third party commercial vendor models to determine the RBC Catastrophe Risk Charge in subsequent reporting periods, unless this is agreed with the lead or domestic state that granted permission.

The contingent credit risk charge should be calculated in a manner consistent with the way the company internally evaluates and manages its modeled net catastrophe risk.

Note that no tax effect offsets or reinstatement premiums should be included in the modeled losses. Further note that the catastrophe risk charge is for earthquake and hurricane risks only.

As per the footnote on this page, modeled losses to be entered PR027A and PR027B in Lines (1) through (4) are to be calculated using one of the third party commercial vendor models – AIR, Equecat, CoreLogic, RMS, KCC, ARA HurLoss (hurricane only); or the Florida Public Model (hurricane only) or the insurer’s own catastrophe model; and using the insurance company’s own insured property exposure information as inputs to the model. The insurance company may elect to use the modeled results from any one of the models, or any combination of results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions but will be expected to use the same exposure data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. Any exceptions must be explained in the required Attestation Re: Catastrophe Modeling Used in RBC Catastrophe Risk Charges within this RBC Report.

The Grand Total (PR027) page includes an interrogatory to support an exemption from filing the catastrophe risk charge. Any company qualifying for exemption from the earthquake risk charge must identify the particular criteria from among (1a), (1b), (2) and (3) that provides its qualification for exemption, and may leave the other three items from this group of four possible qualifications for exemption blank; except identification of criteria (3) as the basis for the exemption requires a further answer to (3a) and (3b). If an insurer does not write or assume earthquake risks leaving no gross exposure, enter an “X” in interrogatory 3, with no need to fill in (3a) and (3b). Any company qualifying for exemption from the hurricane risk charge must identify the particular criteria from among (4a), (4b), (5) and (6) that provides its qualification for exemption, and may leave the other three items from this second group of four possible qualifications for exemption blank. If the company qualifies for exemption from the earthquake risk charge, page PR027A and line (1) on this page may be left blank. If the company qualifies for exemption from the hurricane risk charge, page PR027B and line (2) on this page may be left blank. If an insurer does not write or assume hurricane risks leaving no gross exposure, enter an “X” in interrogatory 6.

In general, the following conditions will qualify a company for exemption: if it uses an intercompany pooling arrangement or quota share arrangement with U.S. affiliates covering 100% of its earthquake and hurricane risks such that there is no exposure for these risks; if it has a ratio of Insured Value – Property to surplus as regards policyholders of less than 50%; or if it writes Insured Value – Property that includes hurricane and/or earthquake coverage in catastrophe-prone areas representing less than 10% of its surplus as regards policyholders.

“Insured Value – Property” includes aggregate policy limits for structures and contents for policies written and assumed in the following annual statement lines – Fire, Allied Lines, Earthquake, Farmowners, Homeowners, and Commercial Multi-Peril.

“Catastrophe-Prone Areas in the U.S.” include:

i. For hurricane risks, Hawaii, District of Columbia and states and commonwealths bordering on the Atlantic Ocean and/or the Gulf of Mexico including Puerto Rico.

ii. For earthquake risk or for fire following earthquake, any of the following commonwealth or states: Alaska, Hawaii, Washington, Oregon, California, Idaho, Nevada, Utah, Arizona, Montana, Wyoming, Colorado, New Mexico, Puerto Rico, and geographic areas in the following states that are in the New Madrid Seismic Zone - Missouri, Arkansas, Mississippi, Tennessee, Illinois and Kentucky.
### CALCULATION OF CATASTROPHE RISK CHARGE FOR EARTHQUAKE  PR027A

<table>
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<th>Earthquake</th>
<th>Reference</th>
<th>(1) Direct and Assumed</th>
<th>(2) Net</th>
<th>(3) Ceded Amounts Recoverable</th>
<th>(4)† Ceded Amounts Recoverable with zero Credit Risk Charge</th>
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<tr>
<td>Worst Year in 50</td>
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<td>Company Records</td>
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</tbody>
</table>

(5) Has the company reported above, its modeled earthquake losses using an occurrence exceedance probability (OEP) basis?

(6) Net Earthquake Risk
(7) Contingent Credit Risk for Earthquake Risk
(8) Total Earthquake Catastrophe Risk (AEP Basis)
(9) Total Earthquake Catastrophe Risk (OEP Basis)
(10) Total Earthquake Catastrophe Risk

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Lines (1)-(4): Modeled losses are to be entered on these lines are to be calculated using one of the following NAIC approved third party commercial vendor catastrophe models - A.I.R., Catastrophe Models, or KCC, the ARK Hurricane Model, or the Reinsure Public Model for hurricane; or a catastrophe model that is internally developed by the insurer and has received permission of use by the lead or domestic state. The insurance company may elect to use the modeled results from any one of the models, or any combination of the results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions, but will be expected to use the same data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. An attestation to this effect and an explanation of the company's key assumptions and model selection may be required, and the company's catastrophe data, assumptions, model and results may be subject to examination.

† Column (3) is modeled catastrophic losses that would be ceded under reinsurance contracts. This should be associated with the Net Modeled Losses shown in Column (2).

‡ Column (4) is modeled catastrophic losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).

Denotes items that must be manually entered on the filing software.

PR027A
CALCULATION OF CATASTROPHE RISK CHARGE FOR HURRICANE  PR027B

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<th>Hurricane Reference</th>
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<td>Worst Year in 500</td>
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(5) Has the company reported above, its modeled hurricane losses using an occurrence exceedance probability (OEP) basis? [Y/N]

(6) Net Hurricane Risk

(7) Contingent Credit Risk for Hurricane Risk

(8) Total Hurricane Catastrophe Risk (AEP Basis)

(9) Total Hurricane Catastrophe Risk (OEP Basis)

(10) Total Hurricane Catastrophe Risk

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Lines (1)-(4): Modeled losses to be entered on these lines are to be calculated using one of the following NAIC approved third party commercial vendor catastrophe models - AIR, CoreLogic, RMS, KCC, the ARA HurLoss Model, or the Florida Public Model for hurricanes or a catastrophe model that is internally developed by the insurer and has received permission of use by the lead or domestic state. The insurance company’s own insured property exposure information should be used as inputs to the model(s). The insurance company may elect to use the modeled results from any one of the models, or any combination of the results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions, but will be expected to use the same data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. An attestation to this effect and an explanation of the company’s key assumptions and model selection may be required, and the company’s catastrophe data, assumptions, model and results may be subject to examination.

† Columns (3) is modeled catastrophe losses that would be ceded under reinsurance contracts. This should be associated with the Net Modeled Losses shown in Column (2).

†† Column (4) is modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., US affiliates and mandatory pools, whether authorized, unauthorized, or certified).

Denotes items that must be manually entered on the filing software.
Capital Adequacy (E) Task Force
RBC Proposal Form

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<td>Health RBC (E) Working Group</td>
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<td>Catastrophe Risk (E) Subgroup</td>
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DATE: 12/16/21
FOR NAIC USE ONLY

| CONTACT PERSON: |   | Eve Yeung |
| TELEPHONE: | 816-783-8407 |
| EMAIL ADDRESS: | eveung@naic.org |
| ON BEHALF OF: | Catastrophe Risk (E) Subgroup |
| NAME: | Wanchin Chou |
| TITLE: | Chair |
| AFFILIATION: | Connecticut Department of Insurance |
| ADDRESS: | 153 Market Street, 7th Floor |
|   | Hartford, CT 06103 |

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

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<td>Life and Fraternal RBC Blanks</td>
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</tbody>
</table>

DESCRIPTION OF CHANGE(S)

The proposed change may add wildfire as one of the catastrophe risk perils for informational purposes only in the Rcat component.

REASON OR JUSTIFICATION FOR CHANGE **

While the Catastrophe Risk (E) Subgroup reviewed the possibility of expanding the current catastrophe framework to include other perils that may experience a greater tail risk under projected climate-related trends, the wildfire has been identified as one of the major drivers of the U.S. insured losses. The Subgroup decided to consider adding wildfire as one of the catastrophe perils in the Rcat component.

Additional Staff Comments:
12/16/21 – The Catastrophe Risk (E) Subgroup exposed the proposal for a 60-day comment period ending by 02-13-22.
2/22/22 – The Catastrophe Risk (E) Subgroup adopted this proposal during the Feb. 22, 2022, virtual meeting.
3/22/22 - Modification of this proposal can be found in 2022-01-CR

** This section must be completed on all forms.

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CALCULATION OF CATASTROPHE RISK CHARGE \( \text{RCAT} \)
\( \text{PR027A, PR027B, PR027C, PR027, AND PR027INT} \)

The catastrophe risk charge for earthquake (PR027A), and hurricane (PR027B), and wildfire for Informational purposes only (PR027C) risks is calculated by multiplying the RBC factors by the corresponding modeled losses and reinsurance recoverables. The risk applies on a net basis with a corresponding contingent credit risk charge for certain categories of reinsurers. Data must be provided for the worst year in 50, 100, 250, and 500; however, only the worst year in 100 will be used in the calculation of the catastrophe risk charge. While projected losses modeled on an Aggregate Exceedance Probability basis is preferred, companies are permitted to report on an Occurrence Exceedance Probability basis if that is consistent with the company’s internal risk management process.

The projected losses can be modeled using the following NAIC approved third party commercial vendor catastrophe models: AIR, Corelogic, RMS, KCC, the ARA HurLoss Model, or the Florida Public Model for hurricane, as well as catastrophe models that are internally developed by the insurer or that are the result of adjustments made by the insurer to vendor models to represent the own view of catastrophe risk (hereinafter “own models”).

However, an insurer seeking to use an own model must first obtain written permission to do so by the domestic or lead state insurance regulator. In the situation where the model output is used to determine the catastrophe risk capital requirement for a single entity, the regulator granting permission to use the own model is the domestic state. In the situation where the model output is used to determine the catastrophe risk capital requirement for a group, the grantor is the lead state regulator. In the situation where the insurer seeking permission is a non-U.S. insurer, the grantor shall be the lead state regulator. Under all scenarios, the regulator that is granting permission should inform other domestic states that have a catastrophe risk exposure and share the results of the review.

To obtain permission to use the own model, the insurer must provide the domestic or lead state insurance regulator with written evidence of each of the following:

1. The use of the own model is reasonable considering the nature, scale, and complexity of the insurer’s catastrophe risk;
2. The own model is used for catastrophe risk management, capital assessment, and the capital allocation process and the model has been used for at least the last 3 years;
3. The perils included in the RBC Catastrophe Risk Charge have been validated by the insurer and that these perils include both US and global exposures, where applicable;
4. The own model has been developed using reasonable data and assumptions and that model results used in determining the RBC Catastrophe Risk Charge reflect exposure data that is no older than six months;
5. The insurer has individuals with experience in developing, testing and validating internal models or engages third parties with such experience. The insurer must provide supporting model documentation and a copy of the latest validation report and the insurer is solely responsible for the relevant cost. For each peril included in the RBC Catastrophe Risk Charge, the validation report should attest that the projected losses are a reasonable quantification of the exposure of the reporting entity. The validation report must provide a description of the scope, content, results and limitations of the validation, the individual qualifications of validation team and the date of the validation. Both the model documentation and the model validation report must be provided at a minimum once every five years, or whenever the lead or domestic state calls an examination; whenever there is a material change in the model; or whenever there is a material change in the insurer’s exposure to catastrophe exposure.
6. The results of the own model should be compared with the results produced by at least one of the following models: AIR, Corelogic, RMS, KCC, ARA HurLoss, or the Florida Public Model. The insurer must provide the comparison and an explanation of the drivers of differences between the results produced by the internal model vs. results produced by the selected prescribed model.
7. If the own model has been approved or accepted by the non-U.S. group-wide supervisor for use in the determination of regulatory capital, the insurer must submit evidence, if available, from the non-US group-wide supervisor of the most recent approval/acceptance including the description of scope, content, results and limitations of the approval/acceptance process and dates of any planned future approval/acceptance, if known. The name and the contact information of a contact person at the non-US group-wide supervisor should also be provided for questions on the approval/acceptance process.

If the lead or domestic state determines that permission to use the own model cannot be granted, the insurer shall be required to determine the RBC Catastrophe Risk Charge through the use of one of the third-party commercial vendor models (AIR, Corelogic, RMS, KCC, ARA HurLoss (hurricane only)), or the Florida Public Model for hurricane, as advised by the lead state or domestic state.
If the lead or domestic state determines that permission to use the own model can be granted to determine the RBC Catastrophe Risk Charge, the model will be subject to additional review through the ongoing examination process. If, as a result of the examination, the lead or domestic state determines that permission to use the own model should be revoked, the insurer may be required to resubmit the risk-based capital filing and any past filings so impacted where own model was used, as directed by the lead state or domestic state. If the insurer obtains permission to use the own model, it cannot revert back to using third party commercial vendor models to determine the RBC Catastrophe Risk Charge in subsequent reporting periods, unless this is agreed with the lead or domestic state that granted permission.

The contingent credit risk charge should be calculated in a manner consistent with the way the company internally evaluates and manages its modeled net catastrophe risk.

Note that no tax effect offsets or reinstatement premiums should be included in the modeled losses. Further note that the catastrophe risk charge is for earthquake and hurricane risks only.

As per the footnote on this page, modeled losses to be entered PR027A, PR027B, and PR027C in Lines (1) through (4) are to be calculated using one of the third party commercial vendor models – AIR, Corelogic, RMS, KCC, ARA HurLoss (hurricane only); or the Florida Public Model (hurricane only) or the insurer’s own catastrophe model; and using the insurance company’s own insured property exposure information as inputs to the model. The insurance company may elect to use the modeled results from any one of the models, or any combination of results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions but will be expected to use the same exposure data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. Any exceptions must be explained in the required Attestation Re: Catastrophe Modeling Used in RBC Catastrophe Risk Charges within this RBC Report.

The Grand Total (PR027) page includes an Interrogatory on page (PR027INT) to supports an exemption from filing the catastrophe risk charge.

Any company qualifying for exemption from the earthquake risk charge must identify the particular criteria from among (1a), (1b), (2) and (3) that provides its qualification for exemption and may leave the other three items from this first group of four possible qualifications for exemption blank except identification of criteria (3) as the basis for the exemption requires a further answer to (3a) and (3b). If an insurer does not write or assume earthquake risks leaving no gross exposure, enter an “X” in PR027INT interrogatory 3, with no need to fill in (3a) and (3b). If the company qualifies for exemption from the earthquake risk charge, page PR027A and line (1) on this page PR027 may be left blank.

Any company qualifying for exemption from the hurricane risk charge must identify the particular criteria from among (4a), (4b), (5) and (6) that provides its qualification for exemption and may leave the other three items from this second group of four possible qualifications for exemption blank. If an insurer does not write or assume hurricane risks leaving no gross exposure, enter an “X” in PR027INT interrogatory 6. If the company qualifies for exemption from the hurricane risk charge, page PR027B and line (2) on this page PR027 may be left blank.

Any company qualifying for exemption from the wildfire risk charge must identify the particular criteria from among (7a), (7b), (8) and (9) that provides its qualification for exemption and may leave the other three items from this third group of four possible qualifications for exemption blank. If an insurer does not write or assume hurricane risks leaving no gross exposure, enter an “X” in PR027INT interrogatory 9. If the company qualifies for exemption from the wildfire risk charge, page PR027C and line (3) on PR027 may be left blank.

In general, the following conditions will qualify a company for exemption: if it uses an intercompany pooling arrangement or quota share arrangement with U.S. affiliates covering 100% of its earthquake, and hurricane and wildfire risks such that there is no exposure for these risks; if it has a ratio of Insured Value – Property to surplus as regards policyholders of less than 50%; or if it writes Insured Value – Property that includes hurricane and/or earthquake and/or wildfire coverage in catastrophe-prone areas representing less than 10% of its surplus as regards policyholders.

“Insured Value – Property” includes aggregate policy limits for structures and contents for policies written and assumed in the following annual statement lines – Fire, Allied Lines, Earthquake, Farmowners, Homeowners, and Commercial Multi-Peril.
“Catastrophe-Prone Areas in the U.S.” include:

i. For hurricane risks, Hawaii, District of Columbia and states and commonwealths bordering on the Atlantic Ocean and/or the Gulf of Mexico including Puerto Rico.

ii. For earthquake risk or for fire following earthquake, any of the following commonwealth or states: Alaska, Hawaii, Washington, Oregon, California, Idaho, Nevada, Utah, Arizona, Montana, Wyoming, Colorado, New Mexico, Puerto Rico, and geographic areas in the following states that are in the New Madrid Seismic Zone - Missouri, Arkansas, Mississippi, Tennessee, Illinois and Kentucky.


Specific Instructions for Application of the Formula

| Column (1) – Direct and Assumed Modeled Losses | These are the direct and assumed modeled losses per the first footnote. Include losses only; no loss adjustment expenses. For companies that are part of an inter-company pooling arrangement, the losses in this column should be consistent with those reported in Schedule P, i.e. losses reported in this column should be the gross losses for the pool multiplied by the company’s share of the pool. |
| Column (2) – Net Modeled Losses | These are the net modeled losses per the footnote. Include losses only; no loss adjustment expenses. |
| Column (3) - Ceded Amounts Recoverable | These are the modeled losses ceded under any reinsurance contract. Include losses only, no loss adjustment expenses, and should be associated with the Net Modeled Losses. |
| Column (4) - Ceded Amounts with Zero Credit Risk Charge | Per the footnote, modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified). |
| Column (5) – Amount | These are automatically calculated based on the previous columns. |
| Column (6) – RBC Requirement | A factor of 1.000 is applied to the reported modeled catastrophe losses calculated on both AEP and OEP basis, and a factor of 0.018 is applied to the reinsurance recoverables. The RBC Requirement is based on either AEP reported results or OEP reported results (not both), consistent with the way the company internally evaluates and manages its modeled net catastrophe risk. |
| Column (7) – Y/N | Please indicate “Y” for OEP basis and “N” for AEP basis. This column should not be blank. |
ATTESTATION RE: CATASTROPHE MODELING USED IN RBC CATASTROPHE RISK CHARGES

(1) Company Name: 

hereby certifies that the modeled catastrophe losses for earthquake risk, hurricane risk, and wildfire risk entered on lines 1 through 4 of Schedule PR027 of this Risk-Based Capital Report were applying the same catastrophe models or combination of models to the same underlying exposure data, and using the same modeling assumptions, as the company uses in its own internal risk management process, with the following exceptions:

(1a) 

These exceptions, if any, are made for the following reasons:

(1b) 

The following describes the company's application of catastrophe modeling to the determination of the Rcat risk charges: (Include which models are used in what combinations for each of the Rcat charges; what key modeling assumptions are used, including but not limited to time dependency, secondary uncertainty, storm surge, demand surge, and fire following earthquake; and the rationale for treatment of each issue or item): (provide attachments if necessary):

(1c) 

The company further certifies that the underlying exposure data used in the catastrophe modeling process is accurate and complete to the best of our knowledge and ability, with the following limitations:

(1d) 

The following describes the extent to which the exposure location data is accurate to GPS coordinates; to zip code; and to a level less accurate than zip code: (provide attachments if necessary):

(1e) 

The following describes the steps taken to validate, to the best of the Company's knowledge and belief, the accuracy and completeness of the exposure data used in the modeling process to determine the Rcat catastrophe risk charges (provide attachments if necessary):

(1f) 

Provide an explanation of the methodology used to derive the amounts in columns 3 and 4 of page PR027A, PR027B and PR027C:

(1g) 

(7) Completed on behalf of: _______________________________________________________

(7) Completed By: 

Last: ___________________ First: ___________________ Middle: ___________________ Title: ___________________

(7) Email: ___________________ (7) Phone: ___________________ Date: ___________________
**CALCULATION OF CATASTROPHE RISK CHARGE FOR WILDFIRE**

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(5) Has the company reported above its modeled wildfire losses using an occurrence exceedance probability (OEP) basis?

(6) Net Wildfire Risk

(7) Contingent Credit Risk for Wildfire Risk

(8) Total Wildfire Catastrophe Risk (AEP Basis)

(9) Total Wildfire Catastrophe Risk (OEP Basis)

(10) Total Wildfire Catastrophe Risk

Lines (1)-(4): Modeled losses to be entered on these lines are to be calculated using one of the following NAIC approved third party commercial vendor catastrophe models - AIR, RMS, or KCC, or a catastrophe model that is internally developed by the insurer and has received permission of use by the lead or domestic state. The insurance company's own insured property exposure information should be used as inputs to the mode(s). The insurance company may elect to use the modeled results from any one of the models, or any combination of the results of two or more of the models. Each insurer will not be required to utilize any prescribed set of modeling assumptions, but will be expected to use the same data, modeling, and assumptions that the insurer uses in its own internal catastrophe risk management process. An attestation to this effect and an explanation of the company's key assumptions and model selection may be required, and the company's catastrophe data, assumptions, model and results may be subject to examination.

† Column (3) is modeled catastrophe losses that would be ceded under reinsurance contracts. This should be associated with the Net Modeled Losses shown in Column (2).

††Column (4) is modeled catastrophe losses that would be ceded to the categories of reinsurers that are not subject to the RBC credit risk charge (i.e., U.S. affiliates and mandatory pools, whether authorized, unauthorized, or certified).

Denotes items that must be manually entered on the filing software.
CALCULATION OF CATASTROPHE RISK CHARGE PR027

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Lines 3 and 4a are for informational purposes only.
## INTERROGATORY TO SUPPORT EXEMPTION FROM COMPLETING PR027 (To be completed by companies reporting no RBC charge in either Lines 1 through 3)

### A. Earthquake Exemption (To be completed by companies reporting no RBC charge in PR027 Line 1)
1. The company has not entered into a reinsurance agreement covering earthquake exposure with a non-affiliate or a non-US affiliate and, either
   - (a) the company participates in an inter-company pooling arrangement with 0% participation, leaving no net exposure for earthquake risks; or
   - (b) the company cedes 100% of its earthquake exposures to its US affiliate(s), leaving no net exposure for earthquake risks.
2. The Company’s Ratio of Insured Value - Property to surplus as regards policyholders is less than 50%.
3. The company has written Insured Value - Property that includes earthquake coverage in the Earthquake-Prone areas representing less than 10% of its surplus as regards policyholders.

For any company qualifying for the exemption under 3, provide details about how the “geographic areas in the New Madrid Seismic Zone” were determined.

- (a) What resource was used to define the New Madrid Seismic Zone?
- (b) Was exposure determined based on zip codes or counties in the zone, was it based on all of the earthquake exposure in the identified states or was another methodology used? Describe any other methodology used.

### B. Hurricane Exemption (To be completed by companies reporting no RBC charge in PR027 Line 2)
4. The company has not entered into a reinsurance agreement covering hurricane exposure with a non-affiliate or a non-US affiliate and, either
   - (a) the company participates in an inter-company pooling arrangement with 0% participation, leaving no net exposure for hurricane risks; or
   - (b) the company cedes 100% of its hurricane exposures to its US affiliate(s), leaving no net exposure for hurricane risks.
5. The Company’s Ratio of Insured Value - Property to surplus as regards policyholders is less than 50%.
6. The company has written Insured Value - Property that includes hurricane coverage in the Hurricane-Prone areas representing less than 10% of its surplus as regards policyholders.

Note: “Hurricane-Prone areas” include Hawaii, District of Columbia and states and commonwealths bordering on the Atlantic Ocean, and/or Gulf of Mexico including Puerto Rico.

### C. Wildfire Exemption (To be completed by companies reporting no RBC charge in PR027 Line 3)
7. The company has not entered into a reinsurance agreement covering wildfire exposure with a non-affiliate or a non-US affiliate and, either
   - (a) the company participates in an inter-company pooling arrangement with 0% participation, leaving no net exposure for wildfire risks; or
   - (b) the company cedes 100% of its wildfire exposures to its US affiliate(s), leaving no net exposure for wildfire risks.
8. The Company’s Ratio of Insured Value - Property to surplus as regards policyholders is less than 50%.
9. The company has written Insured Value - Property that includes wildfire coverage in the wildfire-Prone areas representing less than 10% of its surplus as regards policyholders.

Note: “Wildfire-Prone areas” include any of the following states: California, Idaho, Montana, Oregon, Nevada, Wyoming, Colorado, New Mexico, Washington, Arizona, and Utah.

\[\text{Denotes items that must be manually entered on the filing software.}\]
\[\text{* Item C is for informational purposes only.}\]
Calculation of Total Risk-Based Capital After Covariance

**R4 - Underwriting Risk - Reserves**  
<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(56) One half of Reinsurance RBC</td>
<td>If R4 L(57)+R3 L(51)+R3 L(52), R3 L(52), otherwise, 0</td>
</tr>
<tr>
<td>(57) Total Adjusted Unpaid Loss/Expense Reserve RBC</td>
<td>PR017 L(15)C(20)</td>
</tr>
<tr>
<td>(58) Excessive Premium Growth - Loss/Expense Reserve</td>
<td>PR016 L(13) C(8)</td>
</tr>
<tr>
<td>(59) A&amp;H Claims Reserves Adjusted for LCF</td>
<td>PR024 L(5) C(2) + PR023 L(6) C(4)</td>
</tr>
<tr>
<td>(60) Total R4</td>
<td>L(56)+L(57)+L(58)+L(59)</td>
</tr>
</tbody>
</table>

**R5 - Underwriting Risk - Net Written Premium**  
<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(61) Total Adjusted NWP RBC</td>
<td>PR018 L(15)C(20)</td>
</tr>
<tr>
<td>(62) Excessive Premium Growth - Written Premiums Charge</td>
<td>PR016 L(14)C(8)</td>
</tr>
<tr>
<td>(63) Total Net Health Premium RBC</td>
<td>PR022 L(21)C(2)</td>
</tr>
<tr>
<td>(64) Health Stabilization Reserves</td>
<td>PR025 L(8)C(2) + PR023 L(3) C(2)</td>
</tr>
<tr>
<td>(65) Total R5</td>
<td>L(61)+L(62)+L(63)+L(64)</td>
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</table>

**Rcat - Catastrophe Risk**  
<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(66) Total Rcat</td>
<td>PR027 L(4) C(1)</td>
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**Reat - Catastrophe Risk**  
<table>
<thead>
<tr>
<th>PRBC O&amp;I Reference</th>
<th>RBC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(67) Total RBC After Covariance Before Basic Operational Risk = R0+SQR(T(R1^2+R2^2+R3^2+R4^2+R5^2+Reat^2))</td>
<td>0</td>
</tr>
<tr>
<td>(68) Basic Operational Risk = 0.030 x L(67)</td>
<td>0</td>
</tr>
<tr>
<td>(69) C-4a of U.S. Life Insurance Subsidiaries (from Company records)</td>
<td>0</td>
</tr>
<tr>
<td>(70) Net Basic Operational Risk = Line (68) - Line (69) (Not less than zero)</td>
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</tr>
<tr>
<td>(71) Total RBC After Covariance including Basic Operational Risk = L(67) + L(70)</td>
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</tr>
<tr>
<td>(72) Authorized Control Level RBC including Basic Operational Risk = .5 x L(71)</td>
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<tr>
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<td>2022</td>
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<tr>
<td>Totals</td>
<td>0</td>
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</table>

**Note:** Data in columns 24I through 28III are for informational purposes only.

---

**Catastrophe Experience:***

- **Total U.S. Net Losses Unpaid:**
- **Total U.S. Losses Incurred, Net:**
- **Total Non-U.S. Net Losses Unpaid:**
- **Total Non-U.S. Losses Incurred, Net:**

---

**Earthquake and Hurricane Experience:**

- **Total U.S. Net Losses Unpaid:**
- **Total U.S. Losses Incurred, Net:**
- **Total Non-U.S. Net Losses Unpaid:**
- **Total Non-U.S. Losses Incurred, Net:**

---

**Columns:**

- Column 24I through 28III are for informational purposes only.
- Column 24C is the sum of 24I, 24II, and 24III.
- Column 28C is the sum of 28I and 28II.
- Column 28I is the sum of 28II and 28III.
- Column 28II is the sum of 28I and 28III.
- Column 28III is the sum of 28I and 28II.

---

**Notes:**

- Please provide losses only; no expenses.
- Earthquake losses should be the net losses incurred for the reporting entity, not net losses incurred for the group. 2:If a net of underlying losses, less than, equal to, or more than, total net losses reported in Column 28, please report in Column 28.
- If this line of business has incurred U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, provide only the amount of those catastrophe losses in Catastrophe Experience Columns (24A) and (28A).
- If this line of business has incurred non-U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, provide only the amount of those catastrophe losses in Catastrophe Experience Columns (24B) and (28B).
- If this line of business has incurred non-U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, please report in Column 28C.
- If this line of business has incurred non-U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, please report in Column 28C.
- If this line of business has incurred non-U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, please report in Column 28C.
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- If this line of business has incurred non-U.S. catastrophe losses arising from a hurricane, tropical storm, or earthquake, please report in Column 28C.
## Capital Adequacy (E) Task Force

### RBC Proposal Form

| [ ] Capital Adequacy (E) Task Force | [ ] Health RBC (E) Working Group | [ ] Life RBC (E) Working Group |
| [ ] Catastrophe Risk (E) Subgroup | [ ] Investment RBC (E) Working Group | [ ] Operational Risk (E) Subgroup |
| [ ] C3 Phase II/ AG43 (E/A) Subgroup | [x] P/C RBC (E) Working Group | [ ] Longevity Risk (A/E) Subgroup |

**DATE:** 10/1/2021

**CONTACT PERSON:** Eva Yeung

**TELEPHONE:** 816-783-8407

**EMAIL ADDRESS:** eyeung@naic.org

**ON BEHALF OF:** P/C RBC (E) Working Group

**NAME:** Tom Botsko

**TITLE:** Chair

**AFFILIATION:** Ohio Department of Insurance

**ADDRESS:** 50 W. Town Street, Third Floor – Suite 300

Columbus, OH 43215

---

**IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED**

| [ ] Health RBC Blanks | [ ] Property/Casualty RBC Blanks | [ ] Life and Fraternal RBC Instructions |
| [ ] Health RBC Instructions | [x] Property/Casualty RBC Instructions | [ ] Life and Fraternal RBC Blanks |
| [ ] OTHER ____________________________ | [ ] | [ ] |

**DESCRIPTION OF CHANGE(S)**

The proposed change would remove the embedded 2% operational risk contained in the R3 credit risk component.

**REASON OR JUSTIFICATION FOR CHANGE **

When the reinsurance recoverable credit risk charge was implemented in 2018, a load of operational risk was embedded in the charge. Now, the operational risk is separately addressed in RBC as a standard-alone capital add-on, it results with duplication of the operational risk charge on the reinsurance recoverable component. This proposal intends to eliminate the double-counting effect of the operational risk charge on the component.

**Additional Staff Comments:**

10/25/21 – The PCRBC WG exposed it for a 30-day public comment period ending Nov. 24.

**This section must be completed on all forms.**

© 2022 National Association of Insurance Commissioners
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<th>Secure 3</th>
<th>Secure 4</th>
<th>Secure 5</th>
<th>Vulnerable 6 or Unrated</th>
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### 2020 P&C RBC - Comparison of Action Levels

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<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
<td></td>
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<td>ACL 9</td>
<td>RAL 9</td>
<td>CAL 9</td>
<td>Trend Test 9</td>
<td>No Action 9</td>
<td>Total 9</td>
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**Companies with TAC Between $0 and $5 Million**

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<tr>
<th>2020 RBC Action Level under Current RBC Formula</th>
<th>MCL</th>
<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
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<td>RAL 6</td>
<td>CAL 6</td>
<td>Trend Test 6</td>
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**Companies with TAC Between $5 and $25 Million**

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<th>MCL</th>
<th>ACL</th>
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<th>CAL</th>
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<th>No Action</th>
<th>Total</th>
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</thead>
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<td></td>
<td></td>
</tr>
<tr>
<td>MCL 3</td>
<td>ACL 3</td>
<td>RAL 3</td>
<td>CAL 3</td>
<td>Trend Test 3</td>
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**Companies with TAC Between $25 Million and $75 Million**

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<th>MCL</th>
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<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>MCL 0</td>
<td>ACL 0</td>
<td>RAL 0</td>
<td>CAL 0</td>
<td>Trend Test 0</td>
<td>No Action 0</td>
<td>Total 0</td>
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</table>

**Companies with TAC Between $75 Million and $250 Million**

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<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
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<tr>
<td>MCL 0</td>
<td>ACL 0</td>
<td>RAL 0</td>
<td>CAL 0</td>
<td>Trend Test 0</td>
<td>No Action 0</td>
<td>Total 0</td>
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**Companies with TAC Between $250 Million and $1 Billion**

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<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MCL 0</td>
<td>ACL 0</td>
<td>RAL 0</td>
<td>CAL 0</td>
<td>Trend Test 0</td>
<td>No Action 0</td>
<td>Total 0</td>
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**Companies with TAC Greater Than $1 Billion**

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<th>2020 RBC Action Level under Current RBC Formula</th>
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<th>ACL</th>
<th>RAL</th>
<th>CAL</th>
<th>Trend Test</th>
<th>No Action</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 RBC Action Level under Current RBC Formula</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>MCL 0</td>
<td>ACL 0</td>
<td>RAL 0</td>
<td>CAL 0</td>
<td>Trend Test 0</td>
<td>No Action 0</td>
<td>Total 0</td>
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</table>

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Distributions of Percentage Change in 2020 RBC Ratios by Company Size under Alternative RBC Formula

Alternative RBC: 2.0% Reduction on Reinsurance Recoverable RBC Charge for All Reinsurance Designation Equivalents

<table>
<thead>
<tr>
<th>RBC Ratio Change/TAC Range</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
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<tr>
<td>Less than -50%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>-50% to -25%</td>
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<td>0</td>
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<tr>
<td>25% to -15%</td>
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<td>15% to -5%</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>5% to 5%</td>
<td>227</td>
<td>662</td>
<td>494</td>
<td>381</td>
<td>249</td>
<td>140</td>
<td>2,153</td>
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<tr>
<td>5% to 15%</td>
<td>12</td>
<td>56</td>
<td>33</td>
<td>22</td>
<td>9</td>
<td>8</td>
<td>140</td>
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<tr>
<td>15% to 25%</td>
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<td>21</td>
<td>15</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>58</td>
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<td>25% to 50%</td>
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<td>23</td>
<td>8</td>
<td>3</td>
<td>2</td>
<td>52</td>
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<td>586</td>
<td>434</td>
<td>268</td>
<td>149</td>
<td>2,475</td>
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| R3 - Current             | 71,884,508 | 267,078,272 | 829,927,624 | 1,471,721,675 | 1,935,441,255 | 5,794,628,606 | 10,370,681,940 |
| R3 - Alternative         | 56,439,676 | 183,797,021 | 536,125,852 | 916,477,625   | 1,278,922,632 | 4,052,194,696 | 7,023,957,502  |
| Percentage Change        | -21.5%    | -31.2%     | -35.4%     | -37.7%       | -33.9%        | -30.1%       | -32.3%  |

| R4 - Current             | 394,872,924 | 798,332,703 | 2,428,351,877 | 7,678,683,209 | 19,336,240,304 | 59,340,612,610 | 129,977,039,847 |
| R4 - Alternative         | 385,941,326 | 773,790,796 | 2,381,245,619 | 7,218,689,687 | 19,005,250,705 | 57,021,362,500 | 127,688,287,643 |
| Percentage Change        | -2.3%      | -3.1%      | -1.9%       | -2.1%        | -2.7%         | -1.7%        | -1.8%   |

| RBC After Covariance (incl. Op Risk) - Current | 562,635,200 | 1,914,873,807 | 5,346,308,507 | 14,478,209,005 | 36,933,009,966 | 114,804,512,521 | 375,683,039,100 |
| RBC After Covariance (incl. Op Risk) - Alternative | 547,596,925 | 1,852,683,948 | 5,154,973,094 | 14,028,873,322 | 36,390,302,003 | 112,793,182,948 | 370,075,839,000 |
| Percentage Change        | -2.7%      | -3.2%      | -3.9%       | -3.1%        | -3.5%         | -0.5%        | -0.8%   |

Comparison of 2020 RBC Charge under Alternative RBC Formula

Alternative RBC: 2.0% Reduction on Reinsurance Recoverable RBC Charge for All Reinsurance Designation Equivalents

<table>
<thead>
<tr>
<th>TAC Range ($ Million)</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
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<tbody>
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<td>Percentage Change</td>
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## CAPITAL ADEQUACY (E) TASK FORCE

### WORKING AGENDA ITEMS FOR CALENDAR YEAR 2022

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<tr>
<th>2022 #</th>
<th>Owner</th>
<th>2022 Priority</th>
<th>Expected Completion Date</th>
<th>Working Agenda Item</th>
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<td>1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.</td>
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### Carry-Over Items Currently being Addressed – Life RBC

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<tr>
<td>12</td>
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<td></td>
<td>New Items - RBC IR &amp;E</td>
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<td>2023 or later</td>
<td>Evaluate the appropriate RBC treatment of Asset-Backed Securities (ABS), including Collateralized Loan Obligations (CLO), collateralized fund obligations (CFOs), or other similar securities carrying similar types of tail risk (Complex Assets).</td>
<td>Request from E Committee, SAPWG, VOSTF</td>
<td>Per the request of E Committee, comments were solicited asking if these types of assets should be considered a part of the RBC framework.</td>
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<td>13</td>
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<td></td>
<td>Phase 2 Bond analysis - evaluate and develop an approach to map other ABS to current bond factors following the established principles from Phase 1 where the collateral has an assigned RBC. This project will likely require an outside consultant and the timeline could exceed 2-3 years.</td>
<td>Request from E Committee</td>
<td>Per the request of E Committee, comments were solicited requesting the need for outside review.</td>
</tr>
</tbody>
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### Carry-Over Items Currently being Addressed – P&C RBC

<p>| 14    | Cat Risk SG | 1 | Year-end 2022 or later | Continue development of RBC formula revisions to include a risk charge based on catastrophe model output: a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be. | Referral from the Climate and Resiliency Task Force. March 2021 | 4/26/21 - The SG exposed the referral for a 30-day period. 6/1/21 - The SG forwarded the response to the Climate and Resiliency Task Force. 2/22/22 - The SG adopted proposal 2021-17-CR (adding the wildfire peril for informational purposes only). The SG continues reviewing other perils for possible inclusion in the RBC. | 4/26/2021 |
| 15    | P&amp;C RBC WG | 1 | Year-end 2020 or later | Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsurers that do not trigger growth risk in their own right. | Refer from Operational Risk Subgroup | 1) Sent a referral to the Academy on 6/14/18 conference call. | 1/25/2018 |</p>
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<td>16</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2020 Summer Meeting or later</td>
<td>Continue development of RBC formula revisions based on the Covered Agreement: consider whether the factor for uncollateralized, unrated reinsurers, runoff and captive companies should be adjusted</td>
<td></td>
<td>12/5/19 - The WG exposed Proposal 2018-19-P (Vulnerable 6 or unrated risk charge) for a 30-day exposure period. 2/5/20 - The WG adopted Proposal 2018-19-P. However, the WG intended to evaluate the data annually until reaching any agreed upon change to the factor and the structure. 3/15/21 - The WG exposed Proposal 2021-03-P (Credit Risk Instruction Modification) for a 30-day exposure period. 4/27/21 - The WG adopted proposal 2021-03-P. 6/30/21 - The CADTF adopted this proposal.</td>
<td>8/4/2018</td>
</tr>
<tr>
<td>17</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Evaluate the proposed changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments</td>
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<td></td>
<td>6/10/2019</td>
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<td>18</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2022 Summer Meeting or later</td>
<td>Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.</td>
<td></td>
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<td>6/10/2019</td>
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<tr>
<td>19</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Evaluate the possibility of allowing additional third party models or adjustments to the vendor models to calculate the cat model losses</td>
<td></td>
<td>7/15/21 - The SG is continue evaluating this item. 10/27/21 - The SG exposed the proposal 2021-15-CR (adding KCC model). 12/16/21 - The SG adopted the proposal 2021-15-CR. 3/23/22 - The WG adopted this proposal.</td>
<td>12/6/2019</td>
</tr>
<tr>
<td>20</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2023 Spring Meeting</td>
<td>Evaluate if changes should be made to the P/C formula to better assess companies in runoff.</td>
<td></td>
<td>1/29/20 - received a referral from the Restructuring Mechanism (E) WG. 4/27/21 - The WG forwarded a response to the Restructuring Mechanism (E) WG.</td>
<td>2/3/2020</td>
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<td>21</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2023 Summer Meeting or later</td>
<td>Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.</td>
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<td>7/30/2020</td>
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<td>22</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>Modify instructions to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories</td>
<td>10/27/20 - expose the proposal for 30 day comment period. 3/15/21 - The SG adopted the proposal 2020-08-CR at the Spring National Meeting. 3/23/21 - The CADTF adopted this proposal. 3/25/21 - The WG adopted the proposal.</td>
<td>10/27/2020</td>
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<td>23</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>2022 Summer Meeting</td>
<td>Evaluate R3 Adjustment for Operational Risk Charge</td>
<td>10/25/21 - The WG exposed Proposal 2021-14-P (R3 Factor Adjustment) for a 30 day exposure period. 3/22/22 - The WG adopted the proposal 2021-14-P.</td>
<td>10/27/2020</td>
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<tr>
<td>22</td>
<td>Cat Risk SG</td>
<td>1</td>
<td>2022 Spring Meeting or later</td>
<td>Implement Wildfire Peril in the Rcat component (For Informational Purpose Only)</td>
<td>7/15/21 - The SG is continue studying this item. 2/22/22 - The SG adopted the proposal 2021-17-CR. 3/23/22 - The WG adopted the proposal.</td>
<td>3/8/2021</td>
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### New Items – P&C RBC

| 23     | Cat Risk SG | 1   | Jun-22                     | Evaluate the possibility of modifying exemption criteria for different cat perils in the PR027 Interrogatories. | 3/22/22 - The SG exposed proposal MOD 2021-17-CR for 14 day comment period. | 3/22/2022                                                                 |
| 24     | Cat Risk SG | 2   | 2023 Spring Meeting or later | Evaluate the possibility of enhancing the Independent Model Instructions. | 3/22/2022                                                                 |
| 25     | P&C RBC WG | 1   | Jun-22                     | Remove the trend test footnote in PR033. | 3/25/2022 - The WG exposed proposal 2022-02-P for 30 day comment period. | 3/22/2022                                                                 |

### Ongoing Items – Health RBC

| 26     | Health RBC WG | Yearly | Yearly | Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the 0.5% adjustment to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.0%. | HRBCWG | 11/4/2021 |

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*Priority 1 – High priority
Priority 2 – Medium priority
Priority 3 – Low priority*
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<td>Health RBC WG</td>
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<td>Year-end 2022 RBC or later</td>
<td>Continue to monitor the impact of Federal Health Care Law or any other development of federal level programs and actions (e.g. state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.</td>
<td>4/13/2010 CATF Call</td>
<td>Adopted 2014-01H</td>
<td>Adopted 2014-02H</td>
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| 28     | Health RBC WG | 2 | Year-end 2022 RBC or later | Discuss and monitor the development of federal level programs and actions and the potential impact of these changes to the HRBC formula:  
- Development of the state reinsurance programs;  
- Association Health Plans;  
- Cross-border sales | HRBCWG | Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula. | 1/11/2018 |
| 29     | Health RBC WG | 2 | Year-end 2023 RBC or later | Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula. | HRBC WG | Adopted 2016-06-H | Rejected 2019-04-H | Annual Statement Guidance (Year-End 2020) and Annual Statement Blanks Proposal (Year-End 2021) referred to the Blanks (E) Working Group | |
| 30     | Health RBC WG | 1 | Year-end 2023 or later | Continue to review the premium and reserve ratio in the Health Test Ad Hoc Group in the Health Test and establish an Ad Hoc Group to review the Health Test and review possible annual statement changes for reporting health business in the Life and P/C Blanks. | HRBCWG | Evaluate the applicability of the current Health Test in the Annual Statement instructions in today’s health insurance market. Discuss ways to gather additional information for health business reported in other blanks. Referred Proposal 2022-06BWG to Blanks Working Group for exposure and consideration. | 8/4/2018 | 2/25/2022 |

### Carry-Over Items Currently Being Addressed – Health RBC

- **28 - Health RBC WG**
  - Year-End 2024 RBC or Later
  - Consider changes for stop-loss insurance or reinsurance.
  - AAA Report at Dec. 2006 Meeting

- **29 - Health RBC WG**
  - Year-End 2023 RBC or Later
  - Review the individual factors for each health care receivables line within the Credit Risk H3 component of the RBC formula.

- **30 - Health RBC WG**
  - Year-end 2023 or later
  - Continue to review the premium and reserve ratio in the Health Test Ad Hoc Group in the Health Test and establish an Ad Hoc Group to review the Health Test and review possible annual statement changes for reporting health business in the Life and P/C Blanks.
## Capital Adequacy (E) Task Force

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<td>Health RBC WG</td>
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<td>Year-end 2023 RBC or later</td>
<td>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)</td>
<td>HRBCWG</td>
<td>Review the Managed Care Category and the credit calculated, more specifically the credit calculated when moving from Category 0 &amp; 1 to 2a and 2b.</td>
<td>4/23/2021</td>
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<td>Review the Managed Care Credit calculation in the Health RBC formula - specifically Category 2a and 2b.</td>
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<td>Review Managed Care Credit across formulas.</td>
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<td>As part of the H2 - Underwriting Risk review, determine if other lines of business should include investment income and how investment income would be incorporated to the existing lines if there are changes to the structure.</td>
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<td>Health RBC WG</td>
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<td>Year-end 2023 or later</td>
<td>Review referral letter from the Operational Risk (E) Subgroup on the excessive growth charge and the development of an Ad Hoc group to charge.</td>
<td>HRBCWG</td>
<td>Review if changes are required to the Health RBC Formula.</td>
<td>4/7/2019</td>
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<td></td>
<td>HRBCWG</td>
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<td>Health RBC WG</td>
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<td>Year-End 2023 or later</td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td>HRBCWG</td>
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<td>7/30/2020</td>
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<td>Health RBC WG</td>
<td>3</td>
<td>Year-End 2023 or later</td>
<td>Discuss and determine the re-evaluation of the bond factors for the 20 designations.</td>
<td>Referral from</td>
<td>Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-H - Adopted 5/25/21 by the WG</td>
<td>9/11/2020</td>
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<td>Referral Letter was sent to the Academy on Sept 21. Admitted 5/25/21 by the WG.</td>
<td>Health RBC WG</td>
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<td>Added instructional changes for annual review - Adopted 2/25/22 by WG</td>
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<tr>
<td>35</td>
<td>CADTF</td>
<td>2</td>
<td>2023</td>
<td>Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016</td>
<td>Ad Hoc Group</td>
<td>Structural and instructions changes will be expoed by each individual working group for comment in 2022 with an anticipated effective date of 2023.</td>
<td>1/12/2022</td>
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**New Items – Health RBC**

- Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)

**New Items – Task Force**

**Ongoing Items – Task Force**

**Carry-Over Items not Currently being Addressed – Task Force**

- All investment related items referred to the RBC Investment Risk & Evaluation (E) Working Group

**Priority Levels**

- Priority 1 – High priority
- Priority 2 – Medium priority
- Priority 3 – Low priority
# CAPITAL ADEQUACY (E) TASK FORCE

## WORKING AGENDA ITEMS FOR CALENDAR YEAR 2022

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<td>CADTF</td>
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<td>2021</td>
<td>Receivable for Securities factor</td>
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<td>Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) Factors are exposed for comment. Comments due May 28, 2021 for consideration on June 30th. Factors Adopted for 2021.</td>
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**Carry-Over Items Currently being Addressed – Task Force**

CADTF Working Agenda_v1_2022
EXAMINATION OVERSIGHT (E) TASK FORCE

The Examination Oversight (E) Task Force did not meet at the Spring National Meeting.
FINANCIAL STABILITY (E) TASK FORCE

Financial Stability (E) Task Force and Macroprudential (E) Working Group April 5, 2022, Minutes.................. 9-497
Financial Stability (E) Task Force and Macroprudential (E) Working Group Feb. 22, 2022, Minutes
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The Financial Stability (E) Task Force met in Kansas City, MO, April 5, 2022, in joint session with the Macroprudential (E) Working Group. The following Task Force members participated: Marlene Caride, Chair (NJ); Elizabeth Kelleher Dwyer, Vice Chair (RI); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Tom Hudson (DE); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen (IA); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Gary D. Anderson represented by John Turchi (MA); Timothy N. Schott represented by Vanessa Sullivan (ME); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented by Justin Schrader (NE); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Dale Bruggeman (OH); Andrew R. Stolfi represented by Doug Hartz (OR); Michael Humphreys represented by Matt Milford (PA); Raymond G. Farmer represented by Daniel Morris (SC); Carter Lawrence represented by Trey Hancock (TN); Cassie Brown represented by Jamie Walker (TX); Scott A. White and Greg Chew (VA); and Nathan Houdek and Amy Malm (WI). The following Working Group members participated: Justin Schrader, Chair (NE); Carrie Mears, Vice Chair (IA); Susan Bernard (CA); Kathy Belfi (CT); Philip Barlow (DC); Carolyn Morgan (FL); Susan Berry (IL); Vanessa Sullivan (ME); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); Bob Kasinow (NY); Matt Milford (PA); Jamie Walker (TX); and Greg Chew (VA).

1. **Heard Opening Remarks**

Commissioner Caride said materials for consideration and discussion for this meeting are available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. **Adopted the Task Force’s Feb. 22 Minutes and the Working Group’s March 2 Minutes**

Commissioner Caride said to simplify the process, the Task Force will consider adoption of its Feb. 22 minutes and the Working Group’s March 2 minutes together.

Mr. Schrader made a motion, seconded by Mr. Eft, to adopt the Task Force’s Feb. 22 minutes (Attachment One) and the Working Group’s March 2 minutes (Attachment Two). The motion passed unanimously.

3. **Received a Working Group Update**

Mr. Schrader said since the Task Force adopted the “List of Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers,” the Working Group met with the Statutory Accounting Principles (E) Working Group, the Valuation of Securities (E) Task Force, several risk-based capital (RBC) groups, and the Life Actuarial (A) Task Force to establish a baseline of their activities that relate to the considerations included on the list. The Macroprudential (E) Working Group met March 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to reach an initial conclusion on how to move forward for the first six considerations. Mr. Schrader added that another regulator-only meeting will be held after the national meeting to address the remaining considerations, with the expectation to release the full list of 13 considerations for a brief comment period. He stressed that if state insurance regulators or interested parties have comments or suggestions on the first six considerations, they should direct those to NAIC staff. He
concluded that after considering any comments received on the 13 considerations, the Working Group will finalize the document to consider for adoption by the Financial Stability (E) Task Force with status updates as work progresses.

Mr. Schrader summarized the changes made to the list of considerations so far:

- Added an introductory paragraph that gives a high-level explanation of solvency monitoring.
- Added specific examples from the NAIC *Financial Analysis Handbook* of stipulations state insurance regulators may require addressing outstanding concerns with entities acquiring insurers.
- Added the full list of considerations, updated with a summary of the existing work occurring at other NAIC groups and results of regulator-only discussions.

Mr. Schrader summarized each regulatory response to the list of regulatory considerations:

- For the first consideration, which involves state insurance regulators’ ability to gain a full understanding of the risks to their regulated insurers affected by holding company structures and affiliated/related-party agreements that avoid required disclosures, the Working Group believes it should be referred to the Group Solvency Issues (E) Working Group. He added that state insurance regulators discussed creating an optional set of disclosures for their use when approving a Form A applicant when unresolved regulatory concerns still exist. He also noted that the Macroprudential (E) Working Group recognized the benefit of additional training for states with less experience reviewing Form A applications involving complex holding company structures and agreements.

- For the second consideration, which deals with the potential existence of control and conflicts of interest where ownership is less than or equal to 10%, the Working Group believes it should also be referred to the Group Solvency Issues (E) Working Group. He also noted that the Macroprudential (E) Working Group recognized the benefit of additional training. He added that the Working Group suggested developing ways to better target affiliated agreements to collect, and he questioned if the Form B Insurance Holding Company System Annual Registration Statement needs to be modified.

- For the third consideration, which addresses control and conflict of interest, but specifically within the investment management agreement (IMA), the Working Group believes it should be referred to the Risk-Focused Surveillance (E) Working Group, which is already focused on a project involving other affiliated agreements and Form D filings. He also noted that the Macroprudential (E) Working Group recognized the benefit of additional training, and he questioned if the Valuation of Securities (E) Task Force should have a role in IMA review work due to the increase in bespoke agreements.

- For the fourth consideration, which involves the potential conflict of owners wanting short-term gains compared to the needs of life insurance products’ long-term liabilities and specifically includes fees charged to insurers in service agreements with other holding company entities; The Working Group noted the Life Actuarial (A) Task Force is performing work to address some of this consideration, but suggested the consideration should be referred to the Risk-Focused Surveillance (E) Working Group as well, because it is already addressing issues with affiliated agreements and fees. He added that the Macroprudential (E) Working Group believes increased guidance for capital maintenance agreements should be considered.

- For the fifth consideration, which covers the broader areas of operational, governance, and market conduct practices, and how those areas would be affected by new owners of insurers with a lack of insurance expertise, the Working Group noted the existence of good guidance in the *NAIC Financial Analysis Handbook*. Despite this existing guidance, the Working Group considered a referral to the Risk-Focused Surveillance (E) Working Group, but for now the members opted to keep developing suggestions at the Working Group. Some of the specific suggestions already discussed include optional Form A disclosures and guidance for less experienced states, considering more detailed guidance for financial examinations, and a recognition that this consideration must also address intentional actions.
• For the sixth consideration, which notes the impact of the lack of a widely accepted definition of PE, the Working Group consensus is that a definition of PE is not needed, as the considerations in this list are activity-based, and the activities, along with any remedies developed, apply to any type of owner.

Mr. Schrader reported that the Working Group updated the 2021 Liquidity Stress Testing Framework (LST Framework) document with Lead State Guidance, providing the outstanding economic variables for the adverse liquidity stress test, as well as the templates to use for the 2021 liquidity stress test (LST). He added that those documents are located on the Financial Stability (E) Task Force’s website. He clarified that insurers should use the Lead State Guidance version of the 2021 LST Framework and the updated templates for submitting the 2021 LST filings with a due date of June 30. He added that the Working Group will address questions and issues related to separate accounts with respect to future LST frameworks before discussing the results of those June 30 filings.

4. ** Adopted the Macroprudential Risk Assessment Process**

Mr. Schrader said the Macroprudential Risk Assessment Process (Attachment Three) was updated with:

• Minor amendments based on industry feedback (Attachment Four).
• An NAIC staff summary of industry feedback paired with NAIC staff’s responses followed by each of the industry comment letters (Attachment Four).
• An illustrative version of the Macroprudential Risk Assessment Process to show what a final document could look like (Attachment Five).

Mr. Schrader noted a recurring theme of industry asking for more details, but apart from some minor revisions to enhance understanding, the Working Group opted for more discussion on the matters to address industry concern by asking for feedback on the proposed actions based on the assessment performed rather than on revisions of the Macroprudential Risk Assessment Process document that could result in constant updates with every new metric or risk under consideration.

Miguel Romero (NAIC) summarized four changes to the Macroprudential Risk Assessment Process document based on industry comments:

• The Overview paragraph was updated to better clarify the intent of the risk assessment process.
• The Quantitative Review section changed to clarify that metrics will be presented in a manner that fits the measured risk with historical data also presented to provide the context needed to assess the risk.
• A reference to macro risk assessment was changed to macroprudential risk assessment to be consistent and not to be confused with macroeconomic risk analysis.
• The Conclusion and Presentation of Results paragraph was changed to add a reference to the three transmission channels identified by the Financial Stability Oversight Council (FSOC) as most likely to facilitate the transmission of risk across firms or markets, which are interconnectedness, asset liquidation, and critical function.

Mr. Schrader said a redlined version of the document was not included in the materials because of an administrative oversight in the preparation of the materials but due to the minor nature of the changes, he had still hoped to adopt the updated document as described by Mr. Romero.

For the Working Group, Ms. Bernard made a motion, seconded by Ms. Mears, to adopt the Macroprudential Risk Assessment Process. The motion passed unanimously.

For the Task Force, Mr. Schrader made a motion, seconded by Mr. Rehagen, to adopt the Macroprudential Risk Assessment Process. The motion passed unanimously.
5. **Heard an International Update**

Tim Nauheimer (NAIC) said the International Association of Insurance Supervisors (IAIS) launched the Global Monitoring Exercise (GME) on March 10, which includes the individual insurer monitoring (IIM) and sector-wide monitoring (SWM). He added that the deadline to submit IIM data is May 10 and the SWM data is June 30. He noted that as part of the SWM exercise, additional climate data and new data on cyber are being collected. He said cyber data will be aggregated anonymously and will be published as the IAIS’s special topic for the Global Insurance Market Report (GIMAR) this year. The IAIS is also collecting data on reinsurers as part of the SWM. Mr. Nauheimer emphasized the importance of striking a balance with respect to the burden for insurers and supervisors by limiting the data requested by the IAIS and ensuring that the objective for collecting such data is clear. He added that the work on potential revisions of the IIM systemic risk assessment methodology will be completed this year as part of a three-year cycle review, which is similar to the global systemically important insurer (G-SII) identification process that was replaced with the IAIS holistic framework for systemic risk. He said the implementation of the holistic framework is currently being assessed by the IAIS, and the Financial Stability Board (FSB) will decide towards the end of this year whether to eliminate the G-SII identification process for good or revive the process.

Mr. Nauheimer reported that the IAIS is reviewing comments received on the second public consultation on the development of liquidity metrics, which focuses on developing the Phase II cash flow projection approach and aligns more with the NAIC’s approach to assess liquidity risk. He added that the IAIS intends to issue a publication titled, “Liquidity Metrics as an Ancillary Indicator” this year after analysis of liquidity data received as part of the GME. He said the IAIS formed a climate risk steering group (CRSG) with three workstreams:

- GAP Analysis charged with reviewing the Insurance Core Principles (ICPs) and Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) standards.
- Scenario Analysis charged with best practices and education around scenario analysis.
- Climate Data charged with respect to data collection and analysis.

6. **Discussed Other Matters**

Commissioner Caride congratulated Superintendent Dwyer for being appointed the NAIC’s representative on the FSOC and the new vice chair of the Task Force. Superintendent Dwyer congratulated Commissioner Caride for being appointed the new chair of the Task Force.

Having no further business, the Financial Stability (E) Task Force and the Macroprudential (E) Working Group adjourned.
The Financial Stability (E) Task Force met Feb. 22, 2022, in joint session with the Macroprudential (E) Working Group. The following Task Force members participated: Eric A. Cioppa, Chair (ME); Marlene Caride, Vice Chair (NJ); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Tom Hudson (DE); Amy L. Beard represented by Roy Eft (IN); Doug Ommen (IA); Vicki Schmidt represented by Tish Becker (KS); Gary D. Anderson represented by John Turchi (MA); Chlora Lindley-Myers represented by John Rehagen (MO); Eric Dunning represented by Justin Schrader (NE); Mike Causey and Jackie Obusek (NC); Adrienne A. Harris represented by Bob Kasinow (NY); Judith L. French represented by Tracy Snow (OH); Michael Humphreys represented by Kimberly Rankin and Melissa Greiner (PA); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer represented by Geoffrey Bonhom (SC); Carter Lawrence and Trey Hancock (TN); Cassie Brown represented by Jamie Walker (TX); Scott A. White represented by David Smith (VA); and Nathan Houdek and Amy Malm (WI). The following Working Group members participated: Justin Schrader, Chair (NE); Carrie Mears, Vice Chair (IA); Susan Bernard (CA); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); Bob Kasinow (NY); Melissa Greiner (PA); Mike Boerner (TX); and Greg Chew (VA).

1. **Heard Opening Remarks**

Commissioner Caride said materials for consideration and discussion for this meeting are available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. **Received a Working Group Update**

Mr. Schrader said that the Working Group adopted the document titled “List of Regulatory Considerations Applicable (But not Exclusive) to Private Equity (PE) Owned Insurers” during its meeting on Feb. 1. He stressed that some of the work on the considerations will occur, or is already underway, at other NAIC committee groups, and the Working Group’s role is to monitor those activities and developments. He said that the Working Group has organized a meeting with the various groups’ chairs, vice chairs, and NAIC support staff to establish a baseline of their activities underway that relate to the considerations included on the list of regulatory considerations. He added that after the baseline meeting, the list of regulatory considerations will be updated to reflect changes, and the tracking document will be posted on the Working Group’s web page in the documents section. Mr. Schrader said that after establishing the baseline in early March, the Working Group will hold periodic meetings with the chairs, vice chairs, and NAIC support staff of the various groups to ensure proper coordination occurs. He also promised verbal status updates in open meetings of the Working Group, which will be reflected in the Working Group’s tracking document. Mr. Schrader concluded that the Working Group will consider the risks, existing measures to address the risks, if they are sufficient for now or if further measures should be considered, and if the latter, which group is appropriate to perform the work. He added that the Working Group may need to meet in regulator-to-regulator session when deliberating answers to those questions—for example, to speak about specific companies—but that the answers to these questions will be considered in open meetings with an opportunity for interested parties to comment.

Mr. Schrader said that the Working Group continues to use the unofficial Liquidity Stress Test (LST) Study Group to address the details for the LST project. He added that the LST Study Group has concluded its work on the 2021
LST Framework, which the Working Group will consider for adoption along with the Task Force. He said that the 2021 LST Framework calls for LST filings to be submitted to the lead state regulator by June 30, and once comfortable, the lead state will provide results to NAIC staff to aggregate results. He noted that the LST Study Group will use those results as part of the deliberations for whether and how to modify the 2022 LST Framework. Mr. Schrader added that the LST Study Group will consider issues related to separate accounts, because other than general account guarantees for separate accounts, separate accounts were excluded from the scope. He explained that further considerations to perform some sort of data call and study, as well as whether to modify a future LST Framework to include some aspects of separate accounts, will be considered in the second quarter with any recommendations brought to open meetings of the Working Group.

3. **Adopted the “List of Regulatory Considerations – PE Related and Other”**

Commissioner Caride said that the initial “List of Regulatory Considerations – PE Related and Other” was exposed for a 30-day public comment period, which was extended by two weeks to meet an interested party’s request regarding the year-end holiday season. She added that the Working Group provided its recommended responses in detail to comments received during the Working Group’s meeting on Feb. 1. Commissioner Caride concluded that since no controversial items were raised during the Working Group process, the Task Force is considering adoption without any comment period.

Mr. Schrader made a motion, seconded by Superintendent Cioppa, to adopt the “List of Regulatory Considerations – PE Related and Other” (Attachment One-A). The motion passed unanimously.

4. **Adopted the 2021 LST Framework**

Mr. Schrader said that the 2021 LST Framework drafting began by incorporating the Lead State Guidance items issued last year after the Task Force adopted the 2020 LST Framework document. He added that there were only minor editorial items, such as updating the year and indicating differences of the 2021 LST processes compared to the 2020 LST. He stressed that there is a known set of metrics for the appendices that will need to be updated after the 2021 LST Framework document is adopted. Mr. Schrader said this change and any unexpected changes will be addressed using Lead State Guidance. He said that the 2021 LST Framework document is not being exposed for a public comment period because of this lack of substantive edits from the 2020 LST Framework adopted last year after multiple exposure periods both at the Working Group and the Task Force. Mr. Schrader clarified that all Lead State Guidance elements for the 2020 LST Framework were posted on the Task Force’s web page as they were made in 2021. He concluded that those items being incorporated into the 2021 LST Framework are not new guidance. He added that the insurers in scope that are affected by the minor edits to the 2021 LST Framework document have already signed off during the LST Study Group meetings this year.

For the Macroprudential Working Group’s consideration, Ms. Belfi made a motion, seconded by Ms. Mears, to adopt the 2021 LST Framework (Attachment One-B). The motion passed unanimously.

For the Financial Stability Task Force’s consideration, Commissioner Ommen made a motion, seconded by Ms. Belfi, to adopt the 2021 LST Framework (Attachment One-B). The motion passed unanimously by the Task Force.

5. **Adopted the Working Group’s Feb. 1 Minutes**

The Working Group met Feb. 1 and took the following action: 1) adopted the List of Regulatory Considerations – PE Related and Other; 2) received an update on the 2021 LST Framework, Including Scope Criteria; and 3) heard a macroprudential risk assessment update.
Mr. Schrader made a motion, seconded by Mr. Rehagen, to adopt the Working Group’s Feb. 1 minutes (Attachment One-C). The motion passed unanimously.

6. **Discussed Other Matters**

Commissioner Caride recognized Superintendent Cioppa for his many years of excellent service to the NAIC and wished him the best in his retirement.

Having no further business, the Financial Stability (E) Task Force and Macroprudential (E) Working Group adjourned.
A summary of currently identified regulatory considerations follows with no consideration of priority or importance (green underlined font indicates current or completed work by another NAIC committee group). Most of these considerations are not limited to PE owned insurers and are applicable to any insurers demonstrating the respective activities.

1. Regulators may not be obtaining clear pictures of risk due to holding companies structuring contractual agreements in a manner to avoid regulatory disclosures and requirements. Additionally, affiliated/related party agreements impacting the insurer’s risks may be structured to avoid disclosure (for example, by not including the insurer as a party to the agreement).

2. Control is presumed to exist where ownership is >=10%, but control and conflict of interest considerations may exist with less than 10% ownership. For example, a party may exercise a controlling influence over an insurer through Board and management representation or contractual arrangements, including non-customary minority shareholder rights or covenants, investment management agreement (IMA) provisions such as onerous or costly IMA termination provisions, or excessive control or discretion given over the investment strategy and its implementation. Asset-management services may need to be distinguished from ownership when assessing and considering controls and conflicts.

3. The material terms of the IMA and whether they are arm’s length or include conflicts of interest — including the amount and types of investment management fees paid by the insurer, the termination provisions (how difficult or costly it would be for the insurer to terminate the IMA) and the degree of discretion or control of the investment manager over investment guidelines, allocation, and decisions.

4. Owners of insurers, regardless of type and structure, may be focused on short-term results which may not be in alignment with the long-term nature of liabilities in life products. For example, investment management fees, when not fair and reasonable, paid to an affiliate of the owner of an insurer may effectively act as a form of unauthorized dividend in addition to reducing the insurer’s overall investment returns. Similarly, owners of insurers may not be willing to transfer capital to a troubled insurer.

5. Operational, governance and market conduct practices being impacted by the different priorities and level of insurance experience possessed by entrants into the insurance market without prior insurance experience, including, but not limited to, PE owners. For example, a reliance on TPAs due to the acquiring firm’s lack of expertise may not be sufficient to administer the business. Such practices could lead to lapse, early surrender, and/or exchanges of contracts with in-the-money guarantees and other important policyholder coverage and benefits.

6. No uniform or widely accepted definition of PE and challenges in maintaining a complete list of insurers’ material relationships with PE firms. (UCAA (National Treatment WG) dealt with some items related to PE.) This definition may not be required as the considerations included in this document are applicable across insurance ownership types.

7. The lack of identification of related party-originated investments (including structured securities). This may create potential conflicts of interests and excessive and/or hidden fees in the portfolio structure, as assets created and managed by affiliates may include fees at different levels of the value chain. For example, a CLO which is managed or structured by a related party. (An agenda item and blanks proposal are being developed by SAPWG.)

8. Though the blanks include affiliated investment disclosures, it is not easy to identify underlying affiliated investments and/or collateral within structured security investments. Additionally,
transactions may be excluded from affiliated reporting due to nuanced technicalities. Regulatory disclosures may be required to identify underlying related party investments and/or collateral within structured security investments. This would include, for example, loans in a CLO issued by a corporation owned by a related party. (An agenda item and blanks proposal are being developed by SAPWG.)

9. Broader considerations exist around asset manager affiliates (not just PE owners) and disclaimers of affiliation avoiding current affiliate investment disclosures. (A new Sc Y, Pt 3, has been adopted and will be in effect for year-end 2021. This schedule will identify all entities with greater than 10% ownership — regardless of any disclaimer of affiliation — and whether there is a disclaimer of control/disclaimer of affiliation. It will also identify the ultimate controlling party. Additionally, SAPWG is developing a proposal to revamp Schedule D reporting, with primary concepts to determine what reflects a qualifying bond and to identify different types of investments more clearly, including asset-backed securities.)

10. The material increases in privately structured securities (both by affiliated and non-affiliated asset managers), which introduce other sources of risk or increase traditional credit risk, such as complexity risk and illiquidity risk, and involve a lack of transparency. (The NAIC Capital Markets Bureau continues to monitor this and issue regular reports, but much of the work is complex and time-intensive with a lot of manual research required. The NAIC Securities Valuation Office will begin receiving private rating rationale reports in 2022; these will offer some transparency into these private securities.)

11. The level of reliance on rating agency ratings and their appropriateness for regulatory purposes (e.g., accuracy, consistency, comparability, applicability, interchangeability, and transparency). (VOSTF has previously addressed and will continue to address this issue.)

12. The trend of life insurers in pension risk transfer (PRT) business and supporting such business with the more complex investments outlined above (LATF has exposed questions aimed at determining if an Actuarial Guideline is needed to achieve a primary goal of ensuring claims-paying ability even if the complex assets (often private equity-related) did not perform as the company expects, and a secondary goal to require stress testing and best practices related to valuation of non-publicly traded assets (note — LATF’s considerations are not limited to PRT). Additionally, enhanced reporting in 2021 Separate Accounts blank will specifically identify assets backing PRT liabilities.)

Considerations have also been raised regarding the RBC treatment of PRT business.
   a. Review applicability of Department of Labor protections resulting for pension beneficiaries in a PRT transaction.
   b. Review state guaranty associations’ coverage for group annuity certificate holders (pension beneficiaries) in receivership compared to Pension Benefit Guaranty Corporation (PBGC) protection.

13. Insurers’ use of offshore reinsurers (including captives) and complex affiliated sidecar vehicles to maximize capital efficiency, reduce reserves, increase investment risk, and introduce complexities into the group structure.
NAIC 2021 LIQUIDITY STRESS TEST FRAMEWORK
For Life Insurers Meeting the Scope Criteria

February 15, 2022
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INTRODUCTION

Macroprudential Implications of a Liquidity Stress

Beginning mid-year 2017, the NAIC embarked on a project to develop a liquidity stress testing framework. While the NAIC has existing tools and processes for assessing liquidity risk at a legal entity level (i.e., ‘inward’ impacts to the insurer), there was recognition that the NAIC toolbox could be further enhanced with the addition of more granular data in the annual statement and a tool that would enable an assessment of macroprudential impacts on the broader financial markets (i.e., ‘outward’ impacts) of a liquidity stress impacting a large number of insurers simultaneously.

Post-financial crisis, there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors. To provide more evidence-based analyses, the NAIC decided to develop a Liquidity Stress Test (LST) Framework for large life insurers that would aim to capture the outward impacts on the broader financial markets of aggregate asset sales under a liquidity stress.

The stress test will be run annually and the findings, on an aggregate basis, reported annually as part of the NAIC’s continuous macroprudential monitoring efforts. The NAIC’s pursuit of the liquidity stress test should not suggest any pre-judgement of the outcomes. The NAIC believes there is value to the exercise whether it points to vulnerabilities of certain asset classes or markets or, alternatively, suggests that even a severe liquidity stress impacting the insurance sector is unlikely to have material impacts on financial markets. The NAIC liquidity stress testing framework is intended to supplement, not replace, a firm-specific liquidity risk management framework. The NAIC has not yet discussed steps that might be taken to address any identified
vulnerabilities but acknowledges that any recommendations may require collaboration with other financial regulators.

The NAIC’s revised proposed liquidity stress testing framework is contained in the pages that follow. The NAIC recognizes that, at least in the early years, the stress testing process and analyses will be iterative. We expect refinements as the framework is developed, especially after the first year’s implementation.

BACKGROUND

NAIC Macroprudential Initiative

The NAIC’s Macroprudential Initiative (MPI) commenced in 2017. It recognized the post-financial crisis reforms that became part of our Solvency Modernization Initiative (SMI) that continue to serve us well today. However, in the ensuing years since those reforms, insurers have had to contend with sustained low interest rates, changing demographics and rapid advancements in communication and technology. They have responded by offering new products, adjusting investment strategies, making structural changes, and expanding into new global markets. There are new market players, new distribution channels, and a complex web of interconnections between financial market players.

What has not changed since the financial crisis is the scrutiny on the insurance sector in terms of understanding how insurers react to financial stress, and how that reaction can impact, via various transmission channels, policyholders, other insurers, financial market participants, and the broader public.

The proposed work on macroprudential measures is reflective of the state insurance regulators’ commitment to ensure that the companies they regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. To that end, the NAIC’s three-year strategic plan (2018-2020), “State Ahead”, reflects the objective of “Evaluating Gaps and regulatory opportunities arising from macroprudential surveillance, and develop appropriate regulatory responses.”
The NAIC’s work on macroprudential surveillance is overseen by the Financial Stability Task Force of the NAIC Executive Committee. In April 2017, the Task Force was asked to consider new and improved tools to better monitor and respond to both the impact of external financial and economic risks on supervised firms, as well as the risks emanating from or amplified by these firms that might be transmitted externally. The Task Force, in turn, focused its efforts on potential enhancements to identify and monitor liquidity risk, among other areas. More specifically, the Task Force was requested to further develop the U.S. regulatory framework on liquidity risk with a focus on life insurers due to the long-term cash-buildup involved in many life insurance contracts and the potential for large scale liquidation of assets.

**Liquidity Assessment Subgroup**

To carry out its work on assessing liquidity considerations, the Task Force established the Liquidity Assessment Subgroup (“Subgroup”) mid-year 2017.

**Mandate**

The charges and workplan of the Subgroup reflect the following assignments:

- Review existing public and regulator-only data related to liquidity risk, identify any gaps based on regulatory needs and determine the scope of application, and propose recommendations to enhance disclosures.
- Develop a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee, including the proposed universe of companies to which the framework will apply (e.g., large life insurers).
- Once the stress testing framework is completed, consider potential further enhancements or additional disclosures.

In addition, a small informal study group comprised of regulators, industry participants and NAIC staff was formed to consider the specific data needs and technical aspects of the project. The study group is NOT an official NAIC working group. All recommendations from the study group must be vetted and considered by the Liquidity Assessment Subgroup and/or the Financial Stability (EX) Task Force according to NAIC procedures.
Data Gaps
Prior to undertaking work on the Liquidity Stress Test, the Subgroup constructed an inventory list of existing life insurer disclosures as of 2018 that contribute to an understanding of liquidity risk. When assessing the current state, the Subgroup recognized the availability of significant detailed investment-related disclosures but contrasted it to the relatively sparse liability-related disclosures. To remedy this imbalance, a blanks proposal was constructed to significantly increase the disclosures for life insurance products.

Specifically, the Analysis of Operations by Line of Business schedule was expanded from a single exhibit to five exhibits, one each for Individual Life, Group Life, Individual Annuity, Group Annuity, and Accident and Health. The Analysis of Increase in Reserves schedule was similarly expanded. Within each of the five new exhibits, columns were added for more detailed product reporting. For example, columns were added to the Individual and Group Life exhibits to capture universal life insurance and universal life insurance with secondary guarantees, and columns were added to the Individual and Group Annuity exhibits to capture variable annuities and variable annuities with guaranteed benefits. In addition, two new lines were added to the now five exhibits of the Analysis of Increase in Reserves schedule: one capturing the cash surrender value of the products outstanding and another capturing the amount of policy loans available (less amounts already loaned). A new addition was also proposed to the Life Notes to Financial Statement. The new Note 33 considered the type of liquidity concerns disclosed in Note 32 for annuities and deposit-type contracts and added disclosures for life insurance products not covered in Note 32.

These proposals were exposed and commented upon several times at the Liquidity Assessment Subgroup, the Financial Stability (EX) Task Force, and at the Blanks (E) Working Group. Ultimately, they were adopted by NAIC Plenary for inclusion in the 2019 Life Annual Statement Blank. As an interim step, The Financial Stability Task Force performed a data call requesting a few key lines of information from the newly adopted 2019 format of the Analysis of Operations by Line of Business schedule and the Analysis of Increase in Reserves schedule, as well as the new Note 33, but populated with 2018 year-end data. This data call was completed in July 2019.
Discussions with Insurers
During the latter part of 2017 and first quarter of 2018, the Subgroup conducted calls with several large life insurers who agreed to share their internal liquidity risk assessment processes. The dialogue provided extremely helpful input and informed the establishment of the initial direction of the Liquidity Stress Testing Framework. Feedback from these discussions include:

- Scope criteria should be risk-focused, not solely based on size.
- Stress test framework should align with internal management reporting and leverage the ORSA.
- Stress test should be principle-based and complement a company’s internal stress testing methodology.
- Regulatory guidance should be provided to help define liquidity sources and uses, products/activities with liquidity risk, time horizons, level of aggregation, reporting frequency, and establishing stress scenarios.
- Public disclosure of results should be carefully considered to avoid exacerbating a liquidity crisis.

Regarding the specifics of liquidity assessments/stress test approaches, significant diversity in practices exist. Key observations in this regard included:

- Liquidity tests are performed at the material entity level and at the holding company level. Definitions of material entities differ.
- Most firms determine some sort of coverage ratio (Liquidity Sources) / (Liquidity Uses), for Base and Stress scenarios and monitor results to ensure they align with the firm’s (internal) risk appetite. Categories of liquidity sources and uses differ across firms and assumptions vary depending on time horizon. Some insurers determine coverage ratios utilizing balance sheet values, applying different haircuts by asset class, time horizon and type of stress. Other insurers determine liquidity coverage gaps (Liquidity Inflows – Liquidity Outflows) utilizing a cash flow approach.
- Stress scenarios vary by company, reflecting a combination of market-driven, as well as idiosyncratic and insurer-specific scenarios.
• Time horizons tested also vary, typically ranging from 7 days to 1 year.

**Regulatory Goals of the Liquidity Stress Test**

• The primary goal of this liquidity stress testing, and the specific stress scenarios utilized, is for macroprudential uses – to allow the FSTF regulators to identify amounts of asset sales by insurers that could impact the markets under stressed environments. Thus, the selected stress scenarios are consciously focused on industry-wide stresses – those that can impact many insurers within a similar timeframe. These may not be the most stressful scenarios for specific legal entity insurers, or even their groups. Regulators have indicated the liquidity stress testing is also meant to assist regulators in their micro prudential supervision, in the context of being helpful for domiciliary and lead state regulators to better understand liquidity stress testing programs at those legal entities and groups. There is no intent to require these stress scenarios to be used by individual insurers for some sort of assessment or regulatory intervention mechanism. Similarly, there has not been any consideration given to requiring them in the management of any entities in receivership.

• Regulatory concerns regarding liquidity risk for legal entity insurers and/or groups is more about the stress scenarios of most concern to those entities (not those identified for macro prudential purposes). Similarly, when considering liquidity risk at a legal entity and/or group, regulators need to understand the insurer’s entire risk management framework. Much of this understanding may come from the ORSA filings. Thus, the LST is not meant to be a legal entity insurer requirement, or used as a ranking tool, etc. However, it is recognized that simply reviewing these LST results may help regulators better understand the role of liquidity stress testing within the entities – which may result in more questions and information requests regarding the entities’ own liquidity risk management framework and dynamics of their internal liquidity stress tests.

Section 1. Scope Criteria for Determining Groups Subject to 2021 LST

HISTORY – Scope Criteria for the Initial 2020 LST:

In determining the companies subject to the liquidity stress test (LST), consideration was given to activities assumed to be correlated with liquidity risk. Another consideration was the desirability of tying data used in the criteria back to the statutory financial statements. Ultimately six activities were identified. Those activities are Fixed and Indexed Annuities, Funding Agreements, Derivatives, Securities Lending, Repurchase Agreements and Borrowed Money. Minimum thresholds were established for each of these six activities. A life insurance legal entity or life insurance group exceeding the threshold for any of the six activities is subject to the stress test (see Annex 1 for more details).

While the scope criteria only utilize statutory annual statement data, the stress test is not similarly limited. Thus, the stress test will consider many more liquidity risk elements than the scope criteria, and internal company data will be the source for many of those elements.

Just as the liquidity stress test structure and methodology may change over time, the scope criteria may also be modified, for example, in response to new data points in the NAIC Annual Statement Blank. The scope criteria will be reviewed annually.

Using the agreed criteria, NAIC staff obtained the amounts for all life insurance legal entities from the 2018 annual statutory financial statements (filed by March 1, 2019). If two or more life insurers were part of an insurance group with an NAIC group code, then the numbers for each of those legal entity life insurers was summed together to represent an insurance group result. Thus, a legal entity life insurer not in an insurance group can meet the threshold on its own, or the sum of legal entity life insurers in a group could meet the threshold. Twenty-three insurance groups met the initial scope criteria.
In establishing whether an insurer or group met or exceeded the threshold criteria, the Subgroup members supported using the most current single year activity rather than a multi-year average. This resulted in coverage amounts ranging from 60% to 80% of the industry total for each activity based on 2018 data. It was recognized that using single year activity could result in more instances of an insurance group being in scope one year and out of scope the next, but regulators viewed it more important to have the most recent financial data utilized for determining scope.

To address concerns about insurers moving in and out of scope, regulatory judgment will be used to address an insurer’s exit from or entry to the scope of insurers subject to the liquidity stress test. The lead state regulator will consult with the Task Force in determining when it is appropriate to remove an insurer from the LST requirement if it no longer meets the scope criteria. Similarly, lead state regulators should have the ability to consult with the Task Force and require the LST from an insurer not meeting the scope criteria (e.g., an insurer close to triggering the scope criteria for more than one year).

**CURRENT – Scope Criteria for the 2021 LST:**

Regulators agreed to retain the same 6 criteria and thresholds from the 2020 LST Scope Criteria for use as the 2021 LST Scope Criteria. The 2021 LST Scope Criteria have been applied to the 2020 annual statement data (data as of Dec. 31, 2020, filed by March 1, 2021).

**Section 2. Liquidity Stress Test**

**2.1 Summary**

The stress testing framework employs a company cash flow projection approach incorporating liquidity sources and uses over various time horizons under a baseline assumption and some number of stress scenarios (for 2021 there are 2 stress scenarios and also an insurer-specific request for information). The available assets are then recorded by asset category. The framework then calls for identification of expected asset sales by category, or other funding as allowed in the stress test, to cure any cash flow deficits (liquidity uses exceed liquidity sources) under the stress scenarios. The stress tests are to be performed at the legal entity level; the aggregated group does not perform the LST.
2.2 Time Horizons

The time horizons chosen by regulators are 30 days, 90 days, and 1 year, because, overall, insurance products are designed to be for the benefit of customers as risk protection over the long term and not designed to provide short term liquidity like other financial products. Historical experience in times of stress demonstrate slow policyholder reaction in short periods of time, as opposed to an event that occurs over months or years. Features designed to protect the long-term nature of the product for the policyholders ultimately reduce the likelihood of policyholder reaction to short-term volatility in markets. Therefore, evaluating shorter than 30-day time horizons has been deemed not warranted for the overarching macroprudential purpose of gauging liquidity risk in the Life insurance industry.

Policyholders do not “run” from an insurer in times of economic stress to the extent depositors do from a bank, because insurance is purchased to obtain the protection insurance provides, not as a source of liquidity or discretionary funds. In the United States, life insurance and annuities are purchased primarily for long-term financial protections upon death or retirement. Surrendering a life insurance contract to harvest its cash surrender value would leave the policyholder without death benefit protection that would be expensive or impossible to replace at a future date. Surrendering a variable annuity contract would lock in potentially temporary decreases in account value and could result in the loss of living benefit protection that becomes more valuable when market conditions depress account values below trigger points. Further, mitigating contract features such as surrender charges and the insurer’s right to delay the processing of withdrawals and surrenders for up to 30 days are common.

There are also non-contractual mitigating factors at play, such as potential negative tax consequences, that further reduce the short-term nature of liquidity risk for life insurers.

Simply put, policyholders are highly disincentivized to give up the likely irreplaceable protection for which they have already paid. The run-like mass surrender of insurance policies would require large numbers of policyholders to act against their self-interest.
From a holistic risk perspective, liquidity stress is traditionally experienced on the asset side. One short-term consequence of market turmoil could be a requirement to post collateral in connection with existing derivative contracts. However, even in this scenario, collateral is typically posted in the form of securities, so a demand for cash is not generated.

We do acknowledge liquidity risk does exist with respect to shorter time horizons and that many insurers do consider shorter time horizons (7-days for example) as part of their internal liquidity stress testing framework. This is viewed as a cash management/Treasury function impacting the daily operations of individual insurers, however, that would not affect the industry as a whole. Hence, these considerations are typically reviewed as part of individual/microprudential surveillance efforts in the U.S.

2.3 Insurer’s Internal Liquidity Stress Testing System

Insurers are to use their own internal liquidity stress testing system to perform the regulatory LST, adjusting for regulatory assumptions, metrics, etc., as specified in this document. For example, assessing materiality of stressed cash flows for inclusion in the liquidity uses and sources templates is per the insurer’s own internal methodology, but determining which legal entities are to perform the LST and report on those templates is specified in this document. Insurers should provide a narrative description of their internal liquidity stress testing system and processes, including for example their materiality thresholds for stressed cash flows and methodology for converting foreign currencies to US dollars (see Section 7. Reporting). The stress scenarios may vary from year-to-year and contain variations referred to as “What-if” scenarios. The following sections provide a further description of each of the key components of the framework.

Section 3. Legal Entities Required to Perform the LST for Insurers Meeting the Scope Criteria

The scope of entities included within an insurance group for the purposes of liquidity stress testing to assess the potential for large scale liquidation of assets (i.e., the legal entities within the group which should perform the LST), should include:
U.S. Life insurance legal entities, including reinsurers, regardless of corporate structure, so including captive (regulators specifically want all U.S. life insurance/reinsurance legal entities to perform the 2021 LST for informational purposes – future LST iterations may see a materiality consideration added);

- Non-guaranteed/market value separate accounts are not included in the 2021 LST. However, regulators may want to perform a separate account study in the future. The current thinking is that even though non-guaranteed/market value separate accounts may experience asset sales during stressed environments, those sales are at the policyholder’s discretion and do not generate liquidity stress for the insurer/group. As such they are deemed other market activity rather than insurance entity activity. Thus, for annuities that provide both non-guaranteed and guaranteed benefits, insurers should only include the cash flow impact of the guaranteed benefits.

- Non-U.S. life insurance/reinsurance legal entities should perform the 2021 LST if they pose material liquidity risks to the U.S. group (see below on non-U.S. legal entities).

- Where applicable, holding companies that could be a source or draw of liquidity to the life insurance legal entities; and

- Non-life insurance entities and non-insurance entities with material sources of liquidity, or that carry out material liquidity risk-bearing activities and could, directly or indirectly, pose material liquidity risk to the U.S. group. This materiality consideration should occur within the context of the specific stress scenario (and “what if” modification if applicable). The materiality criteria and initial list of legal entities in scope should be reviewed by the lead state regulator and modified by the insurer as needed based on regulator direction.

- Non-U.S. legal entities (including non-U.S. holding companies) are subject to this materiality consideration and should be subject to performing the LST if they pose material liquidity risk to the U.S. group.
• U.S. non-life insurers and reinsurers are not automatically exempted. If the U.S. non-life insurer poses material liquidity risk, per the stress scenario, to the U.S. group, then that legal entity insurer should perform the LST.

• Legal entity asset managers and mutual funds (both U.S. and non-U.S.) are excluded from performing the 2021 LST.

• However, those legal entities performing the LST (e.g., holding companies that could be a source or use of liquidity for the life insurers) must reflect any material stressed cash flows from/to the legal entity asset manager/mutual fund in their 2021 LST results (e.g., the liquidity sources and liquidity uses templates, as they do with any other type of legal entity that has material stressed cash flows from/to the legal entities performing the LST).

• If such material stressed cash flows from/to the legal entity asset manager/mutual fund exist, the regulators want specific disclosures on those in the results (either by adjusting the templates to include a line for these and/or in the narrative/explanatory disclosures submitted along with the templates).

• Examples of when such legal entity asset manager/mutual fund considerations and disclosures would need to be made for a specific stress scenario include:
  
  o If the holding company or another legal entity(ies) in the group is expected to fund a material liquidity shortfall of a mutual fund/asset manager (i.e., redemptions exceed the ability to sell assets), then the expected cash flows must be reflected (especially where there are established inter-affiliate support agreements);
  
  o If the holding company or another legal entity(ies) in the group is expected to provide capital to the mutual fund/asset manager or is expecting dividends from them, the material expected cash flows must be reflected; and
  
  o If the asset manager manages financial instruments under which it retains some risk, such as new European CLOs, or has contractual risk retention agreements for US CLOs, the required risk retention limit (5% for Europe)
must be reflected if sourced from the holding company or another legal entity(ies) in the group and considered material.

- Legal entity banks (both U.S. and non-U.S.) are excluded from performing the 2021 LST.
  - However, those legal entities performing the LST (e.g., holding companies that could be a source or use of liquidity for the life insurers) must reflect any material stressed cash flows from/to the legal entity bank in their 2021 LST results (e.g., the liquidity sources and liquidity uses templates, as they do with any other type of legal entity that has material stressed cash flows from/to the legal entities performing the LST).
  - If such material stressed cash flows from/to the legal entity bank exist, the regulators want specific disclosures on those in the results (either by adjusting the templates to include a line for these and/or in the explanatory disclosures submitted along with the templates).
  - Examples of when such legal entity bank considerations and disclosures would need to be made for a specific stress scenario include:
    - If the holding company or another legal entity(ies) in the group is expected to fund a material liquidity shortfall of a bank, then the expected cash flows must be reflected (especially where there are established inter-affiliate support agreements); and
    - If the holding company or another legal entity(ies) in the group is expected to provide capital to the bank or is expecting dividends from them, the material expected cash flows must be reflected.

For 2021, the legal entities identified in the bullets above, per a Company’s ORSA and/or other materiality criteria applied to the specific stress scenario, must be considered as material or identified as carrying out material liquidity risk bearing activities and hence subject to internal liquidity stress testing requirements. Although a legal entity in the group may not be required to perform the stress test due to materiality considerations or exemptions, those entities' material cash impacts on entities performing the stress test must be captured in the sources and uses
templates of the entities performing the LST. The insurer will need to disclose the materiality
criteria (agreed upon by the Lead State regulator) used in determining the legal entities subject
to the 2021 LST in the submission of its results. Based on the results of the 2020 initial LST exercise
and those of the 2021 LST, the Subgroup will determine if additional materiality criteria should
be developed to ensure better comparability amongst insurers.

Section 4. Cash Flow Approach – Liquidity Sources and Uses

The Liquidity Stress Testing Framework is anchored by a cash flow approach, utilizing companies’
actual cash flow projections of sources and uses of liquidity over various time horizons based
upon experience and expectations. This contrasts with a Balance Sheet Approach, which employs
static balance sheet amounts and generic assumptions about asset liquidity. While a Balance
Sheet Approach is easier to apply and provides calculation consistency (and thus the perception
of increased comparability), its ‘one-size fits all’ approach could result in a misleading assessment
of liquidity risk and fail to capture certain asset activities or product features under different
stress scenarios and time horizons. The cash flow approach is deemed more dynamic and hence
to capture liquidity risk impacts more precisely.

The insurer should produce cash flow projections for sources of liquidity and uses of liquidity that
cover: operating items, investments and derivatives, capital items, and funding arrangements.
(See Liquidity Sources and Uses templates in Section 7). To clarify an issue regarding funding
arrangements, the projected cash flows for liquidity sources and uses should include already
existing funding arrangements such as FHLB draws outstanding in the current time period. Also,
specific to the holding company, these projected cash flows for liquidity sources and uses should
include material non-U.S. impacts as well.

The insurer will produce these liquidity sources and uses cash flow projections in a baseline,
normal course of business scenario, for each time horizon. The insurer will also produce these
cash flows for each time horizon for a specific number of required stress scenarios (for 2021 there
are 2 stress scenarios and also an insurer-specific worst-case scenario).
4.1 Baseline Assumptions for Cash Flows

Baseline (pre-stress) cash flows are the insurer-specific cash flows from normal expected operations. Insurers should prepare cash flow projections under normal operating conditions and report the net cash flows (projected liquidity sources less uses) for each time horizon. These cash flow projections should be consistent with those used for internal baseline liquidity forecasts, such as those used for financial planning and analysis (FP&A), risk management, etc. A positive net cash flow is presumed in the baseline cash flows since companies are usually not expected to be operating in a net cash flow deficiency state.

Section 5. Stress Scenarios and their Assumptions

For year-end 2021 there are two regulatory liquidity stress scenarios: an adverse liquidity stress scenario for insurers, and an interest rate spike scenario. There is also an insurer-specific information request for each group’s own most adverse liquidity stress scenario(s). The adverse liquidity stress scenario contains a regulator provided narrative, regulator-prescribed assumptions, and company-specific assumptions. The interest rate spike scenario allows all other narrative description components and key metrics (including how much interest rates spike) to be provided by each company. The insurer-specific information request contains a company provided narrative and a description of key company metrics. The regulator provided narrative will be a qualitative description of the specified stress scenario to highlight the particular risks and sensitivities associated with that stress scenario. The regulator prescribed assumptions are specific parameters insurers should incorporate into their process for a particular stress scenario. Company-specific assumptions should be consistent with the information provided in the regulator provided narrative and regulator prescribed assumptions, and represent the detailed assumptions needed for a specific company’s liquidity stress testing process. Examples of where companies should provide their assumptions include: debt issuance, lapse sensitivity, new business sensitivity and mortality sensitivity. Regulators expect insurers to utilize policyholder behavior assumptions (e.g., surrenders and policy loan withdrawals, existence of new sales activity) as well as the insurer’s response (e.g., assuming delays in payment of policyholder...
benefits), consistent with the severity of the stress, and to provide very thorough explanatory information. All key business activities and product-type impacts to liquidity should be considered by the companies.

If the insurer’s internal model does not utilize a specific economic and/or company-specific assumption included in this document, the internal model does not need to be modified to incorporate it. However, if the insurer’s internal model does utilize a specific economic and/or company-specific assumption included in this document, the insurer should use the approach outlined below to calculate the value for that assumption. (This emphasizes the macro surveillance benefit of the 2021 LST, allowing for a level of consistency of assumptions across the industry. As discussed previously, this is not meant to specify assumptions used by the insurers in their own internal liquidity stress testing work.) If there is no specific value included in the 2021 LST Framework and instead there is an illustrative value or suggested guidance, the company should use a value consistent with the illustrative value or suggested guidance. For example, guidance is given below on using Moody’s values for migration, default, and recoveries. However, insurers may use S&P data or other appropriate data sources.

5.1 Adverse Liquidity Stress Scenario for Insurers

5.1.1 Narrative

Insurers are required to apply an adverse liquidity stress scenario as one of the two stress scenarios. The following is a summary of market conditions in the adverse scenario extracted from the Federal Reserve Board’s 2017 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule.

The adverse scenario is characterized by weakening economic activity across all economies included in the scenario. This economic downturn is accompanied by a global aversion to long-term fixed-income assets that, despite lower short-term rates, brings about a near-term rise in long-term rates and steepening yield curves in the United States and the four countries/country blocks in the scenario.
The economic indicator levels described below provide the backdrop for the economic climate insurers should assume in the adverse scenario. The actual levels insurers should use in the adverse scenario are provided in Annex 2.

- **Macroeconomic**
  - Real GDP falls slightly more than 2 percent from the pre-recession peak in the fourth quarter of 2016 to the recession trough in the first quarter of 2018
  - *Unemployment rate increases.*
  - *Headline CPI falls and then rises over the scenario period.*

- **Interest Rates and Credit Spreads**
  - *Short-term Treasury rates fall and remain near zero throughout the stress.*
  - *10-year Treasury yields rise.*
  - *Investment Grade (IG) corporate credit spreads widen.*

- **Asset Valuations**
  - *Equity prices decline by roughly 40%.*
  - *The Volatility Index (VIX) peaks at approximately 35.*
  - *Housing prices and commercial real estate prices decline through 8 quarters.*

- **Description of International Market Conditions**
  - *Recessions and slowdowns in growth are experienced in the Euro area, United Kingdom, Japan, and developing Asia economies.*
  - *All foreign economies experience a decline in consumer prices.*
  - *U.S. Dollar appreciates against the Euro, British Pound, and developing Asia currencies.*
  - *U.S. Dollar depreciates modestly against the Japanese Yen, driven by flight-to-safety capital flow.*

**5.1.2 Regulator-Prescribed Assumptions**

Insurers should utilize the values for the economic indicators from the Federal Reserve Board’s annual Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress
Testing Rules and the Capital Plan Rule as the basis for scenario assumptions, Table A.1 Historical data and Table A.5 (Annex 2i, A) Supervisory adverse scenario. Insurers should use the version published in February 2017 (refer to the tables in Annex 2i). Specifically, insurers should run the adverse liquidity stress scenario using the deltas for the Treasury curve, Corporate spreads, GDP, Unemployment, U.S. Inflation (CPI), Housing Price Index (HPI), S&P 500 index (SPX SPOT), Commercial Real Estate Index (CREI) and VIX index. Theses economic variables should be used to the extent these variables are included in an insurer’s internal liquidity stress test process or models.

Insurers should apply the same change in economic variables experienced between Q4 2016 Table A.1 and the stress scenarios in Table A.5 to current economic variable levels (Annex 2i, D). Insurers should use the tables in Annex 2i for an illustrative example of how the deltas from the 2017 Fed’s CCAR are applied to the current reference quarter (Q4 2020) for the 2020 LST (Annex 2i, B). For example, insurers should use 2021 (or most recent year-end) 10 Yr. Treasury rates and apply the same percentage or absolute b.p. change shown from Q4 2016 to the 2017 Table A.5 amounts in their 2021 LST stress scenarios. Table C (Annex 2i, C) shows the 2017 deltas applied to 2021 year-end levels on an absolute and percentage basis for 3 month and 1-year horizons for ease of use. The deltas to apply are provided for the 30-day, 90-day and 1-year horizons. Note, the tables also include structured spread assumptions described below in section 5.1.4. The tables are included in Annex 2i of this document.

In addition, other market indicators are necessary for insurers to apply to stressed cash flows and to assess the impact on expected asset sales. These are as follows (with details to be found in Annex 2):

- Market Capacity Assumption
- Structured Spreads over Treasuries
- SWAP Spreads
- Swaption Volatility
- Credit Assumptions: Moody’s Transition Matrix/Migration Rates
Credit Assumptions: Moody’s Default Table
Credit Assumptions: Moody’s Recovery Rate Table

5.1.3 Market Capacity Assumption

The following is suggested guidance to determine market constraints on asset categories to be sold in times of stress. It represents standards followed by many insurers to estimate assets sales by stress scenario, asset category and time horizon that can be sold without meaningfully impacting the entire market by widening bid-offer spreads. We recognize each company has its own individual methodology for determining potential asset sales under stress, and we request a written narrative be provided as to how they make their determination.

Once an asset class has been identified as available to be sold to satisfy a cash deficiency from cash flow stress testing, the insurer should calculate its percentage of the total amount issued and outstanding. Next the insurer should obtain average daily trading volumes (ADTV) and make an assumption for the haircut amount to apply to that volume to reflect stressed conditions (the “haircut ADTV”). Next, the insurer would apply its calculated percentage of total outstanding owned to the haircut ADTV, and the result would be divided by the number of days in the stress testing time horizon to arrive at a daily amount that can be sold. This daily amount able to be sold would be multiplied by the number of days in the prescribed time horizon: 30 days for the 30-day horizon, 60 days for the 90-day horizon (31-90 days) and 274 days for the 1-year horizon (91-365 days). An illustrative example best explains the above-described process.

Illustrative example (also included in Appendix 2ii):

Step 1: Estimate Unconstrained Sales Per Day

Insurer A has a $100 billion portfolio of investment-grade corporate bonds, priced at par. Insurer A estimates that it holds approximately 5% of outstanding corporate bonds. In the adverse liquidity stress scenario, Insurer A’s unconstrained liquidity stress testing model assumes that it can sell:
<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>% Able to Be Sold</th>
<th>Sale Price</th>
<th>Total Sale</th>
<th>Sales / Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>10%</td>
<td>97</td>
<td>$9.7 B</td>
<td>$440 M</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>20%</td>
<td>94</td>
<td>$18.8 B</td>
<td>$430 M</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>50%</td>
<td>90</td>
<td>$45.0 B</td>
<td>$230 M</td>
</tr>
</tbody>
</table>

**Step 2: Add Market Capacity Constraint**

Assume the average daily trading volume in the secondary market for investment grade corporate bonds has been $13.0 Billion over the past year. Insurer A estimates that trading volumes would decline by 40% in the adverse liquidity stress scenario to $8.0 B per day. Since Insurer A is 5% of the market, Insurer A can only trade $400 M per day ($8B x 5%) without paying a significant illiquidity premium and impacting the overall market.

Insurer A then repeats this process for every asset class in its investment portfolio.

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>Unconstrained Sales / Day</th>
<th>Market Capacity Assumption</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>$440 M</td>
<td>$400 M</td>
<td>($40 M)</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>$430 M</td>
<td>$400 M</td>
<td>($30 M)</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>$230 M</td>
<td>$400 M</td>
<td>$0</td>
</tr>
</tbody>
</table>

### 5.1.4 Structured Spreads Over Treasuries

Insurers should use Annex 2i and 2iii to assist in determining cash flows, asset values and the quantity of assets to be sold in stressed markets. For baseline values, the industry shall submit year-end spreads to the regulators shortly after year-end. The regulators will review and approve the values for use in the table for liquidity stress testing purposes. Structured spread data was derived from the JPMorgan ABS Weekly Asset Spread Datasheet. The spreads were scaled to a stressed economic environment consistent with an adverse scenario as described by the Fed, described above and adopted for this stress testing. For the 2020 LST, economic conditions experienced in March of 2020 were deemed consistent with an adverse scenario. Therefore, structured spreads from March 2020 were used as the basis for the stressed spreads assumptions for insurers to use in their stress testing scenario for the 30-day, 90-day and 1-year horizons.
Note, to calculate structured spreads for CLO/CDO 5.5-7 year and ABS Auto3 year, it was necessary to construct a Treasury yield curve with 3-year and 7-year points. These points were calculated using a straight-line linear interpolation method. For the 2021 LST, the same March 2020 structured spreads were deemed appropriate for use.

Regulators ask industry members to agree on one set of structured spread values amongst themselves to submit for approval, not each insurer submitting values that each need to be approved. Regulators and/or the NAIC need to do a reasonableness check of current baseline/market levels of spreads insurers use before applying the stressed amounts in the JPMorgan spreadsheet. For example, if current spreads are already greater than the JPMorgan stressed spread amounts, regulators may have to consider alternatives or additional stressed levels. One agreed upon set of values will help provide uniformity, consistency, and comparability of stress testing results across insurers.

When utilizing these spreads, insurers should assume the percentage increase in spreads experienced in March 2020 from the JPMorgan ABS Weekly Asset Spread Datasheet; and apply the absolute increase to the agreed upon December 31 baseline spreads. These tables are provided in Annex 2iii, A & B.

Since the reasonableness check is merely a check of current market rates, it is not anticipated that it will be burdensome for insurers to provide an agreed upon set of December 31 baseline values to regulators by January 31 of each year or for the regulators to be able to respond by February 28 of every year to allow insurers sufficient time to incorporate into their stress testing framework. Baseline amounts are included in Annex 2iii, B.

For the 2021 LST – Industry agreed upon values are to be established as Lead State guidance after the 2021 LST Framework has been adopted. Industry plans to develop an alternative process for future LST iterations which will allow NAIC staff to establish the values to include in these appendices.
5.1.5 SWAP Spreads

Stressed spread levels may impact assets prices for expected sales calculations necessary for the stress scenarios. Insurers should complete the SWAP Spread table in Annex 2iv to document assumptions used in determining asset values and the quantity of assets to be sold in stressed markets. SWAP spread source data is no longer provided in the Federal Reserve’s H.15 FRED data. Use of Bloomberg Swap Spreads is preferred – if options exist within Bloomberg, identify which option was used. If a different source from Bloomberg is used, then identify the source and option.

5.1.6 Swaption Volatility

Insurers should use the table in Annex 2v to assist in determining asset values and the quantity of assets to be sold in stressed markets. Insurers should obtain the information to populate the table using Bloomberg’s Swaption Volatility for various time horizons and expiry. For consistency, insurers should use the table found on Bloomberg at NSV [Go].

5.1.7 Moody’s Transition Matrix/Migration Rates

Insurers should use the table in Annex 2vi to assist in determining corporate credit migrations, asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 39 - Average one-year alphanumeric rating migration rates, 1983-2019. If available, insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds and the appropriate Moody’s tables for structured /asset-backed securities. Alternative sources may be used but should be disclosed as well as the rationale for their use.

5.1.8 Moody’s Default Table

Insurers should use the table in Annex 2vii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 45 - Average cumulative issuer-weighted global default rates by letter rating, 1983-2019. Insurers should use the equivalent Moody’s tables for U.S. Public...
Finance for municipal bonds and the appropriate Moody’s tables for structured /asset-backed securities. Alternative sources may be used but should be disclosed as well as the rationale for their use.

5.1.9 Moody’s Recovery Rate Table

Insurers should use the table in Annex 2viii to assist in determining asset values and the quantity of assets to be sold in stressed markets. The table is imported from Moody’s Corporate-Global: Annual default study, Exhibit 8 - Average corporate debt recovery rates measured by ultimate recoveries, 1987-2019. Insurers should use the equivalent Moody’s tables for U.S. Public Finance for municipal bonds and the appropriate Moody’s tables for structured /asset-backed securities. Alternative sources may be used but should be disclosed as well as the rationale for their use.

If relevant for a given insurer, the adverse liquidity stress scenario for insurers can be run considering sources other than expected asset sales (e.g., FHLB credit line draws, bank lines of credit and holding company contributions). Should that be the case, the insurer must clearly identify the sources other than asset sales utilized to meet expected liquidity deficiencies.

5.1.10 “What If” Modification

The “What if” modification to the adverse liquidity stress scenario removes the ability for insurers to use extraordinary internal and external funding sources to satisfy any liquidity deficiency under stress, i.e., no actions taken in response to the stress (as opposed to ongoing operational funding agreements included in the insurer’s baseline templates) or in response to a liquidity deficiency. Intragroup “keep well” agreements would be considered extraordinary transactions. Thus, expected asset sales will be the primary source of meeting any liquidity deficiency for the “What if” scenario. Any existing funding such as commercial paper will not be assumed to roll, nor will FHLB facilities ability to roll upon maturity.

5.1.11 Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above adverse liquidity stress scenario for insurers. Company specific assumptions should be consistent with the above scenario as narrative and regulator prescribed assumptions. Examples include the
inability to roll or issue new debt, potential increases in lapse rates, new business sensitivity, mortality experience and policyholder behavior (e.g., surrenders and policy loans).

5.2 Interest Rate Spike Scenario

5.2.1 Narrative

Insurers should run an interest rate spike stress test that resembles the late 70’s/early 80’s inflationary period as it most closely mirrors the regulatory desired interest rate spike scenario. Historical data from the late 70’s/early 80’s show the following economic conditions:

- Inflationary forces caused interest rates to rise quickly.
- Investors rotated out of fixed income and into equities, real estate, and commodities.
- Central bank responded by tightening monetary policy in tandem, eventually causing the yield curve to invert.

Insurers should provide a detailed narrative outlining their scenario and assumptions around general economic conditions bulleted above and specific assumptions for economic variables for each time horizon. The economic variables in the table below and the amount of expected movement in each variable should be fully described in the narrative to the extent are used in a company’s internal model. The table outlines the directional movement of the relevant economic indicators. Insurers should specify the amount of movement for each variable they consider to be part of the scenario for a severe interest rate spike. For example, insurers may indicate a parallel shift in Treasury rates up 100bps in the first 30 days, up 200bps in 90 days and 300bps over 12 months. The table is a guide and not to be interpreted as a strict template and may be supplemented or customized by the insurer. Narrative/Explanatory disclosures should explain these assumptions.

5.2.2 Regulator-Prescribed Assumptions

Regulators did not adopt any regulator-prescribed assumption values for this stress scenario. Instead, they provided the below regulator guidance for insurers to use when establishing their own company specific assumptions for this stress scenario.
<table>
<thead>
<tr>
<th>Economic Variable</th>
<th>Expected Movement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasury rates</td>
<td>Increase rapidly</td>
<td>Critical factors for modeling impacts to asset prices, collateral flows, and product cash flows</td>
</tr>
<tr>
<td>Equity prices</td>
<td>Increase rapidly</td>
<td></td>
</tr>
<tr>
<td>Credit spreads</td>
<td>Increase moderately</td>
<td></td>
</tr>
<tr>
<td>Inflation rates</td>
<td>Increase rapidly</td>
<td>These factors help define the macroeconomic conditions of the scenario</td>
</tr>
<tr>
<td>Real GDP growth</td>
<td>Flat</td>
<td>These factors help define the macroeconomic conditions of the scenario</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>Flat</td>
<td></td>
</tr>
<tr>
<td>Real estate prices</td>
<td>Increase</td>
<td></td>
</tr>
<tr>
<td>Swap spreads</td>
<td>Increase</td>
<td>Impact derivative collateral requirements</td>
</tr>
<tr>
<td>FX rates</td>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>Implied volatility</td>
<td>Increase</td>
<td></td>
</tr>
<tr>
<td>Credit assumptions</td>
<td>Unclear</td>
<td>May not be an important assumption to define for the scenario</td>
</tr>
<tr>
<td>(transition, default, recovery rates)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2.3 Company-Specific Assumptions

Insurers must construct the assumptions needed for their internal models to run the above stress scenario. Companies are encouraged to provide more information beyond these guidelines as they feel is appropriate to help regulators understand their assumptions for the scenario. Company specific assumptions should be consistent with the stress scenario’s narrative and regulator prescribed assumptions.

5.3 Insurer Specific Information Request - Worst-Case Scenario

5.3.1 Narrative

This information request requires insurers to provide a detailed narrative of their most severe liquidity stress scenario(s) to obtain greater insight to the drivers of liquidity risk for specific insurers. The most severe scenario should be one that results in the largest liquidity deficiency (liquidity sources less uses) from their existing internal liquidity stress testing process. The
scenario should be focused on the insurer's internal model scenario with the worst-case outcome for the group. Regulators may use this information to inform future prescribed stress scenarios.

Insurers should provide a comprehensive narrative describing the stress scenario(s) and the economic environment(s). This stress scenario(s) could be a combination of multiple stressors.

Section 6. Available and Expected Asset Sales

Once the stressed sources and uses of liquidity have been established, and the net cash flows calculated, insurers then project the assets available at the end of the time horizon by asset category (please refer to the asset categories in the Assets Template in Section 7). The valuation of available assets for the baseline scenario utilizes current and projected asset values for a normal operating environment. The valuation of available assets for a stress scenario will be based upon fair value haircuts per the specific stress scenario narrative, its regulatory prescribed assumptions, and/or the company assumptions based on the narrative and regulatory prescribed assumptions (e.g., fair market value haircuts and capacity indicators). Note: Any securities pledged as part of institutional funding agreements (e.g., FHLB) should be excluded and considered encumbered. However, any pre-pledged assets that are not securing credit that has been extended and remains outstanding (i.e., excess) should be considered unencumbered.

To the extent that stressed cash inflows are insufficient to meet the anticipated cash outflows, the insurer must provide for cash flows to meet the deficiency. Unless a stress scenario (or "What-if" modification of a stress scenario) indicates otherwise, the insurer can utilize internal and external funding sources (e.g., FHLB new draws) as well as asset sales to satisfy a liquidity deficiency. Any expected asset sales must be reported in the appropriate column(s) of the template. Insurers decide which categories of available assets to sell, as well as the quantity to sell. (Please refer to the Assets Template in Section 7.)

Asset sales will appear in two different places - 1) within the liquidity sources template for expected/planned activity during the time horizon (pre-liquidity deficiency calculation), and 2) in the assets template for any amount of asset sales used to meet a liquidity deficiency (Liquidity Sources less Liquidity Uses). If an insurer has no liquidity deficiency, then there are no asset sales.
needed in the Assets Template (though available assets still apply). Similarly, if cash on hand was sufficient to meet the liquidity deficiency and the insurer chose to utilize that cash, then no asset sales would be reported in the Assets template.

The expected asset sales amounts calculated based on the insurer’s own models should also be subjected to portfolio manager and/or Chief Investment Officer (CIO) feedback. This feedback may take the form of “topside” adjustments to the expected asset sales. Regulators expect robust disclosures around the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales. The intent is for these asset sales to most accurately represent what actions the insurer could reasonably take in the given scenario, market conditions, and the company’s anticipated investment policy and/or strategy.

Section 7. Reporting

Insurers should submit data in the reporting template for liquidity sources, liquidity uses, and assets (available assets and expected asset sales) in US dollars. These templates utilize categories for 30-day, 90-day and 1-year time horizons. The assets template further illustrates available assets and final expected asset sales by asset sub-category to cover any liquidity deficiency (negative amounts of net liquidity sources less liquidity uses over the prescribed time horizons). Use of these consistent sub-categories of assets is critical for allowing the Task Force to aggregate the asset sales results.
Liquidity Sources and Liquidity Uses Templates:
A liquidity sources report and a liquidity uses report should be generated for each legal entity within the group that was subjected to liquidity stress testing, using the NAIC templates. These legal entity amounts should also be aggregated into a group liquidity sources report and a group liquidity uses report for submission (the LST is not performed at the group level; rather it is performed at the legal entity level and those results are aggregated to present a group level report).

- For the Baseline, the Adverse Liquidity stress scenario, and the Interest Rate Spike stress scenario, Liquidity Sources and Liquidity Uses templates at both the individual entity level and the aggregated group level are to be submitted.
- For the insurer’s own “Worst Case” scenario, only the group level Liquidity Sources and Liquidity Uses templates are required to be submitted, not the legal entity templates.
- For the “What If” Variation of the Adverse Liquidity stress scenario, a group level Liquidity Sources template and/or a group level Liquidity Uses template is only required if there is a material difference from the Adverse Liquidity stress scenario’s group level Liquidity Sources and Liquidity Uses templates.

Assets Template:
As with the Liquidity Uses and Liquidity Sources templates, the Assets template is to be generated for each legal entity performing the LST. For the 2021 LST, the insurer may submit the assets template at the group level only, without submission of the legal entity asset sales templates.

- A group level assets template is required for the Baseline and all stress scenarios, including the insurer’s own “Worst Case” scenario and the “What If” variation of the Adverse Liquidity stress scenario.

Modification of Templates:
Insurers are allowed to add lines to the templates to provide more detailed breakdown of existing categories (e.g., for cash flows to/from legal entity asset manager/mutual funds as well as banks), but deletions of existing lines/categories are highly discouraged.
Submission Deadline:

The reporting templates and many other narrative disclosures referenced in this document are to be submitted to the Lead State by June 30, 2022.

Section 8. Templates

8.1 Liquidity Sources Template

Note 1: Certain flows could be settled in securities (e.g., margins on derivatives, capital contributions/dividends, etc.). See the more specific Security Collateral guidance within the Excel templates.

Note 2: Asset Sales (pending settlement) should include trades executed prior to the reporting date with a known settlement date after the reporting date (for example 12/30 trade date and 01/03 settle date).

Note 3: Asset Commitments should include anticipated cash flows related to settlement of a future obligation to a counterparty to the extent, and in the amount, appropriate for the specific stress scenario and economic assumptions. Examples could include capital calls for alternative investments, mortgage loanings, etc., and should include each company’s best estimate as to what they would expect to fund under each scenario. If these commitments have been explicitly prefunded/collateralized by highly liquid assets, asset commitments should be reported on a net basis, including proceeds from the sale of the highly liquid assets in an amount consistent with the specific stress scenario and economic assumptions. This line item may include some percentage amount of commitments to fund private placement revolvers consistent with the specific stress scenario and economic assumptions, but revolvers and lines of credit themselves should be captured in the credit facilities line in the Sources Funding section.
## 8.2 Liquidity Uses Template

<table>
<thead>
<tr>
<th>Cash Flow</th>
<th>CF Type</th>
<th>CF Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varies</td>
<td>Operating</td>
<td>Non-Executor Benefits / Claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administrative Expenses - Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expenses - Interscompny Settlements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insurance Product Commitments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tax Payments (Outflows)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Flows</td>
</tr>
<tr>
<td></td>
<td>Investment and Derivatives</td>
<td>Asset Commitments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Initial and Variation Margin Paid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Collateral Pledged</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asset Purchase (Pending Settlement)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Flows</td>
</tr>
<tr>
<td></td>
<td>Capital</td>
<td>Shareholder/Policyholder Dividends</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capital Contributions to Subsidiaries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dividends to Parent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Flows</td>
</tr>
<tr>
<td></td>
<td>Funding</td>
<td>Debt Maturities / Debt Servicing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GIC Benefits / Maturities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FHLB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repo / Securities Lending</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intercompany Loans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Flows</td>
</tr>
<tr>
<td></td>
<td>Total Uses</td>
<td></td>
</tr>
</tbody>
</table>

### Group Summary

<table>
<thead>
<tr>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Legal Entity 1

<table>
<thead>
<tr>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note 1:** Certain flows could be settled in securities (e.g., margins on derivatives, capital contributions/dividends, etc.). See the more specific Security Collateral guidance within the Excel templates.

**Note 2:** Asset Purchases (pending settlement) should include trades executed prior to the reporting date with a known settlement date after the reporting date (for example 12/30 trade date and 01/03 settle date).

**Note 3:** Asset Commitments should include anticipated cash flows related to settlement of a future obligation to a counterparty to the extent, and in the amount, appropriate for the specific stress scenario and economic assumptions. Examples could include capital calls for alternative investments, mortgage loan fundings, etc., and should include each company’s best estimate as to what they would expect to fund under each scenario. If these commitments have been explicitly prefunded/collateralized by highly liquid assets, asset commitments should be reported on a net basis, including proceeds from the sale of the highly liquid assets in an amount consistent with the specific stress scenario and economic assumptions. This line item may include some percentage amount of commitments to fund private placement revolvers consistent with the specific stress scenario and economic assumptions, but revolvers and lines of credit themselves should be captured in the credit facilities line in the Sources Funding section.
# 8.3 Assets Template

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>Asset Sub-Category</th>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>Cash &amp; Cash Equivalents</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Government Securities</strong></td>
<td>Treasury &amp; Agency Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other IG Sovereigns &amp; Regional Government</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG Sovereigns &amp; Regional Government</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Agency CMO</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Agency MBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Agency CMBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Agency ABS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Public Bonds</strong></td>
<td>IG Public Corporate Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG Municipal Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG Public Corporate Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG Municipal Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Private Bonds</strong></td>
<td>IG Private Placement Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG 144As</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG Private Placement Bonds</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG 144As</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Non-Agency Structured Debt</strong></td>
<td>IG CMO</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG MBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG CMBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG ABS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>IG CLO</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG CMO</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG MBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG CMBS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG ABS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Below IG CLO</td>
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<tr>
<td><strong>Equity</strong></td>
<td>Common Stock</td>
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<tr>
<td></td>
<td>Preferred Stock</td>
<td>-</td>
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<tr>
<td></td>
<td>Other Equity and Alternative Investments</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Other</strong></td>
<td>Commercial, Residential, Agricultural, Bank and Other Loans</td>
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</tr>
<tr>
<td></td>
<td>Net Security Collateral Posted</td>
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<td>-</td>
<td>-</td>
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<tr>
<td></td>
<td>Other</td>
<td>-</td>
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<tr>
<td><strong>Total Invested Assets Available for Sale</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
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</tbody>
</table>

## Scenario

**Summary**

<table>
<thead>
<tr>
<th>As of Date</th>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
</table>

**Group Summary**

<table>
<thead>
<tr>
<th>Total Sources (before Asset Sales)</th>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Uses</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net Sources &amp; Uses (Deficit before Asset Sales)</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Invested Assets Available for Sale</th>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash applied to deficit</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deficit Sub-total</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Assets Sold</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deficit satisfied if zero or greater</td>
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<td>-</td>
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## Legal Entity 1

<table>
<thead>
<tr>
<th>1 Month</th>
<th>3 Month</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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Note 1: Insurers will enter “Illiquid” in a data field for any asset category deemed such within a specific time horizon. (Regulators can then follow up with questions later if there are concerns, etc.)

Note 2: Any securities pledged as part of institutional funding agreements (e.g., FHLB) should be excluded and considered encumbered. However, any pre-pledged assets that are not securing credit that has been extended and remains outstanding (i.e., excess) should be considered unencumbered.

Note 3: Reminder that regulators want robust disclosures regarding the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales. Might need to supplement the template comments with additional narrative disclosures.

Note 4: Excluding the “What If” variation, insurers are to provide disclosures indicating when affiliated amounts are provided to assist a legal entity in addressing a liquidity deficiency.
Narrative/Explanatory Disclosures noted in the 2021 LST

Narrative/explanatory disclosures are expected to be in English.

- Insurers should provide a narrative description of their internal liquidity stress testing system and processes, including for example their materiality thresholds for stressed cash flows and methodology for converting foreign currencies to US dollars.
- Specific disclosures on material stressed cash flows to/from legal entity banks/asset managers/mutual funds if needed.
- Company-specific narrative on assumptions and metrics used for the adverse liquidity stress scenario for insurers, for example the inability to roll or issue new debt, potential increases in lapse rates, new business sensitivity, mortality experience and policyholder behavior (e.g., surrenders and policy loans).
- Company-specific narrative on the interest rate shock scenario, assumptions around general economic conditions bulleted in 5.2.1 Narrative, and specific metrics for economic variables for each time horizon. The economic variables in the table in 5.2.2 Regulator-Prescribed Assumptions should be fully described in the narrative, to the extent they are use in the company’s internal model.
- Insurers should provide a comprehensive narrative describing their worst-case liquidity stress scenario(s) and the economic environment(s), including assumptions, key metrics and results.
- Written narrative on the insurer’s own individual methodology for determining asset sales under stress.
- Robust disclosures regarding the chief investment officer’s (or equivalent title or designee) assumptions and decisions on expected asset sales, if needed.
- Excluding the “What If” variation, disclosures to identify when affiliated amounts are contributed to assist a legal entity in addressing a liquidity deficiency.
- Disclose when a regulatory prescribed variable is not used for the LST because it is not used in the internal liquidity stress testing process or models.
[End of 2021 Liquidity Stress Testing Framework – to be included as an appendix in the NAIC Financial Analysis Handbook]

**Data Aggregation**

Given the NAIC’s primary focus is on macroprudential impacts of a liquidity stress impacting the life insurance sector, the NAIC will aggregate final expected asset sales data across the insurance groups subject to the liquidity stress test. The aggregation will be done by asset category. The NAIC aims to compare the aggregated results against various benchmarks, potentially including normal and/or stressed trading volumes and asset values for various asset classes, to determine the impact such sales may have on the capital markets in times of stress. Findings from this analysis may also inform expected asset sale assumptions utilized in future runs of the liquidity stress test.

As part of its macroprudential surveillance, the insurance regulators and/or NAIC may reach out to other regulatory agencies to discuss aggregate results that may impact other regulated industries such as banks, securities brokers, and asset managers. Insurance regulators may also coordinate with other agencies to identify appropriate and perhaps coordinated action they may take to prevent or minimize the effect large asset sales may have on the financial markets and overall economy.

**Regulatory Authority**

For the 2020 liquidity stress test, lead state regulators utilized their examination authority to collect the reporting results from insurers and to keep the data confidential. A long-term solution was developed at the Financial Stability (EX) Task Force in coordination with addressing similar issues related to the Group Capital Calculation project, resulting in revisions to Model #440. However, it will take several years for states to adopt these revisions. As a result, regulators will utilize their examination authority for the 2021 LST as well.
Confidentiality

For the 2020 liquidity stress test, lead state regulators utilized their examination authority to collect the reporting results from insurers identified by the scope criteria. Existing protocols for collecting confidential/sensitive data for each state and insurer were utilized. A long-term solution was developed at the Financial Stability (EX) Task Force in coordination with addressing similar issues related to the Group Capital Calculation project, resulting in revisions to Model #440. However, it will take several years for states to adopt these revisions. As a result, regulators will utilize their examination authority for the 2021 LST as well.

Timeline

- January 2022 – Incorporate all appropriate Lead State Guidance into the 2020 LST Framework document as the starting place for the 2021 LST Framework and begin work on changes specific to the 2021 LST.
- Regulators agreed to make no substantive changes for the 2021 LST Framework, including the Scope Criteria. Minor template revisions and clarity improvements to the 2021 LST Framework document need to be finalized early in 2022 to allow insurers adequate time to generate the 2021 LST filings in time for the June 30, 2022, filing deadline; ideally by the end of January 2022.
- Any additional revisions necessary after adoption by the Financial Stability (E) Task Force, such as updates to Annex 2 for 2021 values, will be implemented as Lead State Guidance.
**Annex 1: Original Scope Criteria with Annual Statement References**

The Subgroup proposes to include in the scope of the Liquidity Stress Testing Framework any insurer/group that exceeds the following thresholds for any of the noted activities (or account balance as a proxy for that activity). The thresholds have been established taking into consideration both the account balance of the insurer/group to the total balance for the life insurance sector, as well as the aggregate account balance of insurers/groups within scope to the aggregate account balance for the life insurance sector.

<table>
<thead>
<tr>
<th>Account Balances</th>
<th>Threshold in $B “greater than”</th>
<th>Reference to 2017 NAIC life/accident and health (A&amp;H) annual financial statement blank</th>
</tr>
</thead>
</table>
| Fixed and Indexed Annuities              | 25                            | Analysis of Increase in Annuity Reserves  
  Page: Supplement 62  
  Line: Reserves December 31, current year (15)  
  Column: Sum of Individual Fixed Annuities, Individual Indexed Annuities,  
  Group Fixed Annuities, and Group Indexed Annuities |
| Funding Agreements and GICs             | 10                            | Deposit-Type Contracts  
  Page: Exhibit 7 – Deposit-Type Contracts  
  Line: 9  
  Column: Guaranteed Investment Contracts (Column 2)  
  +  
  Column: Premium and Other Deposit Funds (Column 6) IF the amount of FHLB  
  Funding Reserves from Note 11.B(4)(b) suggests funding agreements are not  
  reported in Column 2 of Exhibit 7  
  +  
  Synthetic GICS  
  Page: Exhibit 5 – Interrogatories  
  Line: 7.1 |
| Derivatives–Notional Value (absolute value) | 75                            | Derivatives – Notional Value (absolute value)  
  Pages: Schedule DB, Part A; Schedule DB, Part B, Section 1  
  Column: Notional Value (sum all) |
| Securities Lending                      | 2                             | Securities Lending Collateral Assets  
  Pages: Schedule DL, Part 1; Schedule DL, Part 2  
  Line: Total (9999999)  
  Column: Fair Value |
| Repurchase Agreements                   | 1                             | Repurchase Agreements  
  Page: Notes to Financial Statement Investments Restricted Assets  
  Line: Sum of 05L1C, 05L1D, 05L1E, 05L1F  
  Column: Total (General Account Plus Separate Account) |
In performing the addition of the FHLB funding agreement amount to the GICs amount, NAIC staff discovered that the reporting of FHLB funding agreements is not consistent in Exhibit 7, Deposit-Type Contracts. The source of the FHLB amount is Note 11.B(4)(b):

Line: Funding agreements, current year, amount as of the reporting date, borrowing from FHLB, collateral pledged to FHLB
Column: Funding Agreement Reserves Established

For some insurers, we were able to match amounts from the FHLB funding agreement footnote to the exact same amount in Exhibit 7, either Column 2 (GICs) or Column 6 (Premiums and Other Deposit Funds). For those insurers where the FHLB amount matched Exhibit 7, Column 2, we did not add the FHLB funding agreement amount to the GICs amount, because that would be double-counting the FHLB funding agreements. For other insurers, even though the amounts did not match exactly, we were able to assume the FHLB funding agreements were reported in either Column 2 or Column 6 (e.g., the amount in Exhibit 7, Column 2 was zero or much smaller than the FHLB note, while the Column 6 amount was larger). However, for several insurers, we were not able to make an informed assumption (e.g., both Column 2 and Column 6 amounts were larger than the FHLB funding agreement amount). To be conservative in these instances, we added the FHLB funding agreement amount to the GICs amount. Overall, for the $10 billion threshold, adding FHLB funding agreements to GICs does not result in a different list of insurance groups from the list with GICs of more than $10 billion.

---

1 In performing the addition of the FHLB funding agreement amount to the GICs amount, NAIC staff discovered that the reporting of FHLB funding agreements is not consistent in Exhibit 7, Deposit-Type Contracts. The source of the FHLB amount is Note 11.B(4)(b):

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Annex 2: Regulatory Prescribed Assumptions

Annex 2i. Economic and Market Variables

A. Fed reference Table A.5 Adverse Scenario

![CCAR Adverse Scenario Table]

<table>
<thead>
<tr>
<th>Date</th>
<th>Real GDP growth</th>
<th>Nominal GDP growth</th>
<th>Real disposable income growth</th>
<th>Nominal disposable income growth</th>
<th>Unemployment rate</th>
<th>CPI inflation rate</th>
<th>3-month Treasury rate</th>
<th>5-year Treasury yield</th>
<th>BBB corporate yield</th>
<th>Mortgage rate</th>
<th>Prime rate</th>
<th>Dow Jones Total Stock Market Index</th>
<th>House Price Index</th>
<th>Commercial Real Estate Price Index</th>
<th>Market Volatility Index</th>
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<tr>
<td>Q1 2017</td>
<td>1.5</td>
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<td>1.8</td>
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<td>101</td>
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<td>3.3</td>
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<td>254</td>
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<tr>
<td>Q3 2018</td>
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<td>6.0</td>
<td>0.6</td>
<td>2.4</td>
<td>7.3</td>
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<td>1.0</td>
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<td>53</td>
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<td>1.01</td>
<td>164</td>
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</tr>
<tr>
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<td>6.4</td>
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<tr>
<td>Q1 2019</td>
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<td>6.3</td>
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<td>3.4</td>
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<tr>
<td>Q2 2019</td>
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<td>6.3</td>
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<tr>
<td>Q3 2019</td>
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<td>6.3</td>
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<td>1.01</td>
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<td>254</td>
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<td>53</td>
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<tr>
<td>Q2 2020</td>
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<td>6.5</td>
<td>2.0</td>
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<td>7.0</td>
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<td>1.0</td>
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<td>Q4 2020</td>
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<td>6.5</td>
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<td>3.8</td>
<td>7.0</td>
<td>0.1</td>
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<td>53</td>
<td>3.3</td>
<td>1.01</td>
<td>164</td>
<td>254</td>
</tr>
</tbody>
</table>

Notes: The U.S. economy experiences a moderate recession. Real GDP falls slightly more than 2 percent from the pre-recession peak, while the unemployment rate rises steadily, peaking at about 7% percent in the third quarter of 2019. The U.S. recession is accompanied by an initial fall in inflation through the third quarter of 2017, with the rate of increase in consumer prices then rising steadily and reaching 2 percent by the middle of 2018. Reflecting weak economic conditions, short-term interest rates in the United States fall and remain near zero for the rest of the scenario period. With the increase in term premiums, 5-year Treasury yields gradually rise to a little less than 2% by the second half of 2018. Financial conditions tighten for corporations and households during the recession. Spreads between investment grade corporate bond yields and 10-year Treasury yields widen to about 3% percentage points by the end of 2017, while spreads between mortgage rates and 10-year Treasury yields widen to about 2% percentage points over the same period. Asset prices decline in the adverse scenario accompanied by a rise in equity market volatility. Aggregate house prices and commercial real estate prices experience less sizable but more sustained declines compared to equity prices; house prices fall 12 percent through the first quarter of 2019 and commercial real estate prices fall 15 percent through the fourth quarter of 2018. Following the recession in the United States, output activity picks up slowly at first and then gains momentum, growth is real 2% GDP per annum from an increase of 0 percent at an annual rate in the second quarter of 2018 to an increase of 3 percent at an annual rate by the middle of 2019. The unemployment rate declines modestly.

Source: Federal Reserve

Source: 2017 Supervisory Scenarios for Annual Stress Tests Required under the Dodd-Frank Act Stress Testing Rules and the Capital Plan Rule
B. Economic data deltas to apply to current levels

**Assumptions for all companies to use:**

<table>
<thead>
<tr>
<th>Inputs to Use</th>
<th>Adverse: 1 Mo</th>
<th>Adverse: 3 Mo</th>
<th>Adverse: 12 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP Growth</td>
<td>-1.5</td>
<td>-1.5</td>
<td>-1.5</td>
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<tr>
<td>Nominal GDP Growth</td>
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<tr>
<td>Real Disposable Income Growth</td>
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<td>Nominal Disposable Income Growth</td>
<td>2.4</td>
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</table>

*Use 3 month value for 1 month horizon since CCAR does not prescribe monthly values.*

<table>
<thead>
<tr>
<th>Deltas to Apply</th>
<th>Adverse: 1 Mo</th>
<th>Adverse: 3 Mo</th>
<th>Adverse: 12 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
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<tr>
<td>CPI Inflation Rate</td>
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</tr>
<tr>
<td>3M Treasury</td>
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<td>-0.3</td>
</tr>
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<tr>
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<td>7Y Treasury</td>
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<td>0.0</td>
<td>0.2</td>
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<tr>
<td>10Y Treasury</td>
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<td>0.3</td>
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<tr>
<td>BBB Corporate Yield</td>
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<td>2.1</td>
</tr>
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<td>Agency MBS 10 Year Yield</td>
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<td>0.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Non-Agency MBS 10 Year AA Yield</td>
<td>0.3</td>
<td>0.9</td>
<td>4.1</td>
</tr>
<tr>
<td>CMBS 10 Year AA Yield</td>
<td>0.3</td>
<td>0.9</td>
<td>4.2</td>
</tr>
<tr>
<td>CLO/CDO 5.5-7 Year AA Yield</td>
<td>0.2</td>
<td>0.7</td>
<td>3.4</td>
</tr>
<tr>
<td>ABS - Cards 5 Year AAA Yield</td>
<td>0.2</td>
<td>0.6</td>
<td>2.7</td>
</tr>
<tr>
<td>ABS - Auto Near prime 3 year AAA Yield</td>
<td>0.1</td>
<td>0.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Mortgage Rate</td>
<td>0.3</td>
<td>0.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Prime Rate</td>
<td>-0.1</td>
<td>-0.2</td>
<td>-0.3</td>
</tr>
<tr>
<td>Dow Jones</td>
<td>-10%</td>
<td>-31%</td>
<td>-40%</td>
</tr>
<tr>
<td>House Price Index</td>
<td>-0.4%</td>
<td>-1.1%</td>
<td>-5.5%</td>
</tr>
<tr>
<td>Commercial Real Estate Price Index</td>
<td>-0.3%</td>
<td>-1.0%</td>
<td>-9.2%</td>
</tr>
<tr>
<td>VIX</td>
<td>4.9</td>
<td>14.6</td>
<td>9.5</td>
</tr>
</tbody>
</table>

*1 month delta is 1/3 of 3 month value*
<table>
<thead>
<tr>
<th>Proposal</th>
<th>Ref Quarter (Q420)</th>
<th>Adverse: 3 Mo</th>
<th>Adverse: 12 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP Growth</td>
<td>3.7</td>
<td>-0.9</td>
<td>-0.9</td>
</tr>
<tr>
<td>Nominal GDP Growth</td>
<td>5.0</td>
<td>0.3</td>
<td>-0.1</td>
</tr>
<tr>
<td>Real Disposable Income Growth</td>
<td>-8.1</td>
<td>-9.0</td>
<td>-10.2</td>
</tr>
<tr>
<td>Nominal Disposable Income Growth</td>
<td>-7.5</td>
<td>-9.6</td>
<td>-10.8</td>
</tr>
<tr>
<td>Unemployment</td>
<td>6.8</td>
<td>7.3</td>
<td>8.9</td>
</tr>
<tr>
<td>CPI Inflation Rate</td>
<td>2.2</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>3M Treasury</td>
<td>0.1</td>
<td>-0.2</td>
<td>-0.2</td>
</tr>
<tr>
<td>3Y Treasury</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>5Y Treasury</td>
<td>0.4</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>7Y Treasury</td>
<td>0.6</td>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>10Y Treasury</td>
<td>0.9</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>BBB Corporate Yield</td>
<td>2.3</td>
<td>3.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Agency MBS 10 Year Yield</td>
<td>1.3</td>
<td>1.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Non-Agency MBS 10 Year AA Yield</td>
<td>2.3</td>
<td>3.2</td>
<td>6.5</td>
</tr>
<tr>
<td>CMBS 10 Year AA Yield</td>
<td>2.2</td>
<td>3.1</td>
<td>6.4</td>
</tr>
<tr>
<td>CLO/CDO 5 - 7 Year AA Yield</td>
<td>2.5</td>
<td>3.1</td>
<td>5.8</td>
</tr>
<tr>
<td>ABS -Cards 5 Year AAA Yield</td>
<td>1.0</td>
<td>1.6</td>
<td>3.7</td>
</tr>
<tr>
<td>ABS-Auto Near prime 3 Year AAA Yield</td>
<td>0.5</td>
<td>0.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Mortgage Rate</td>
<td>2.8</td>
<td>3.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Prime Rate</td>
<td>3.3</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Dow Jones</td>
<td>39,220</td>
<td>31,903</td>
<td>29,925</td>
</tr>
<tr>
<td>House Price Index</td>
<td>225</td>
<td>223</td>
<td>213.5</td>
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<tr>
<td>Commercial Real Estate Price Index</td>
<td>727</td>
<td>730</td>
<td>720</td>
</tr>
<tr>
<td>VIX</td>
<td>40.3</td>
<td>49.8</td>
<td>49.8</td>
</tr>
</tbody>
</table>

**Notes:**
- Absolute change for rate variables
- Percent change for indexes
- Use actual amount from CCAR
## D. 2017 CCAR Economic variable delta calculations

<table>
<thead>
<tr>
<th>2017 CCAR</th>
<th>12/31/2016</th>
<th>Adverse: Q1</th>
<th>Adverse: Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Real GDP Growth</td>
<td>3.1</td>
<td>-1.5</td>
</tr>
<tr>
<td>2</td>
<td>Nominal GDP Growth</td>
<td>6.1</td>
<td>0.9</td>
</tr>
<tr>
<td>3</td>
<td>Real Disposable Income Growth</td>
<td>1.6</td>
<td>0.7</td>
</tr>
<tr>
<td>4</td>
<td>Nominal Disposable Income Growth</td>
<td>4.5</td>
<td>2.4</td>
</tr>
<tr>
<td>5</td>
<td>Unemployment</td>
<td>4.7</td>
<td>5.2</td>
</tr>
<tr>
<td>6</td>
<td>CPI Inflation Rate</td>
<td>3.4</td>
<td>1.8</td>
</tr>
<tr>
<td>7</td>
<td>3M Treasury</td>
<td>0.4</td>
<td>0.1</td>
</tr>
<tr>
<td>8</td>
<td>3Y Treasury</td>
<td>1.3</td>
<td>1.2</td>
</tr>
<tr>
<td>9</td>
<td>5Y Treasury</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>10</td>
<td>7Y Treasury</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>11</td>
<td>10Y Treasury</td>
<td>2.2</td>
<td>2.3</td>
</tr>
<tr>
<td>12</td>
<td>BBB Corporate Yield</td>
<td>4.1</td>
<td>5.6</td>
</tr>
<tr>
<td>13</td>
<td>Agency MBS 10 Year Yield</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>14</td>
<td>Non-Agency MBS 10 Year AA Yield</td>
<td>3.5</td>
<td>4.3</td>
</tr>
<tr>
<td>15</td>
<td>CMBS 10 Year AA Yield</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>16</td>
<td>CLO/CDO AA 5.5-7 Year AA Yield</td>
<td>3.8</td>
<td>4.5</td>
</tr>
<tr>
<td>17</td>
<td>ABS-Cards 5 Year AAA Yield</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>18</td>
<td>ABS-Auto Near prime 3 year AAA Yield</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>19</td>
<td>Mortgage Rates</td>
<td>3.9</td>
<td>4.7</td>
</tr>
<tr>
<td>20</td>
<td>Prime Rate</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>21</td>
<td>Dow Jones</td>
<td>23,277</td>
<td>15,960</td>
</tr>
<tr>
<td>22</td>
<td>House Price Index</td>
<td>183</td>
<td>181</td>
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<tr>
<td>23</td>
<td>Commercial Real Estate Price Index</td>
<td>294</td>
<td>291</td>
</tr>
<tr>
<td>24</td>
<td>VIX</td>
<td>22.5</td>
<td>37.1</td>
</tr>
</tbody>
</table>

**Spreads (%)**

<table>
<thead>
<tr>
<th>2016:Q4</th>
<th>Averages*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.712</td>
<td>1.260</td>
</tr>
<tr>
<td>1.388</td>
<td>1.857</td>
</tr>
<tr>
<td>0.500</td>
<td>0.440</td>
</tr>
</tbody>
</table>

*Quarterly averages; Spread to treasuries

**Spreads over horizon (in %)**

<table>
<thead>
<tr>
<th>2016:Q4</th>
<th>Averages*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.71</td>
<td>1.56</td>
</tr>
<tr>
<td>2.03</td>
<td>5.10</td>
</tr>
<tr>
<td>2.23</td>
<td>5.29</td>
</tr>
<tr>
<td>2.50</td>
<td>5.00</td>
</tr>
<tr>
<td>1.15</td>
<td>3.04</td>
</tr>
<tr>
<td>0.67</td>
<td>2.07</td>
</tr>
</tbody>
</table>

*Spread to treasuries
Annex 2ii. Market Capacity Assumption

Illustrative Example only

Step 1: Estimate Unconstrained Sales Per Day

Insurer A has a $100 billion portfolio of investment-grade corporate bonds, priced at par. Insurer A estimates that it holds approximately 5% of outstanding corporate bonds. In the adverse liquidity stress scenario, Insurer A’s unconstrained liquidity stress testing model assumes that it can sell:

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>% Able to Be Sold</th>
<th>Sale Price</th>
<th>Total Sale</th>
<th>Sales / Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>10%</td>
<td>97</td>
<td>$9.7 B</td>
<td>$440 M</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>20%</td>
<td>94</td>
<td>$18.8 B</td>
<td>$430 M</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>50%</td>
<td>90</td>
<td>$45.0 B</td>
<td>$230 M</td>
</tr>
</tbody>
</table>

Step 2: Add Market Capacity Constraint

Assume the average daily trading volume in the secondary market for investment grade corporate bonds has been $13.0 Billion over the past year. Insurer A estimates that trading volumes would decline by 40% in the adverse liquidity stress scenario to $8.0 B per day.

Since Insurer A is 5% of the market, Insurer A can only trade $400 M per day ($8B x 5%) without paying a significant illiquidity premium and impacting the overall market.

Insurer A then repeats this process for every asset class in its investment portfolio.

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>Unconstrained Sales / Day</th>
<th>Market Capacity Assumption</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 30 Days</td>
<td>$440 M</td>
<td>$400 M</td>
<td>($40 M)</td>
</tr>
<tr>
<td>31-90 Days</td>
<td>$430 M</td>
<td>$400 M</td>
<td>($30 M)</td>
</tr>
<tr>
<td>91-365 Days</td>
<td>$230 M</td>
<td>$400 M</td>
<td>$0</td>
</tr>
</tbody>
</table>
Annex 2iii, A. Structured Spreads over Treasuries

Proposed Structured Credit Spreads

<table>
<thead>
<tr>
<th>Structured Spreads Over U.S. Treasuries</th>
<th>December 31, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asset Type</td>
<td>Baseline</td>
</tr>
<tr>
<td>Agency MBS</td>
<td>45 bps</td>
</tr>
<tr>
<td>Non-Agency MBS</td>
<td>100 bps</td>
</tr>
<tr>
<td>CMBS</td>
<td>121 bps</td>
</tr>
<tr>
<td>CLO/CDO</td>
<td>167 bps</td>
</tr>
<tr>
<td>ABS-Cards</td>
<td>45 bps</td>
</tr>
<tr>
<td>ABS-Auto</td>
<td>16 bps</td>
</tr>
</tbody>
</table>

*Aligned with CCAR 2017 “Adverse Scenario” process (see page 3 and path B of capital credit spreads over time: difference between BBB Corporate yields and 10-Year Treasury yields). ABS-Cards/Auto are spreads to bor/swap for baseline.

Note 1: Non-Agency MBS baseline is based on expert judgment.
Note 2: Stress Scenario is calibrated to the Federal Reserve 2017 CCAR “Adverse Scenario.”
Note 3: Assumes deteriorating financial conditions peaking in 12 month consistent with the path of 2017 CCAR “adverse scenario” and March 2020 spread levels; credit spreads peak at March 2020 levels.

Note 4: Y/NB interbank rates and credit spreads are quarterly averages. All structured spread instructions are point-in-time and end-of-period - i.e., year end, December 31.

Sources: JPMorgan ABS Weekly Spreads Datasheet, Deutsche Bank Securitized Product Market Databank and internal calculations.

Annex 2iii, B. Year-end Structured Spread Baseline Values

<table>
<thead>
<tr>
<th>Reported Baseline Spreads (%)</th>
<th>Dec 31, 2020</th>
<th>Spreads (%) 2020:Q4 Averages*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency MBS 10 Year Yield</td>
<td>0.42</td>
<td>0.533</td>
</tr>
<tr>
<td>Non-Agency MBS 10 Year AA Yield</td>
<td>1.00</td>
<td>1.440</td>
</tr>
<tr>
<td>CMBS 10 Year AA Yield</td>
<td>1.21</td>
<td>1.279</td>
</tr>
<tr>
<td>CLO/CDO 5.5-7 Year AA Yield</td>
<td>1.67</td>
<td>1.859</td>
</tr>
<tr>
<td>ABS-Cards 5 Year AAA Yield</td>
<td>0.45</td>
<td>0.560</td>
</tr>
<tr>
<td>ABS-Auto Near prime 3 Year AAA Yield</td>
<td>0.13</td>
<td>0.260</td>
</tr>
</tbody>
</table>

*Quarterly averages; Spread to treasuries
Annex 2iv. SWAP Spread Table

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Baseline</th>
<th>1 Mo.</th>
<th>3 Mo.</th>
<th>6 Mo.</th>
<th>9 Mo.</th>
<th>12 Mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Mo.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>20 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>30 Yr</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1 - (Nominal) Swap Spreads (in BPS)
2 - IR Par Swap Spreads for USD, EUR, JPY, GBP, AUD and CAD

Source: Federal Reserve

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### Annex 2v. Implied Volatility of IR Swaptions

#### Implied Volatility

#### Implied Normal Volatility of IR Swaption by Tenor and Expiry

<table>
<thead>
<tr>
<th>Time Horizon</th>
<th>Tenor/Expiry</th>
<th>3Y</th>
<th>7Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Mo.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3Y</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5Y</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7Y</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10Y</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Annex 2vi. Credit Assumptions: Moody’s Transition Matrix/Migration Rates

#### Exhibit 37 Average one-year alphanumeric rating migration rates, 1983-2020

<table>
<thead>
<tr>
<th>Source: Moody’s Investors Service</th>
</tr>
</thead>
</table>

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## Annex 2vii. Credit Assumptions: Moody’s Default Table

<table>
<thead>
<tr>
<th>Priority position</th>
<th>Emergence Year 2020</th>
<th>Emergence Year 1987-2020</th>
<th>Default Year 2020</th>
<th>Default Year 1987-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revolvers*</td>
<td>78.6%</td>
<td>89.6%</td>
<td>86.3%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Term Loans**</td>
<td>48.5%</td>
<td>58.1%</td>
<td>72.6%</td>
<td>50.1%</td>
</tr>
<tr>
<td>Senior Secured Bonds</td>
<td>34.8%</td>
<td>45.9%</td>
<td>61.4%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Senior Unsecured Bonds</td>
<td>8.6%</td>
<td>31.3%</td>
<td>46.9%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Subordinated Bonds</td>
<td>0.9%</td>
<td>24.7%</td>
<td>27.9%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

* Includes cash revolvers and borrowing base facilities
** Includes all types of term loans: first, second-lien, unsecured

## Annex 2viii. Credit Assumptions: Moody’s Recovery Rate Table

Exhibit 8 Average debt recovery rates measured by ultimate recoveries, 1987-2020

Source: Moody’s Investors Service

<table>
<thead>
<tr>
<th>Priority position</th>
<th>Emergence Year 2020</th>
<th>Emergence Year 1987-2020</th>
<th>Default Year 2020</th>
<th>Default Year 1987-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revolvers*</td>
<td>78.6%</td>
<td>89.6%</td>
<td>86.3%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Term Loans**</td>
<td>48.5%</td>
<td>58.1%</td>
<td>72.6%</td>
<td>50.1%</td>
</tr>
<tr>
<td>Senior Secured Bonds</td>
<td>34.8%</td>
<td>45.9%</td>
<td>61.4%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Senior Unsecured Bonds</td>
<td>8.6%</td>
<td>31.3%</td>
<td>46.9%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Subordinated Bonds</td>
<td>0.9%</td>
<td>24.7%</td>
<td>27.9%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

* Includes cash revolvers and borrowing base facilities
** Includes all types of term loans: first, second-lien, unsecured
Mr. Schrader said that during its Dec. 7, 2021, meeting, the Financial Stability (E) Task Force exposed the list of “Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers” for a 30-day public comment period, which was subsequently extended to Jan. 18, 2022. He thanked the following groups for their comments: the American Council of Life Insurers (ACLI); the American Investment Council (AIC); the National Alliance of Life Companies (NALC); the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and Risk & Regulatory Consulting (RRC). Mr. Schrader reported that the Task Force met Jan. 24 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 4 (internal or administrative matters of the NAIC and any NAIC staff), to discuss the comments received. He added that the finalized edits to the proposed list of PE-related and other regulatory considerations was distributed via email and posted on the Working Group’s web page on Jan. 27.

Mr. Schrader requested that Todd Sells (NAIC) walk through the proposed edits to receive any final comments before considering the list for adoption, which would then be submitted to the Financial Stability (E) Task Force and the Financial Condition (E) Committee for consideration.

Mr. Sells stressed that the Working Group is only finalizing a list of considerations, which has no bearing if any item on the list will be acted upon in the future. Mr. Sells asked the ACLI if adding “Asset management services may need to be distinguished from ownership, when assessing, and considering controls and conflicts” reflected their comments (regulatory consideration #2). David Leiffer (ACLI) said that an asset management agreement would not typically raise issues of control, so he agreed with adding that sentence. Ed Toy (RRC) said that with respect to risks that are part of the Financial Condition Examiners Handbook, a private asset adds to more market volatility, liquidity, and potentially more credit risks due to being potentially opaque, but those assets are not riskier by simply being private (regulatory consideration #10). Mr. Sells indicated those comments will be sent for consideration to staff supporting the Financial Condition Examiners Handbook. Mr. Sells thanked NOLHGA for sending a 2016 report that compared pensions under the Pension Benefit Guaranty Corporation (PBGC) versus state guarantee coverage for those group annuity certificate holders (regulatory consideration #12B). Mr. Sells noted that for regulatory consideration 13, the ACLI asked for more specifics, so the Working Group added “reduce reserves” and “increase investment risk” as examples to the list of regulatory considerations regarding insurers’ use of offshore reinsurers (including captives) and complex affiliated sidecar vehicles. He emphasized that the list of regulatory considerations has no bearing if any item on the list will be acted upon. David Leiffer (ACLI) agreed that those examples were sufficient.
Michael Hachey (UNITE HERE) said that he is a researcher for a labor organization that represents workers in the U.S. and Canada and that supports the work of the Working Group, especially regulatory consideration #12 and #13. He added that for #12, the Working Group should examine U.S. Department of Labor (DOL) protections for pension beneficiaries that have seen their pensions transferred from an insurer to PE. He added that for #13, the Working Group should examine how there is risk transfer from the U.S. to Bermuda through offshore captives, reinsurance, or side car vehicles and work cooperatively with federal agencies to avoid groups operating outside the reach of prudential regulation. Mr. Schrader thanked Mr. Hachey for his comments and said that the Working Group welcomes future comments through the NAIC’s open and transparent process.

Ms. Belfi made a motion, seconded by Mr. Wolf, to adopt the amended “Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers” (see NAIC Proceedings – Spring 2022, Financial Stability (E) Task Force, Attachment One-A). The motion passed unanimously.

2. Received an Update on the 2021 LST Framework, Including Scope Criteria

Mr. Schrader said that the liquidity stress test (LST) study group, an unofficial NAIC group composed of interested state insurance regulators, lead states, representatives of in scope insurers, and NAIC staff constructed the 2020 LST framework, which included a Sept. 30, 2021, filing deadline because the framework requirements were not finalized until April 2020. He added that LST results need to be provided by June 30 to allow time to review the results and use them in considering any framework and/or scope criteria changes by Dec. 31 of the data year as required once the revisions of the Insurance Holding Company System Regulatory Act (#440) are in force. He concluded that to accomplish the June 30 deadline, LST study group regulators have agreed not to make any substantive changes to the 2021 LST, including the scope criteria. He added that for consistency in the process, the original 22 groups, which is down from 23 due to merger/acquisition activity, are still participating to avoid groups frequently falling in and out of scope. He stressed that new life insurance groups scoped in by their 2020 data are invited to participate this year in the LST study group discussions as well, in anticipation of their filing the 2022 LST. He added that the LST study group intends to finalize the proposed 2021 LST framework document soon, but the lead state adjustments for some market metrics will be finalized for lead state guidance in February or March. Mr. Schrader said that the proposed 2021 LST framework will be considered for adoption possibly jointly by the Working Group and the Financial Stability (E) Task Force, but there will be no exposure period since there are no substantive changes from the 2020 LST framework, which was exposed many times and only the scoped-in life insurance groups are affected.

3. Heard a Macroprudential Risk Assessment

Tim Nauheimer (NAIC) said that NAIC staff and state insurance regulators are designing a process that:

- Allows state insurance regulators to assess risks at an industry-wide level (mainly inward, but may also consider outward).
- Allows industry input to be sought at appropriate junctures.
- Incorporates the branded risk categories albeit tailored to a macro perspective.
- Leverages existing NAIC data and publicly available quantitative and qualitative inputs.
- Allows the risk assessment to culminate in the issuance of a public risk dashboard supported by detailed analysis that may be regulator-only.

Mr. Nauheimer added that an overview of documentation for the risk dashboard will be exposed in February and said he anticipates biweekly Working Group meetings by state insurance regulators to work on the risk dashboard. Mr. Nauheimer said that the risk dashboard currently under development has a goal of publishing a first edition in late 2022, ideally in junction with the Fall Risk Alert.
Mr. Schrader said that state insurance regulators will try to avoid duplicating any information that is already in the Fall Risk Alert and seek industry input. He emphasized that the goal is to provide as much useful regulatory-only information as possible that can be shared with both state and federal regulators.

Having no further business, the Macroprudential (E) Working Group adjourned.
The Macroprudential (E) Working Group of the Financial Stability (E) Task Force met March 2, 2022. The following Working Group members participated: Justin Schrader, Chair (NE); Carrie Mears, Vice Chair (IA); Susan Bernard (CA); Kathy Belfi (CT); Ray Spudeck (FL); Lynn Beckner (MD); Vanessa Sullivan (ME); Steve Mayhew (MI); Fred Andersen (MN); John Rehagen (MO); David Wolf (NJ); Bob Kasinow and Bill Carmello (NY); Kimberly Rankin (PA); Jamie Walker and Mike Boerner (TX); and Stephen Thomas (VA).

1. **Heard Opening Remarks and Updates**

Mr. Schrader said for several years, the NAIC has been supporting state insurance regulators in the development of macroprudential tools. He added that the NAIC started with the Macroprudential Initiative (MPI), which led to the development of the Liquidity Stress Testing Framework (LST Framework) and continues with the introduction of a Macroprudential Risk Assessment process that, although not listed in the MPI, is a logical extension of an activities-based approach to supervision. Mr. Schrader asked Miguel Romero (NAIC) to present on the Macroprudential Risk Assessment process.

2. **Received an Update on the Macroprudential Risk Assessment Process**

Mr. Romero explained that he would spend most of his time on the PowerPoint presentation summarizing what Macroprudential Risk Assessment process could look like (Attachment Two-A), which does not go into enough detail but may generate questions. He added that the details are provided in a Word document (Attachment Two-B), which includes an overview, quantitative review, qualitative review, and overall conclusions of the Macroprudential Risk Assessment process.

Mr. Romero summarized the goals of the Macroprudential Risk Assessment process:

- Process Document: Explains the Macroprudential Risk Assessment process in terms of what goes into it and how it is used.
- Risk Dashboards: Supports the risk and trend assessments contained in the report by providing a mix of data and analysis for state insurance regulators only.
- Risk Report: Documents a summary of state insurance regulators’ views on industry developments by providing information on the activities-based supervisory approach for the public.

Mr. Romero added that the Macroprudential Risk Assessment process is designed to support the activities-based supervisory approach to macroprudential supervision by relying extensively on existing data sources:

- Results of microeconomic surveillance.
- Aggregated industry data.
- Publicly available data, where necessary.

Mr. Romero concluded that the analysis includes both a quantitative and qualitative review, which may be useful for both micro and macroprudential supervision, while trying to avoid duplication. He added that the results of the assessment may lead to requests for further study by the NAIC and policy discussions at the Financial Stability...
(E) Task Force. He noted that the work is structured around risk categories, but it is still under active development. He added that a public report will hopefully be ready later this year.

Lauren Sarper (Prudential) asked if Mr. Romero could share a list of existing resources and documentation publicly. Mr. Romero responded that:

- Qualitative Sources are listed on page 2 of the Macroprudential Risk Assessment process document.
- Quantitative Sources are sector wide data found on the NAIC website, but the analysis may go deeper.

Mr. Schrader said he intends to release the NAIC Macroprudential Risk Assessment process document with an exposure period that allows enough time for the NAIC to incorporate comments before the Working Group meets jointly with the Financial Stability (E) Task Force on April 5 at the Spring National Meeting. After hearing no objection from interested parties or state insurance regulators and support from Mr. Rehagen, Mr. Schrader exposed the NAIC Macroprudential Risk Assessment process for a public comment period ending March 21.

Having no further business, the Macroprudential (E) Working Group adjourned.
Macro Risk Assessment

March 2, 2022

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Macroprudential Risk Assessment - Overview

- Process Document
  - Goal - Explains the Macro Risk Assessment process
    - What goes into it
    - How it’s used
- Risk Dashboards
  - Goal - Support the risk and trend assessments contained in report
    - Provide mix of data and analysis (text)
    - Regulator only
- Risk Report
  - Goal - Demonstrate/document a summary of regulator views on industry developments
    - Important piece of activities based supervisory approach
    - Public document
Macropudential Risk Assessment - Summary

- Key Details of Macropudential Risk Assessment:
  - Designed to support activities based supervisory approach to macropudential supervision
  - Relies extensively on existing data sources
    - Results of microeconomic surveillance
    - Aggregated industry data
    - Publicly available data, where necessary
  - Includes both a Quantitative and Qualitative review
  - Results of the assessment may lead to:
    - Requests for further study and analysis (regulators/NAIC staff)
    - Policy discussions at Financial Stability (E) Task Force
NAIC Macroprudential Risk Assessment

Overview
As a logical extension of the NAIC’s Macroprudential Initiative, the Macroprudential Working Group was charged with developing, implementing, and maintaining a macroprudential risk assessment system. The macroprudential risk assessment is a key component of the NAIC’s overall Macroprudential Supervision that enhances regulators’ ability to monitor industry trends from a macroprudential perspective. This document summarizes the process to conduct the macroprudential risk assessment.

A key objective of the NAIC’s macroprudential risk assessment is to identify and assess industry-wide insurance risks. The proactive identification of risks allows insurance regulators to consider and incorporate, as needed, various macroprudential surveillance measures across the insurance sector. The risk dashboard tools developed in this process may provide valuable insight to insurance regulators, the industry, and the public about activities that may pose systemic risk or threaten U.S. financial stability. The NAIC’s membership on FSOC provides a forum to communicate and monitor such systemic risks or activities.

The NAIC uses the definition of systemic risk used by the International Monetary Fund, Bank for International Settlements and Financial Stability Board for the macroprudential risk assessment process. That definition is “a risk of disruption to financial services that is caused by an impairment of all or parts of the financial system and has the potential to have serious negative consequences for the real economy.”

The NAIC’s macroprudential risk assessment is designed to incorporate both quantitative and qualitative assessment factors to facilitate the identification of key risk exposures. Quantitative factors can be used to track and measure risk exposures by establishing key risk indicators for ongoing monitoring and objective assessment. In addition, qualitative factors may be used to supplement the risk indicators by incorporating information from a broader range of sources into the risk assessment process to identify emerging issues and industry trends for consideration. The risk dashboard primarily considers inward risks but may also consider outward risks. This document describes the steps to review and consider both quantitative and qualitative factors.

Quantitative Review
In conducting a quantitative assessment, NAIC staff and state insurance regulators will identify, aggregate, and track the performance of targeted insurance industry and macroeconomic risk indicators on a biannual basis. Targeted indicators are classified within established risk assessment categories to facilitate both the assessment process and presentation of results. Risk indicators are sourced from aggregated NAIC Annual Statement data as well as public data sources and are reviewed and updated as needed to quantify emerging material risk exposures. Industry exposures and indicators are aggregated across statement types/lines of business as appropriate and compared against historical results and averages for purposes of review and assessment.

Assessment Categories (subject to ongoing review and adjustment):
1. Macroeconomic – This category assesses the potential impact of macroeconomic factors affecting the broader economy, with a focus on those most likely to impact the insurance industry.
2. Interconnectedness – This category assesses the impact of interconnectedness with other financial sectors on the overall financial stability of the insurance industry.
3. Capitalization & Reputation – This category assesses the overall capitalization of the insurance industry, as well as how perceptions of financial strength (including ratings and outlooks) could affect industry performance.
4. Underwriting & Profitability – This category assesses the exposure of the insurance industry to risks associated with insurance underwriting performance, reserve development, and overall profitability.
5. Credit – This category assesses the exposure of the insurance industry to the risk that amounts collected or collectible by insurers are less than those contractually due (i.e., debt securities, reinsurance recoverable, and other counterparties).

6. Market – This category assesses the exposure of the insurance industry to the risk that changes in interest rates and/or prices adversely affect the value of investments and liabilities.

7. Liquidity – This category assesses the exposure of the insurance industry to the risk that insurers are unable to meet financial obligations (i.e., cash demands) as they become due without incurring unacceptable losses.

8. Other – This category assesses the exposure of the insurance industry to other key risks that do not fit into the above categories, which could include operational and strategic risk exposures.

Qualitative Review and Research
In addition to quantitative analysis, the process of macro risk assessment utilizes various qualitative tools and resources to identify emerging risk exposures, market conditions and industry activities that have the potential to impact the macroprudential risk assessment. These tools and resources may include results of company surveillance efforts, industry news, internal/external research, as well as insights from federal and international resources. By conducting ongoing study and research in these areas, topics for consideration in the overall macroeconomic risk assessment may be identified, as well as additional indicators for incorporation into the quantitative assessment. The qualitative assessment and research may also result in the identification of factors that could potentially influence the quantitative assessment of exposures discussed above.

Qualitative Review Sources (subject to ongoing review and adjustment):

   a. Results of Microeconomic Surveillance – Incorporation of findings and takeaways from the NAIC FAWG process, ORSA reviews, input from chief regulators, etc.
   b. Industry News – Ongoing review and tracking of issues identified through a review of news feeds including Rating Agency reports & outlooks, industry periodicals, etc.
   c. Internal/External Research & Studies – Ongoing review and consideration of research performed by the NAIC’s CMB, the NAIC’s CIPR, rating agencies and various external research agencies and sources (i.e., academics, JIR, III), etc.
   d. Federal Resources – Review of information highlighted in FSOC Reports and inquiries, Federal Reserve/FIO/OFR reports, etc.
   e. International Resources – Review of information highlighted in IAIS’s Global Monitoring Exercise reports and other reports (i.e., GIMAR), FSB data and reports, IMF data and reports, etc.

Overall Conclusions and Presentation of Results
Insights from both the quantitative and qualitative reviews are aggregated to reach a baseline assessment of industry exposure to various macroprudential risks. The baseline assessment will then be evaluated, adjusted as needed, and approved by the Macroprudential (E) Working Group. The final assessment will consist of an overall level and trend for each risk category.

Assessment Levels – Assessment levels are documented on a four-tier scale consisting of High, Moderate-High, Moderate-Low or Low. Assessments are based on current and historical risk indicators and expert judgment.

Trend Levels – Trend levels are documented on a five-tier scale to consist of Rapidly Increasing, Increasing, Static, Decreasing or Rapidly Decreasing. Trends are based on the changes in risk indicators and expert judgment.
The macroprudential risk assessment are compiled and presented in a public report describing regulator views on risk exposures (i.e., risk dashboards), ongoing supervisory efforts to address exposures, and additional policy considerations in response to higher risk assessments, if warranted. The public report will also highlight specific quantitative and qualitative elements that support the overall assessments.

**Use in Ongoing Macroprudential and Microprudential Surveillance**

The results of the macroprudential risk assessment process can be used by state insurance regulators for various purposes, including the identification of sector-wide risks and potential systemic risks within the financial system related to insurance sector activities. The risk dashboard may be used to identify interplays between industry-wide risks identified in the dashboard and individual insurer risk analysis.

Insurance regulators may also consider using the risk dashboard in a top-down, risk-focused, supervisory approach. Starting at the top with a sector-wide risk dashboard, insurance regulators may wish to channel their supervisory resources towards identifying individual insurers who contribute to higher assessed sector-wide risks and potential systemic risk or activities. Further analysis may warrant additional supervision and oversight of select insurers. When monitoring an individual insurer, the insurance regulator should be aware of the broader market in which the insurer operates to be able to better understand the context of certain risk factors. To assist state insurance regulators in this regard, the results may be used to complement the NAIC’s Solvency Monitoring Risk Alert and act as a regulator-only supplement to NAIC Handbooks for use in addressing risk exposures and industry trends in conducting financial analysis and examinations.

Macroprudential risks can also be presented to the Financial Stability (E) Task Force for general policy consideration, which could include the development of additional tasks, policies, practices, or disclosures to address sector-wide risk exposures. In addition, assessments could be shared with federal and international regulators for broader financial sector and macroprudential surveillance purposes.
NAIC Macroprudential Risk Assessment

Overview
The Macroprudential Working Group was charged with development, implementation, and maintenance of a macroprudential risk assessment system. This project is a logical extension of the NAIC’s Macroprudential Initiative. The macroprudential risk assessment is also a key component of the NAIC’s overall Macroprudential Supervision that enhances regulators’ ability to monitor industry trends from a macroprudential perspective. This document summarizes the process to conduct the macroprudential risk assessment.

A key objective of the NAIC’s macroprudential risk assessment is to identify and assess industry-wide insurance risks. The proactive identification of risks allows insurance regulators to consider and incorporate, as needed, various macroprudential surveillance measures across the insurance sector. The risk dashboard tools developed in this process may provide valuable insight to insurance regulators, the industry, and the public about activities that may pose systemic risk or threaten U.S. financial stability. The NAIC’s membership on FSOC provides a forum to communicate and monitor such systemic risks or activities.

The NAIC uses the definition of systemic risk used by the International Monetary Fund, Bank for International Settlements and Financial Stability Board for the macroprudential risk assessment process. That definition is “a risk of disruption to financial services that is caused by an impairment of all or parts of the financial system and has the potential to have serious negative consequences for the real economy.”

The NAIC’s macroprudential risk assessment is designed to incorporate both quantitative and qualitative assessment factors to facilitate the identification of key risk exposures. Quantitative factors can be used to track and measure risk exposures by establishing key risk indicators for ongoing monitoring and objective assessment. In addition, qualitative factors may be used to supplement the risk indicators by incorporating information from a broader range of sources into the risk assessment process to identify emerging issues and industry trends for consideration. The risk dashboard primarily considers inward risks but may also consider outward risks. This document describes the steps to review and consider both quantitative and qualitative factors.

Quantitative Review
In conducting a quantitative assessment, NAIC staff and state insurance regulators will identify, aggregate, and track the performance of targeted insurance industry and macroeconomic risk indicators on a biannual basis. Targeted indicators are classified within established risk assessment categories to facilitate both the assessment process and presentation of results. Risk indicators are sourced from aggregated NAIC Annual Statement data as well as public data sources and are reviewed and updated as needed to quantify emerging material risk exposures. Industry exposures and indicators are aggregated/presented in a manner that logically fits the measured risk exposure under evaluation (i.e., by line of business, product type, legal structure, etc.). Careful consideration will also be given to the historical data that best provides context necessary to evaluate the exposure.

Assessment Categories (subject to ongoing review and adjustment):
1. **Macroeconomic** – This category assesses the potential impact of macroeconomic factors affecting the broader economy, with a focus on those most likely to impact the insurance industry.
2. **Interconnectedness** – This category assesses the impact of interconnectedness with other financial sectors on the overall financial stability of the insurance industry.
3. **Capitalization & Reputation** – This category assesses the overall capitalization of the insurance industry, as well as how perceptions of financial strength (including ratings and outlooks) could affect industry performance.
4. **Underwriting & Profitability** – This category assesses the exposure of the insurance industry to risks associated with insurance underwriting performance, reserve development, and overall profitability.

5. **Credit** – This category assesses the exposure of the insurance industry to the risk that amounts collected or collectible by insurers are less than those contractually due (i.e., debt securities, reinsurance recoverable, and other counterparties).

6. **Market** – This category assesses the exposure of the insurance industry to the risk that changes in interest rates and/or prices adversely affect the value of investments and liabilities.

7. **Liquidity** – This category assesses the exposure of the insurance industry to the risk that insurers are unable to meet financial obligations (i.e., cash demands) as they become due without incurring unacceptable losses.

8. **Other** – This category assesses the exposure of the insurance industry to other key risks that do not fit into the above categories, which could include operational and strategic risk exposures.

**Qualitative Review and Research**

In addition to quantitative analysis, the process of macroprudential risk assessment utilizes various qualitative tools and resources to identify emerging risk exposures, market conditions and industry activities that have the potential to impact the macroprudential risk assessment. These tools and resources may include results of company surveillance efforts, industry news, internal/external research, as well as insights from federal and international resources. By conducting ongoing study and research in these areas, topics for consideration in the overall macroeconomic risk assessment may be identified, as well as additional indicators for incorporation into the quantitative assessment. The qualitative assessment and research may also result in the identification of factors that could potentially influence the quantitative assessment of exposures discussed above.

**Qualitative Review Sources** (subject to ongoing review and adjustment):

a. **Results of Microeconomic Surveillance** – Incorporation of findings and takeaways from the NAIC FAWG process, ORSA reviews, input from chief regulators, etc.

b. **Industry News** – Ongoing review and tracking of issues identified through a review of news feeds including Rating Agency reports & outlooks, industry periodicals, etc.

c. **Internal/External Research & Studies** – Ongoing review and consideration of research performed by the NAIC’s CMB, the NAIC’s CIPR, rating agencies and various external research agencies and sources (i.e., academics, JIR, III), etc.

d. **Federal Resources** – Review of information highlighted in FSOC Reports and inquiries, Federal Reserve/FIO/OFR reports, etc.

e. **International Resources** – Review of information highlighted in IAIS’s Global Monitoring Exercise reports and other reports (i.e., GIMAR), FSB data and reports, IMF data and reports, etc.

**Overall Conclusions and Presentation of Results**

Insights from both the quantitative and qualitative reviews are aggregated to reach a baseline assessment of industry exposure to various macroprudential risks. The baseline assessment will then be evaluated, adjusted as needed, and approved by the Macroprudential (E) Working Group. The assessment considers how each risk aligns with the three transmission channels, identified by FSOC as most likely to facilitate the transmission of risk across firms or markets. Those transmission channels are interconnectedness, asset liquidation, and critical function. The final assessment will consist of an overall level and trend for each risk category.

**Assessment Levels** – Assessment levels are documented on a four-tier scale consisting of High, Moderate-High, Moderate-Low or Low. Assessments are based on current and historical risk indicators and expert judgment.
Trend Levels – Trend levels are documented on a five-tier scale to consist of Rapidly Increasing, Increasing, Static, Decreasing or Rapidly Decreasing. Trends are based on the changes in risk indicators and expert judgment.

The macroprudential risk assessment are compiled and presented in a public report describing regulator views on risk exposures (i.e., risk dashboards), ongoing supervisory efforts to address exposures, and additional policy considerations in response to higher risk assessments, if warranted. The public report will also highlight specific quantitative and qualitative elements that support the overall assessments.

Use in Ongoing Macroprudential and Microprudential Surveillance
The results of the macroprudential risk assessment process can be used by state insurance regulators for various purposes, including the identification of sector-wide risks and potential systemic risks within the financial system related to insurance sector activities. The risk dashboard may be used to identify interplays between industry-wide risks identified in the dashboard and individual insurer risk analysis.

Insurance regulators may also consider using the risk dashboard in a top-down, risk-focused, supervisory approach. Starting at the top with a sector-wide risk dashboard, insurance regulators may wish to channel their supervisory resources towards identifying individual insurers who contribute to higher assessed sector-wide risks and potential systemic risk or activities. Further analysis may warrant additional supervision and oversight of select insurers. When monitoring an individual insurer, the insurance regulator should be aware of the broader market in which the insurer operates to be able to better understand the context of certain risk factors. To assist state insurance regulators in this regard, the results may be used to complement the NAIC’s Solvency Monitoring Risk Alert and act as a regulator-only supplement to NAIC Handbooks for use in addressing risk exposures and industry trends in conducting financial analysis and examinations.

Macroprudential risks can also be presented to the Financial Stability (E) Task Force for general policy consideration, which could include the development of additional tasks, policies, practices, or disclosures to address sector-wide risk exposures. In addition, assessments could be shared with federal and international regulators for broader financial sector and macroprudential surveillance purposes.
**Summary of Industry Input**

In general, industry appears supportive of the NAIC’s efforts on macroprudential risk assessment.

NAIC staff believes the majority of industry’s input can be addressed as our process is executed without a need to change the process document.

The following tables are NAIC’s attempt to summarize industry’s input with responses by NAIC staff for regulators and industry to consider.

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<th>Reference</th>
<th>Summary of Comments</th>
<th>Interested Parties</th>
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<tbody>
<tr>
<td>1</td>
<td>Industry suggests that we focus the assessment to outward risks and that we align the assessment with the three, distinct “transmission channels” of interconnectedness, asset liquidation, and critical function.</td>
<td>ACLI, APCIA, NA CRO Council</td>
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</table>

NAIC staff appreciates industry’s input and agrees that it is helpful to align our process with the concept of FSOC’s transmission channels. Although our current process does not separately categorize the three transmission channels it does incorporate the underlying concepts within the eight categories we have identified. Therefore, NAIC staff have proposed a change to the “Overall Conclusions and Presentation of Results” section of the process memo to more clearly express the inclusion of the concepts as a part of the risk assessment process.

However, the change does not alter the focus of the risk assessment process to preserve the regulator freedom to freely identify risks both inward and outward. While FSOC’s role is generally macroprudential in nature, state regulators have both a macroprudential and microprudential perspective and, therefore, this tool is designed to be useful towards both lenses of regulator discussions.

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<td>2</td>
<td>Industry suggests that we “Avoid building overly complicated risk dashboards comprised of disparate metrics- and instead focus on prioritizing a manageable set of the indicators that are most relevant to assessing vulnerabilities.”</td>
<td>NA CRO Council</td>
</tr>
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</table>

NAIC staff’s early experience in constructing the macroprudential risk assessment process aligns with industry’s input. While our discussions on specific risks often start with several data points, many of our discussions have resulted in a final analysis that is simpler and therefore easier to discuss.

However, given that no two risks are the same, NAIC staff suggests we avoid any prescriptions on number of the number of metrics per risk as each risk may require differing levels of information.

NAIC staff also believes that industry’s input can be applied without needing a change to the process document.
Reference | Summary of Comments | Interested Parties
--- | --- | ---
3 | Industry suggests that we “Identify and contextualize metrics that will underly each assessment category.” | NA CRO Council

NAIC staff’s early experience in constructing the macroprudential risk assessment process aligns with industry’s input. Our discussions and the data/metrics we present on each risk allow for context as industry suggests. Context can be quantitative or qualitative with NAIC staff working to make sure all relevant context is available for any risk under discussion.

However, given that no two risks are the same, NAIC staff suggests we avoid any prescriptions on the exact information that is required to be presented per risk as each risk may require differing levels of information.

NAIC staff have suggested a change to the “Quantitative Review” section to attempt to address this feedback.

Reference | Summary of Comments | Interested Parties
--- | --- | ---
4 | Industry suggests that we “Avoid unnecessary duplication for supervisors and the industry.” | ACLI
AFCIA
NA CRO Council

Industry’s input is consistent with regulator input provided in other settings and therefore NAIC staff have been mindful to not create a process that is burdensome to anyone involved.

The intent is that this process be run twice a year, based on data that is available. In other words, where data is unavailable, that will likely mean the risks for which that data is relevant, may not be re-assessed until the annual analysis. Moreover, each risk will be presented at the level which makes the most sense for the risk (generally by line of business).

As with any new process, flexibility is key. Therefore, while the intention is to perform the risk assessment semi-annually, that is a design choice that can be revisited as experience dictates.

NAIC staff also believes that industry’s input can be applied without needing a change to the process document.
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<td>5</td>
<td>Industry suggests that we “engage in ongoing and iterative dialogue with stakeholders.”</td>
<td>NA CRO Council</td>
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NAIC staff also believes that industry’s input can be applied without needing a change to the process document with the Macroprudential (E) Working Group providing the setting for ongoing dialogue. We will also seek more opportunities for industry involvement as our work progresses.

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<td>6</td>
<td>Industry suggests that we “identify explicit elements of the financial sector that may be influenced by industry contributions to the transmission channels.”</td>
<td>NA CRO Council</td>
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Both the macroprudential dashboards and the report will be constructed to allow the reader/user of the information to understand the risk exposure as well as the context necessary to understand the potential for the risk to be magnified via a transmission channel.

NAIC staff also believes that industry’s input can be applied without needing a change to the process document.

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<td>7</td>
<td>Industry suggests that we “include an assessment on risk management.”</td>
<td>NA CRO Council</td>
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In past settings, other industry groups and regulators have expressed concern with such a practice. Therefore, the process was designed to allow regulators to consider such insights in so far as industry wide observations can be drawn (see Qualitative Review Sources) without needing to make public assessments of industry wide risk management practices. Moreover, NAIC staff believe that it would be difficult to meaningful describe industry wide risk management practices at the level at which the report is anticipated to be written.

NAIC staff also believes that industry’s input can be applied (in a limited capacity) without needing a change to the process document.
Industry suggests that we “provide further insight on how the Assessment is envisioned to fit into the existing regulatory risk and solvency reporting scheme.”

The section of the process document entitled “Use in Ongoing Macroprudential and Microprudential Surveillance” attempts to provide this insight. In short, the new macroprudential risk assessment process is intended to be a complimentary tool to the suite of existing microprudential surveillance tools, policies, and procedures.

To the extent further insights are needed, it’s likely that meetings at the Working Group level would be a better venue for the requested information to be provided.

Industry suggests no edits are necessary to the process document to reflect industry comments

We have in fact separated property, life and health data for certain risk categories where it makes sense and is feasible to do so. For example, the dashboard for underwriting risk, is separated by industry sector.

The change made related to feedback item # 2, discussed above, was also made with the intent of addressing this piece of feedback.
Gabrielle Griffith  
Senior Policy Analyst and NAIC Coordinator  
202-624-2371  
gabriellegriffith@acli.com

March 25, 2022

Miguel Romero, Financial Regulatory Services Manager  
MARomero@naic.org

Re: NAIC Macroprudential (E) Working Group exposure of the Macroprudential Risk Assessment Tool

Dear Mr. Romero:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit comments in response to the NAIC Macroprudential (E) Working Groups exposure of its Macroprudential Risk Assessment Tool (“risk assessment tool”). At a high level, we are supportive of the NAIC’s development of the macroprudential risk assessment tool as part of the Macroprudential Initiative and agree that, if designed appropriately, could provide valuable insight to regulators, the industry, and the public. To that end, we would like to offer the following feedback to help improve its design and achieve the tool’s intended goals.

General

We believe the risk dashboard, while being mindful of inward risks, should primarily be directed to surveillance for outward risks to the financial system (i.e., an activities based approach) as state regulators have access to other tools that are better positioned to help them determine if an individual insurer warrants additional monitoring (e.g., LST).

We believe NAIC should develop guiding principles for how it will use existing data and assess each risk category and seek stakeholder collaboration as it builds out and evolves these assessments overtime.

Further, we recommend that the NAIC conduct the monitoring process and dashboard update on an annual basis rather than biannual. Most of the key information used for the exercise is only updated once a year (annual statements, blue book, LST, GCC, ORSA, etc.). Biannual may require additional data that is not available in quarterly filings and we want to avoid unnecessary and burdensome data calls since this exercise is supposed to be leveraging existing data sources.
We also agree with the NAIC relying on the established definition of systemic risk used by various international organizations.

Quantitative Review

We agree with the 8 risk assessment categories, and note that they are broadly aligned with those identified in the EIOPA risk dashboard that was included in the IAIS Application Paper on Macroprudential Supervision published last year. However, it is hard to comment on the categories without additional information or something tangible to review. We understand there needs to be a balance between regulator discretion and prescriptive metrics when assessing risk. The process needs to be data informed, but not data driven. We believe NAIC should develop guiding principles for how it will use existing data and assess each risk category and seek stakeholder collaboration as it builds out and evolves these assessments overtime.

Additionally, the risk categories should be mapped back to the transmission channels identified by the FSOC 2019 guidance and IAIS’s holistic framework. As noted above, we are concerned that these assessment categories are primarily focused on inward risks and could limit or downplay valuable insight about activities that may pose systemic risk or threaten US financial stability. We request the NAIC provide more detail on the metrics/risk indicators for each category, including how they will map to existing data collections and provide ample time for industry comments to ensure the metrics are appropriate for the dashboard’s stated use.

It would also be helpful to understand how the working group envisions the macroprudential risk assessment tool will influence existing risk assessment and mitigation work at the Macroprudential Working Group and more broadly the NAIC (i.e., RBC, actuarial modeling, accounting, etc.).

Qualitative Review and Research

We agree that a qualitative component of the tool is an important complement to the quantitative component, particularly to the extent that the qualitative tool may be more responsive to emerging risks.

Overall Conclusions and Presentation of Results

We agree on the use of assessment levels and trend levels in the presentation of results.

Thank you in advance for the consideration of our comments. ACLI and its members look forward to continuing our work with you on the important matter of improving macroprudential surveillance tools.

Sincerely,

Gabrielle Griffith
Senior Policy Analyst
202-624-2371
gabriellegiffith@acli.com
March 25, 2022

Justin Schrader, Chair
Macroprudential (E) Working Group
National Association of Insurance Commissioners

Re: Proposed Macroprudential Risk Assessment

Dear Chairman Schrader:

The American Property Casualty Insurance Association (APCIA) welcomes the opportunity to comment on the NAIC Macroprudential (E) Working Group’s proposed Macroprudential Risk Assessment. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

The NAIC, through the collective participation of state regulators, has made significant progress in developing an effective framework for monitoring and addressing insurers’ risks, and the development of a macroprudential risk assessment to monitor systemic vulnerabilities is a natural complement to that framework. The proposed assessment is essential to support the priorities laid out in the December 2019 interpretative guidance from the Financial Stability Oversight Council (FSOC) regarding nonbank financial company designations, which utilizes an activities-based approach (ABA) for identifying and addressing potential risks to financial stability. Consistent with the FSOC’s interpretative guidance, the NAIC is appropriately developing an ABA that is designed to address the risk profile of the insurance sector.

In general, APCIA believes the proposed Macroprudential Risk Assessment sets forth a reasonable process for monitoring industry-wide risk within an activities-based approach for monitoring systemic risk.

As this process moves forward, we believe the proposed assessment should identify and focus on metrics that are relevant with and responsive to the risks associated with an ABA, including a focus on the Interconnectedness, Asset Liquidation, and Critical Function transmission channels. Further, the focus of the assessment should be on potential financial vulnerabilities that can occur on a macroprudential level from these transmission mechanisms over identified time periods rather than assessment of a particular insurer’s overall risk profile. As an example, if a transmission occurs over the course of a year or longer, the potential impact would be very different from that if the transmission occurs within one week. For this reason, we would also caution against aggregating life and property & casualty insurer data together, as the transmission time horizons are very different for these two business models, even though both types of insurance are collectively part of the insurance sector.
In addition, it is critical that any conclusions about macroprudential risks be drawn within the context of the broader economy. Exposures that may seem large within the insurance industry may be significantly smaller when compared with other financial service providers. If the Macroprudential Risk Assessment too narrowly focuses on the collective risk exposures of insurers, without considering the broader economy, this could result in supervisory measures that are not cost-beneficial and that do not focus, as intended, on true sector-wide or systemic risks. Likewise, we agree the Macroprudential Risk Assessment should leverage federal and international resources, such as broad macro-level and cross-sectoral data, because this will ensure the assessment properly looks at the impact of risks on insurers in the context of the broader economy.

Furthermore, we agree with the proposal’s approach to identifying, collecting, and aggregating data, including data collected from U.S.-based insurers through the Individual Insurer Monitoring data collection exercise conducted by the Bank of International Settlements, because the Macroprudential Risk Assessment should not require any additional reporting from or analysis of individual insurers. As discussed above, we would also caution against aggregating life and property & casualty insurer data together. Similarly, individual company data should remain confidential and aggregated reporting should be done separately for the life and property & casualty segments of the insurance sector.

Thank you for considering the points addressed in this letter, and please do not hesitate to contact us if you have any questions.

Sincerely,

____________________  ____________________
Stephen W. Broadie    Matthew Vece
Vice President, Financial & Counsel  Director, Financial & Tax Counsel
March 21, 2022

Justin Schrader
Chair, Macroprudential (E) Working Group
National Association of Insurance Commissioners

Re: CRO Council Feedback on NAIC Macroprudential Risk Assessment

Dear Justin,

The North American CRO Council (CRO Council) is a professional association of Chief Risk Officers (CROs) of leading insurers based in the United States, Bermuda, and Canada. Member CROs currently represent 35 of the largest Life and Property and Casualty insurers in North America. The CRO Council seeks to develop and promote leading practices in risk management throughout the insurance industry and provide thought leadership and direction on the advancement of sensible risk-based assessments.

General Comments

The CRO Council supports the initiative to collect quantitative and qualitative information that informs the identification of risk exposures, emerging issues, and industry trends that may warrant further oversight and/or consideration by state regulators. The NAIC, through the state regulators, has made demonstrable progress in developing a credible and effective construct for monitoring and addressing risks – including potential systemic vulnerabilities. Such a construct is essential to supporting the priorities laid out in the Financial Stability Oversight Council’s (FSOC) December 2019 interpretative guidance regarding nonbank financial company designations, which implements an activities-based approach (ABA) for identifying and addressing potential risks to financial stability. Consistent with the FSOC’s guidance, the NAIC, through the state regulators, are appropriately assuming primary responsibility for crafting and implementing an ABA that is tailored to the risk profile of the insurance sector.

Our mandate as CROs very much aligns with those of our supervisors in seeking to protect policyholders and promote financial stability. In this spirit, we are pleased to offer the following feedback on the NAIC’s proposal.

Thematic Feedback

• **Anchor the Assessment – and the specific metrics chosen to help implement it – with the three distinct “transmission channels” for how risks might propagate across the financial system.**

While the assessment categories the NAIC has identified are pertinent to the assessment of insurance-related risk factors, they appear to be overly inward-focused. We believe that the Assessment – while being mindful of inward risks – should primarily be directed to surveillance for outward risks to the financial system. To this end, we believe that the assessment should filter and focus on metrics that align with, and are directly instrumental to, implementation of an ABA including focus on the Interconnectedness, Asset Liquidation, and Critical Function transmission channels. Further, the focus of the assessment should be on potential macroprudential vulnerabilities resulting from these transmission mechanisms rather than assessment of a particular insurer’s overall risk profile.
Avoid building overly complicated risk dashboards comprised of disparate metrics - and instead focus on prioritizing a manageable set of the indicators that are most relevant to assessing vulnerabilities. As CROs, one of our primary responsibilities is to discern “signal” from “noise” among the plethora of financial indicators at our disposal. Making risk-informed decisions depends on identifying – and then contextualizing – a tractable subset within a vast array of metrics. Given the macroprudential nature of the NAIC’s initiative, we encourage careful selection of distinct metrics that address potential drivers of risk – including emerging risks and potential systemic vulnerabilities – such as those that address leverage, liquidity, and risk concentrations. An overly broad dashboard of indicators could introduce potential statistical error (e.g., multicollinearity problems) as well as cognitive biases and limitations. With respect to drawing conclusions from the assessment, greater insight on how the information will be compiled/aggregated across the various indicators/metrics will inform the lens through which the results should be interpreted – especially when housed next to data points that may be based on different approaches (e.g., assumptions, models, etc.) or where results will only be applicable for a subset of the industry.

Identify and contextualize metrics that will underly each assessment category relative to the NAIC’s objectives, historical trends, and broader market developments. It would be helpful to get a better sense of the specific metrics the NAIC’s will monitor for each respective category, the intended rationale, and the mode of analysis. Context is critical. For example, credit spreads are potentially useful indicators. However, as a measure of fundamental credit risk (e.g., CDS-implied default probabilities), spreads are prone to volatility and “false positives” in which the implied default likelihood of individual obligors is vastly overstated. Moreover, for insurers that apply disciplined asset and liability management (ALM), an increase in spreads during an illiquidity-related stress period might create opportunities to reinvest at higher yields, which ultimately creates more income to defease policyholder liabilities. A period of sustained low spreads, on the other hand, might create complacency or a generalized underpricing of risk and, in this scenario, could be a better leading indicator of stress than elevated spreads. This nuance underscores that regulators should avoid a hardwired, data-mining reliance on risk dashboards and automatic triggers for action and instead consider the broader situational context surrounding a given metric. More broadly, it is critical that any conclusions about macroprudential risks be drawn within the context of the broader economy. Insufficient consideration of the broader economy when assessing metrics could result in supervisory measures that are not cost-beneficial and that do not focus, as intended, on true sector-wide or systemic risks.

Avoid unnecessary duplication for supervisors and the industry. We appreciate and support the NAIC stating it will rely extensively on existing data sources and encourage it to fit its data gathering and assessment into the existing regulatory risk assessment and solvency reporting scheme (e.g., Liquidity Stress Testing, RBC, Form F, the Group Capital Calculation, ORSA, etc.). Additionally, we note that any new data gathering and/or assessment should be given appropriate confidentiality protections. Further, it would be helpful to understand whether the NAIC intends to conduct the same assessment on a semi-annual basis as the varying scope of information insurers file on an annual versus quarterly basis is likely to necessitate different content for a year-end versus mid-year assessment. It would also be helpful to understand if the NAIC intends to present results in aggregate for the industry or separate by line of business,
life versus P&C, mutual versus stock companies, etc.

- **Engage in ongoing and iterative dialogue with stakeholders.** We recognize the important role regulatory practices can play in promoting sound behavior across the industry and would welcome the opportunity to assist the NAIC with the development of the risk assessment tool, the review and interpretation of the biannual results, and efforts to identify and understand emerging risks.

**Structural Feedback**

As noted above, the nuances of the assessment criteria – including how they are interpreted – will be critically important to making the assessment beneficial to state regulators. To this end, the CRO Council recommends the NAIC consider incorporating the following structural elements into the assessment:

1. Use the prevailing “transmission channel” framework to enable a stronger linkage of each assessment category/criteria to a specific macroprudential concern. Numerous regulator and industry groups, both within and outside the US, have coalesced on a “transmission channel” approach to the assessment of macroprudential risk and how such risk could potentially impact financial stability. As noted above, the three transmission channels previously identified are: Interconnectedness, Asset Liquidation, and Critical Function. Regulators should map the existing “Assessment Categories” to a transmission channel to ensure the ultimate assessment criteria metrics align with the pathway for macroprudential risk transmission. The table below reflects a potential mapping of the existing assessment categories to the transmission channels.

<table>
<thead>
<tr>
<th>Transmission channel</th>
<th>Existing assessment categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interconnectedness</td>
<td>2. Interconnectedness</td>
</tr>
<tr>
<td></td>
<td>3. Capitalization and reputation</td>
</tr>
<tr>
<td></td>
<td>5. Credit</td>
</tr>
<tr>
<td></td>
<td>6. Market (non-derivative)</td>
</tr>
<tr>
<td>Asset liquidation</td>
<td>6. Market (derivative)</td>
</tr>
<tr>
<td></td>
<td>7. Liquidity</td>
</tr>
<tr>
<td>Critical function</td>
<td>4. Underwriting and profitability</td>
</tr>
<tr>
<td>Other</td>
<td>1. Macroeconomic</td>
</tr>
<tr>
<td></td>
<td>8. Other</td>
</tr>
</tbody>
</table>

2. Identify explicit elements of the financial sector that may be influenced by industry contributions to the transmission channels. The Council recommends further identifying the areas of the financial sector that may be affected by the insurance industry through the identified transmission channels. We think this will be necessary to establish thresholds outlined in the “Assessment Levels” that align with a macroprudential risk.

3. Include an assessment on risk management. The proposed Assessment focuses almost solely on risk exposure. We suggest also expressly incorporating an assessment of industry risk management as managed risks are not likely to turn into significant vulnerabilities or transmission of systemic risk.

4. Provide further insight on how the Assessment is envisioned to fit into the existing regulatory
risk and solvency reporting scheme. For example, it would be helpful to have a deeper understanding of what new information the NAIC expects the Assessment to deliver relative to the existing financial solvency regulatory tools. Further, it also would be helpful to obtain additional information regarding how state regulators may be expected to incorporate information from the Assessment into their supervision of insurers.

In Closing

The nuances of the Assessment will be critically important to success of the tool. The Council would welcome the opportunity to further engage with the NAIC on this project, both as development of the assessment framework progresses and post implementation to help ensure it evolves as may be necessary over time.

Sincerely,

Geoffrey Craddock
Chair of the North American CRO Council
NAIC Macroprudential Risk Assessment

Overview

As a logical extension of the NAIC’s Macroprudential Initiative, the Macroprudential Working Group was charged with developing, implementing, and maintaining a macroprudential risk assessment system. The macroprudential risk assessment is a key component of the NAIC’s overall Macroprudential Supervision that enhances regulators’ ability to monitor industry trends from a macroprudential perspective. This document summarizes the process to conduct the macroprudential risk assessment.

A key objective of the NAIC’s macroprudential risk assessment is to identify and assess industry-wide insurance risks. The proactive identification of risks allows insurance regulators to consider and incorporate, as needed, various macroprudential surveillance measures across the insurance sector. The risk dashboard tools developed in this process may provide valuable insight to insurance regulators, the industry, and the public about activities that may pose systemic risk or threaten U.S. financial stability. The NAIC’s membership on FSOC provides a forum to communicate and monitor such systemic risks or activities.

The NAIC uses the definition of systemic risk used by the International Monetary Fund, Bank for International Settlements and Financial Stability Board for the macroprudential risk assessment process. That definition is “a risk of disruption to financial services that is caused by an impairment of all or parts of the financial system and has the potential to have serious negative consequences for the real economy.”

The NAIC’s macroprudential risk assessment is designed to incorporate both quantitative and qualitative assessment factors to facilitate the identification of key risk exposures. Quantitative factors can be used to track and measure risk exposures by establishing key risk indicators for ongoing monitoring and objective assessment. In addition, qualitative factors may be used to supplement the risk indicators by incorporating information from a broader range of sources into the risk assessment process to identify emerging issues and industry trends for consideration. The risk dashboard primarily considers inward risks but may also consider outward risks. This document describes the steps to review and consider both quantitative and qualitative factors.
Quantitative Review

In conducting a quantitative assessment, NAIC staff and state insurance regulators will identify, aggregate, and track the performance of targeted insurance industry and macroeconomic risk indicators on a biannual basis. Targeted indicators are classified within established risk assessment categories to facilitate both the assessment process and presentation of results. Risk indicators are sourced from aggregated NAIC Annual Statement data as well as public data sources and are reviewed and updated as needed to quantify emerging material risk exposures. Industry exposures and indicators are aggregated across statement types/lines of business as appropriate and compared against historical results and averages for purposes of review and assessment.

Assessment Categories (subject to ongoing review and adjustment):

1. Macroeconomic  This category assesses the potential impact of macroeconomic factors affecting the broader economy, with a focus on those most likely to impact the insurance industry.

2. Interconnectedness  This category assesses the impact of interconnectedness with other financial sectors on the overall financial stability of the insurance industry.

3. Capitalization & Reputation  This category assesses the overall capitalization of the insurance industry, as well as how perceptions of financial strength (including ratings and outlooks) could affect industry performance.

4. Underwriting & Profitability  This category assesses the exposure of the insurance industry to risks associated with insurance underwriting performance, reserve development, and overall profitability.

5. Credit  This category assesses the exposure of the insurance industry to the risk that amounts collected or collectible by insurers are less than those contractually due (i.e., debt securities, reinsurance recoverable, and other counterparties).

6. Market  This category assesses the exposure of the insurance industry to the risk that changes in interest rates and/or prices adversely affect the value of investments and liabilities.

7. Liquidity  This category assesses the exposure of the insurance industry to the risk that insurers are unable to meet financial obligations (i.e., cash demands) as they become due without incurring unacceptable losses.

8. Other  This category assesses the exposure of the insurance industry to other key risks that do not fit into the above categories, which could include operational and strategic risk exposures.
Qualitative Review and Research

In addition to quantitative analysis, the process of macro risk assessment utilizes various qualitative tools and resources to identify emerging risk exposures, market conditions and industry activities that have the potential to impact the macroprudential risk assessment. These tools and resources may include results of company surveillance efforts, industry news, internal/external research, as well as insights from federal and international resources. By conducting ongoing study and research in these areas, topics for consideration in the overall macroeconomic risk assessment may be identified, as well as additional indicators for incorporation into the quantitative assessment. The qualitative assessment and research may also result in the identification of factors that could potentially influence the quantitative assessment of exposures discussed above.

Qualitative Review Sources (subject to ongoing review and adjustment):

a. Results of Microeconomic Surveillance – Incorporation of findings and takeaways from the NAIC FAWG process, ORSA reviews, input from chief regulators, etc.

b. Industry News – Ongoing review and tracking of issues identified through a review of news feeds including Rating Agency reports & outlooks, industry periodicals, etc.

c. Internal/External Research & Studies – Ongoing review and consideration of research performed by the NAIC’s CMB, the NAIC’s CIPR, rating agencies and various external research agencies and sources (i.e., academics, JIR, III), etc.

d. Federal Resources – Review of information highlighted in FSOC Reports and inquiries, Federal Reserve/FIO/OFR reports, etc.

e. International Resources – Review of information highlighted in IAIS’s Global Monitoring Exercise reports and other reports (i.e., GIMAR), FSB data and reports, IMF data and reports, etc.

Overall Conclusions and Presentation of Results

Insights from both the quantitative and qualitative reviews are aggregated to reach a baseline assessment of industry exposure to various macroprudential risks. The baseline assessment will then be evaluated, adjusted as needed, and approved by the Macroprudential (E) Working Group. The final assessment will consist of an overall level and trend for each risk category.

1. Assessment Levels – Assessment levels are documented on a four-tier scale consisting of High, Moderate-High, Moderate-Low or Low. Assessments are based on current and historical risk indicators and expert judgment.

2. Trend Levels – Trend levels are documented on a five-tier scale to consist of Rapidly Increasing, Increasing, Static, Decreasing or Rapidly Decreasing. Trends are based on the changes in risk indicators and expert judgment.
The macroprudential risk assessment are compiled and presented in a public report describing regulator views on risk exposures (i.e., risk dashboards), ongoing supervisory efforts to address exposures, and additional policy considerations in response to higher risk assessments, if warranted. The public report will also highlight specific quantitative and qualitative elements that support the overall assessments.

**Use in Ongoing Macroprudential and Microprudential Surveillance**

The results of the macroprudential risk assessment process can be used by state insurance regulators for various purposes, including the identification of sector-wide risks and potential systemic risks within the financial system related to insurance sector activities. The risk dashboard may be used to identify interplays between industry-wide risks identified in the dashboard and individual insurer risk analysis.

Insurance regulators may also consider using the risk dashboard in a top-down, risk-focused, supervisory approach. Starting at the top with a sector-wide risk dashboard, insurance regulators may wish to channel their supervisory resources towards identifying individual insurers who contribute to higher assessed sector-wide risks and potential systemic risk or activities. Further analysis may warrant additional supervision and oversight of select insurers. When monitoring an individual insurer, the insurance regulator should be aware of the broader market in which the insurer operates to be able to better understand the context of certain risk factors. To assist state insurance regulators in this regard, the results may be used to complement the NAIC’s Solvency Monitoring Risk Alert and act as a regulator-only supplement to NAIC Handbooks for use in addressing risk exposures and industry trends in conducting financial analysis and examinations.

Macroprudential risks can also be presented to the Financial Stability (E) Task Force for general policy consideration, which could include the development of additional tasks, policies, practices, or disclosures to address sector-wide risk exposures. In addition, assessments could be shared with federal and international regulators for broader financial sector and macroprudential surveillance purposes.
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force April 6, 2022, Minutes ................................................................. 9-586
Restructuring Mechanisms (E) Working Group Referral (Attachment One) ............................................................ 9-589
National Conference of insurance Guaranty Funds (NCIGF) Presentation (Attachment Two) .......................... 9-595
The Receivership and Insolvency (E) Task Force met in Kansas City, MO, April 6, 2022. The following Task Force members participated: Cassie Brown, Vice Chair, represented by Brian Riewe (TX); Lori K. Wing-Heier represented by David Phifer (AK); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Anoush Brangaccio (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Justin McFarland (KS); Gary D. Anderson represented by Christopher Joyce (MA); Timothy N. Schott represented by Robert Wake (ME); Chlora Lindley-Myers represented by Shelley Forrest (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented by Lindsay Crawford (NE); Michael Humphreys represented by Laura Lyon Slaymaker and Crystal McDonald (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron and Patrick Smock (RI); Carter Lawrence represented by Trey Hancock (TN); Jon Pike represented by Reed Stringham (UT); and Mike Kreidler represented by Charles Malone (WA).

1. **Adopted its 2021 Fall National Meeting Minutes**

Ms. Cross made a motion, seconded by Mr. Stringham, to adopt the Task Force’s Nov. 30, 2021, minutes (see NAIC Proceedings – Fall 2021, Receivership and Insolvency (E) Task Force). The motion passed unanimously.

2. **Received the Report of the Receiver’s Handbook (E) Subgroup**

Mr. Baldwin said the Receiver’s Handbook (E) Subgroup has not met in 2022. However, it has established drafting groups that have met in 2022 to draft revisions to Chapter 3, Chapter 4, and Chapter 5 of the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook). The Subgroup plans to schedule a meeting to expose those revisions for public comment.

3. **Received a Referral from the Restructuring Mechanisms (E) Working Group and Exposed a Request for NAIC Model Law Development**

Mr. Riewe said the Restructuring Mechanisms (E) Working Group sent a referral to the Task Force (Attachment One). The Working Group was charged to look at state laws regarding insurance business transfers (IBTs) and corporate divisions (CDs). The Working Group is in the process of developing a white paper on the topics. One area it identified where model laws may need to be amended was regarding how policyholders retain guaranty fund coverage after such transactions. The referral outlines the positions of both the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) and the National Conference of Insurance Guaranty Funds (NCIGF). Mr. Riewe said for property/casualty (P/C), the referral states that needed revisions have been identified for the Property and Casualty Insurance Guaranty Association Model Act (#540). The NCIGF suggested that possible technical gaps may exist in states that have adopted Model #540 within the definitions of “covered claim,” “member insurer,” “insolvent insurer,” and “assumed claims transaction.” The referral includes a draft Request for NAIC Model Law Development to amend Model #540. The Working Group has not received any opposition to addressing the coverage gap in Model #540.

Mr. Riewe said the Task Force will consider advancing the Request for NAIC Model Law Development to the Financial Condition (E) Committee. While there are suggested model law edits within the request, the language is not final. There will be opportunity to draft the language after the request has been approved by Executive (EX) Committee.
Mr. Riewe said that upon the Executive (EX) Committee’s approval, he recommends delegating the Receivership Law (E) Working Group to finalize the edits to Model #540.

Barbara Cox (Barbara Cox LLC, representing NCIGF) said NCIGF supports the Request for NAIC Model Law Development to amend Model #540.

Mr. Gendron, Mr. Baldwin, and Mr. Wake stated they support the Task Force’s consideration of this Request for NAIC Model Law Development. Mr. Wake said the Task Force should also consider a review of the Life and Health Insurance Guaranty Association Model Act (#520) to determine if any amendments are necessary to preserve guaranty association coverage in assumption novation. Mr. Riewe said he agrees with Mr. Wake’s comments.

Hearing no objection, Mr. Riewe said the Request for NAIC Model Law Development will be exposed for 30-day public comment period ending May 6.

4. Heard a Presentation from the NCIGF

Roger Schmelzer (NCIGF) delivered a presentation of the NCIGF on the topic of pre-receivership coordination and information sharing (Attachment Two). He said the number of insolvencies has declined over the past 20 years. He said the NCIGF is not bringing complaints. The short runway is an outdated business model for the protection of insurers. Companies that fail are more complex, including multi-state, multi-line carriers; a high volume of electronic claims files; claims operations that are delegated to third-party administrators (TPAs)/multiple information technology (IT) systems; and today there are fewer people with specialized insolvency data management expertise due to fewer insolvencies. He said the NCIGF’s need is consistent and timely transfer of usable claims data to guaranty funds and receivers at the time of insolvency. This is only going to happen if there is enhanced pre-liquidation coordination between receivers, state insurance regulators, and guaranty funds. Mr. Schmelzer said the NCIGF has invested in IT solutions and that currently guaranty funds handle roughly 90% of claims data extraction activities in insolvencies.

Mr. Schmelzer said the public policy solution is the confidential exchange of fundamental information between state insurance regulators, receivers, and guaranty funds well before the liquidation order is signed. There are four advantages. First, there may be insights gained from the data exchange that might affect the regulatory decision on timing as ideally the liquidation order would not be signed until all parties agreed the data is ready to be transferred. Second, guaranty fund operations may need time to scale operations to handle the scope of the liquidation. Third, the receivers will have usable data sooner. Fourth, it would reduce the cost of insolvency management.

Mr. Schmelzer said the confidential information that would be shared is triggered when state insurance regulators see an insurer is headed to insolvency. The type of information would be policy information, claims records, and information about TPA relationships. This information is important as it relates to cyber liability coverage and services that need to be offered.

Mr. Schmelzer said there has been progress made with the recent amendments to model laws and revisions to the Financial Condition Examiners Handbook. There is also ongoing work on the Receiver’s Handbook and the recent discussion on the Restructuring Mechanisms (E) Working Group referral.

Ms. Cox said to share information at an earlier time may require states implement statutory changes. She said a proposal in Illinois calls for changes to Model #540, the Insurance Holding Company System Regulatory Act (#440), and the Model Law on Examinations (#390). She said another approach is a memorandum of understanding (MoU). She said California is exploring this option with its guaranty fund and has put the MoU on hold pending the Task Force’s consideration of this proposal. Both drafts are included in Attachment Two. She said everyone is
concerned by confidentiality. She said the guaranty fund system is populated by industry personnel. They serve on the NCIGF board of directors, state guaranty association board members, and committees. She said to protect confidentiality, the information would not be shared with the NCIGF or state board members. She said the NCIGF has a plan to work through that.

Patrick Hughes (Faegre Drinker Biddle & Reath) said that is one idea to face these challenges. He said updates to NAIC handbooks is another way to document and potentially join various legal authorities and the coordination with receivers, state insurance regulators, and guaranty funds. Updating various handbooks may be able to be advanced more easily. He said NCIGF is trying to reach practical solutions and have sought feedback from state insurance regulators to develop this proposal. He said every state may not be the same and may have different legal structures and preferences as to which options works.

Mr. Schmelzer said he recognizes that other foreign jurisdictions may not believe the U.S. resolution system is as coordinated as it should be. Guaranty funds and state insurance regulators have worked to disprove that belief, and this is another important step. He said under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), the federal government has an opportunity if state insurance departments do not respond quickly enough. The guaranty funds need to be as robust as possible.

Hearing no objection, Mr. Riewe said the Receivership Law (E) Working Group will be referred to consider options to address the issues raised by the NCIGF, including review of the MoU and draft statutory language. Mr. Baldwin and Ms. Slaymaker, Receivership Law (E) Working Group co-chairs, agreed.

5. **Heard an Update on Federal Activities**

Patrick Celestine (NAIC) said the NAIC’s proposed State Insurance Receivership Priority (SIRP) Act establishes a clear claim filing deadline in the Federal Priority Act (FPA) for the U.S. Department of Justice (DOJ) to file claims of the U.S. to insolvent insurance company estates and to ensure state insurance regulators are not held personally liable if claims of the government are not paid first. Several members of the Task Force and NAIC staff are working with U.S. Rep. Madeleine Dean’s (D-PA) office and the DOJ to finalize edits to the SIRP Act. It is expected to be introduced to the U.S. House of Representatives this year.

6. **Heard an Update on International Activities**

Mr. Wake said he worked with NAIC staff, the NOLHGA, and the NCIGF to complete a survey of the International Association of Insurance Supervisors (IAIS) to gather information to inform the development of an application paper on policyholder protection schemes. Mr. Wake said the U.S. recently completed its in-person meetings for the IAIS-targeted jurisdictional assessment regarding the holistic framework, which included an assessment of insurance receivership, and recovery and resolution planning.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
MEMORANDUM

TO: Receivership and Insolvency (E) Task Force

FROM: Restructuring Mechanisms (E) Working Group

DATE: March 28, 2022

RE: Referral Regarding Potential Change to NAIC Model

The NAIC formed the Restructuring Mechanisms (E) Working Group because of recent changes to state laws in the areas of Insurance Business Transfer (IBT) and Corporate Divisions (CD). The Working Group is in the process of drafting a white paper that, among other things, documents the issues the statutes are designed to address and some of the legal issues. Specific to that point, during public discussions, the Working Group received input from both the National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on how policyholders can retain guaranty fund coverage after such a transaction. The following summarizes such input, which is further explained at the end of this memorandum.

NCIGF – The NCIGF’s position is that where there was guaranty fund coverage before the IBT or CD, state insurance regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate, or in any way affect guaranty fund coverage. A CD or IBT should not create, expand, or in any way affect coverage. The NCIGF suggested that possible technical gaps may exist in states that have adopted the Property and Casualty Insurance Guaranty Association Model Act (#540) and proposed specific changes to the model to address.

NOLHGA – Described the three conditions that are needed for guaranty fund coverage after an IBT or CD. In general, restructuring statutes (or state insurance regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

To that end, attached is a Request for NAIC Model Law Development form, which sets forth proposed changes to Model #540, as suggested by the NCIGF. The Working Group is not the technical expert in this area, but it does support the intent of retaining guaranty fund coverage; therefore, the Working Group asks the Receivership and Insolvency (E) Task Force to review the attached and determine where such changes could generally be supported. We are not trying to determine if this is the exact change to make to the model at this time, but rather whether the Task Force supports the project and would
be willing to complete an update to the language if approved by the Financial Condition (E) Committee and the Executive (EX) Committee. To the extent possible, perhaps the Task Force could expose the attached Request for NAIC Model Law Development form, debate it, and return it to the Working Group prior to the Summer National Meeting, where the request could be made to the Financial Condition (E) Committee.

Please let the Working Group know if you have any questions.

The following is a more comprehensive summary of the positions of the NGIGF and the NOLHGA:

The Working Group received input from the NOLHGA about the concerns for insurance consumers of personal lines life and health insurance business. The NOLHGA indicated that for there to be guaranty association coverage in the event of a life or health insurer insolvency, there are three conditions that must be present. Those conditions are:

1. The consumer seeking protection must be an eligible person under the guaranty association statute; typically, this is achieved by being a resident of the guaranty association’s state at the time of the insurer’s liquidation.

2. The product must be a covered policy.

3. The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state to write the lines of business covered by the guaranty association.

In most states, coverage can also be provided for an “orphan” policyholder of the insurer by the guaranty association in the insolvent insurer’s domestic state. Orphan policyholders are policyholders who are residents of states where the guaranty association cannot provide coverage because the insolvent insurer is not a member insurer due to not being licensed at the time required by the Life and Health Insurance Guaranty Association Model Act (#520). The orphan policyholder situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed—i.e., is a member of the guaranty association—but subsequently moves to a state where the issuing insurance company was never licensed; i.e., is not a member of the guaranty association. The provision in Model #520, and the laws of most states, that provides that orphan policies are covered by the guaranty association in the insolvent insurer’s domestic state is designed to plug the gap in these rare situations.

A key factor when considering a life or health IBT or CD transaction is whether the resulting insurer is or will be a member insurer in each state. If the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer, guaranty association coverage will be preserved and not changed for all policyholders. Of course, specific guaranty association coverage will be determined if/when the resulting insurer is placed under an order of liquidation with a finding of insolvency. If the resulting insurer is not a member insurer of the same guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or be covered as orphans by the guaranty association in the insurer’s
domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to the domestic state guaranty association could result in guaranty association coverage being concentrated in that state.

To address these concerns with respect to IBT and CD transactions involving life or health insurance, restructuring statutes (or state insurance regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

One interpretation of Model #540 is that based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction,” an orphan policyholder could not be covered by the state guarantee association. Consequently, there is a concern that no guaranty association coverage would be provided if policies are transferred to a nonmember insurer. Many property/casualty (P/C) guaranty fund statutes require that the policy be issued by the now-insolvent insurer, and it must have been licensed either at the time of issue or when the insured event occurred. However, these limitations are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an assessable policy later transferred to an insurer that was not a member at the time the policy was issued. Moreover, the restrictions exist to prevent claims resulting from a company regulated as surplus lines, or a similar structure, to benefit from the protections afforded licensed business when a licensed company is liquidated.

The NCIGF’s position is that where there was guaranty fund coverage before the IBT or CD, state insurance regulators should ensure there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate, or in any way affect guaranty fund coverage. A CD or IBT should not create, expand, or in any way affect coverage. The NCIGF suggested that possible technical gaps may exist in states that have adopted Model #540. These gaps could include the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claims Transaction” found in Section 5 of the model.

Fulfilling this intent will likely require that P/C guaranty fund statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. The NCIGF indicated that it created a subcommittee to address this issue and oversee a coordinated national effort to enact the necessary changes in each state. It should be noted that the same membership and timing issues that are raised by IBTs could also be raised in the case of any other policy novation, including the assumption reinsurance transactions.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: □ New Model Law or ☑ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Restructuring Mechanisms (E) Working Group

2. NAIC staff support contact information:

Dan Daveline
ddaveline@naic.org
816-783-8134

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

• Property and Casualty Insurance Guaranty Association Model Act (#540)

In 2019, the Financial Condition (E) Committee formed the Restructuring Mechanisms (E) Working Group who was charged with the following:

1. Evaluate and prepare a white paper that:
   a. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
   b. Summarizes the existing state restructuring statutes.
   c. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
   d. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
   e. Identifies and addresses the legal issues associated with restructuring using a protected cell.

Background for Proposed Change

This proposed change is being precipitated by discussions within the NAICs Restructuring Mechanisms (E) Working Group initiative, which is focused on documenting in the form of a White Paper, the various issues related to insurance business transfers (IBT) and corporate division (CD) transactions. The number of states adopting laws that permit either of these transactions is still relatively low, however one of the most significant issues that has been discussed during the meetings of the Working Group is the need for policyholders of such transactions to retain guaranty fund coverage. Representatives of the National Conference of Insurance Guaranty Funds (NCIGF) have suggested that an amendment to a state’s guaranty fund act, or other related law is necessary to address this issue. They have specifically suggested that the NAIC update the Property and Casualty Insurance Guaranty Association Model Act to incorporate specific language they have developed to address this issue. This will better enable those states that have incorporated #540 into their laws to update their laws for this important issue. This change is needed to ensure policyholders in all states retain their coverage, which is necessary regardless of how few states adopt changes to their laws to allow IBT and CD transactions.

Scope of the Proposed Revisions to Model 540
The scope of the request is limited to addressing the issue of guaranty fund coverage and as a result would be limited to specific suggestion of additional language within the definition of “Covered Claim” within #540. The following is the additional language (underlined language) that is being proposed to be added to Section 5, Definitions, within #540.

H. “Covered claim” means the following:

(a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or

(b) The claim is a first party claim for damage to property with a permanent location in this State.

(c) Notwithstanding any other provision in this Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as “Division” or “Insurance Business Transfer” statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.

(d) An insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection (a) shall not be considered to have been issued by a member insurer for the purposes of this Act.

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)

If yes, please explain why:

This proposed change is needed to ensure policyholders in all states retain their guaranty fund coverage, which is necessary regardless of how few states adopted changes to their laws to allow IBT and CD transactions.

It should be noted that with respect to guaranty fund coverage for life and health insurance, the National Organization of Life and Health Insurance Guaranty Associations are suggesting a different approach in addressing the same issue which centers around the need for such transaction to require the assuming or resulting insurer to be licensed in all states where the issuing insurer was licensed or ever was licensed to retain the needed coverage for policyholders.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law? ☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary: See previous discussion.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

Not referenced in Accreditation Standards.

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
Protecting Consumers:
New Opportunities for Cooperation

Roger H. Schmelzer, President & CEO
National Conference of Insurance Guaranty Funds

Barbara Cox
Public Policy Counsel to NCIGF

Patrick Hughes, Partner
Faegre Drinker Biddle & Reath LLP

NAIC Receivership and Insolvency Task Force
April 6, 2022

Regulators are Doing a Good Job:
P&C Insolvencies 2000-2021
The Short Runway Insolvency is an Outdated Biz Model for the Protection of Insurance Consumers

The few companies that fall are more complex than ever:
- Multi-state, multi-line carriers
- High volume of electronic claims files
- Claims operations delegated to TPAs/Multiple IT systems
- Limited specialized insolvency data management expertise due to fewer insolvencies

The Need
Consistent and timely transfer of usable claims data via UDS to guaranty funds and receivers at the time of insolvency

Achieved through enhanced PRE-LIQUIDATION coordination (Regulators/Receivers/Guaranty Funds)

- Smooth, seamless (as possible), transitions are important for the reputation of the U.S. state regulatory system
- Delay and appearance of chaos undermines stakeholder confidence

Public Policy & Technology Solutions Exist
Level Setting: UDS

✓ Specialized NAIC Communications Protocol developed for GFs and Receivers to read and process claims.

✓ Not an industry standard, but regulator approved; data must be converted for receivers and guaranty funds to meet their statutory obligations to consumers—this can be tricky.

✓ NCIGF has developed and maintains Data Mapper and SUDS, the support software for UDS

UDS Back to the Receiver: Monthly, Quarterly and Annual Reporting from GFs

Urgency

✓ Ongoing periodic benefits for workers compensation claimants

✓ In auto claims, essential transportation for work or medical needs

✓ Smooth, seamless as possible, transitions are important for the reputation of the US state regulatory system

✓ Delay and appearance of chaos is never good

Impediments

✓ Files controlled by third parties using various data systems

✓ Third parties may not treat transition with the same urgency as receivers and gas

✓ As liquidation is imminent, TPA may be laying off people due to loss of business

✓ High volume of data – imaged files – takes time to transition

✓ Antiquated Data systems
The Technology Solution

NCIGF Members have invested heavily in these competencies and established a subsidiary (GSI) to assist receivers with the extraction and conversion of claims data to UDS.

NCIGF and GSI can step in at the early, chaotic, but crucially important parts of an insolvency. We make sure data gets where it needs to go, then step away once the transition becomes more orderly.

Essential to making this work for all parties is delivery of these services through a legally separate subsidiary to mitigate claims-paying responsibilities to NCIGF and its member guaranty funds.

The Public Policy Solution

A Confidential Exchange of Fundamental Information

- Regulators, Receivers & GFs
- Well Before the Liquidation Order is Signed

Advantages

- Regulators can gain valuable insight into data transition readiness and complex product lines
- GFs involved can more fully prepare to pay claimants
- Receivers will have usable data sooner in order to track reinsurance recoveries and process POCs.
Confidential Information to Be Shared

- Triggered when regulators see an insurer headed toward insolvency
- Access to the troubled insurer policy information and claims records in advance of a liquidation.
- Advance information about troubled insurer TPA relationships. (large quantities of data in unknown formats and questionable condition/on unknown computer systems/security controls) Ownership of and gaining access to this data is crucial.

This information is typically deemed confidential and protected from disclosure under the state Holding Company and Examination Acts.

- In some states regulators may have the authority to disclose to GFs under current law

Data Elements of a Pre-Liquidiation Readiness Strategy

1. Demonstration and documentation that a troubled carrier’s data is segregated from third party data and can be extracted completely and quickly (within 24 hours)
2. Understanding all troubled carrier’s systems (including legacy) and the UDS framework
3. Skill and resources to extract large data sets of sensitive information and transmit them securely

GFs and Receivers need enough data, quickly enough to make “UDS”:
Claim files, file notes, payments/transactions, and images

With meaningful preplanning, we can help make the export even easier
On the Horizon: Cyber Liability Coverage

✔ Policies providing CL coverage use broad and non-standard language requiring the insurer to cover certain losses and provide ancillary services in case of a cyber incident.

✔ GFs & Receivers will need additional time to coordinate with regulators to review and analyze the CL policies of a member insurer heading toward imminent insolvency to determine and fulfill statutory obligations.

This is one example of a complex product line that needs attention BEFORE insolvency!

Developments Moving the Needle

2021 Holding Company Act Changes Already Adopted by the NAIC As a Result of a Referral from RITF!

✔ More controls on affiliated companies holding claims data and other essential information.

✔ IT Examination Working Group has adopted additional steps for the examination structure to address new holding company law requirements.

Combined with new requirements for TPA UDS competency @ appropriate RBC level, these are critical readiness tactics already in place.
We Have Proposed A Next Step

NAIC model law amendments or guidance to facilitate pre-receivership cooperation and coordination

- Further revisions to state holding company laws and regulations, exam laws and guaranty fund acts in some states. Others could do this with a memorandum of understanding (MOU) providing for and preserving confidentiality.
- Information sharing would improve cooperation and coordination.
- Addresses our mutual interest of protecting insurance consumers.
- NCIGF has amendments and a draft MOU ready for consideration.

Traction: 2022 Proposals in IL & CA based on the NCIGF amendments

How it Would Work

Once a Regulator makes a finding of insolvency and subsequent liquidation in the next 3-12 months, we recommend the following:

Step 1: Regulator schedules initial meeting with GF manager (no documents necessary)
Step 2: First meeting covered by statute being proposed or an MOU if delinquency proceeding is highly likely then detailed confidentiality agreement is required to move forward.
Step 3: GFs begin review of claim data, policy information and other documents to prepare for an orderly transfer.
Step 4: Regulator and GF manager develops plan for transition to liquidation (other GFs may be involved)
Step 5: GFs can advise Regulator on condition and location of data which may be useful to Regulator in deciding when to sign liquidation order.

Much of this could be done during a rehabilitation period if there is sufficient time and access.
Protecting Communications, Part I

- Guaranty Funds have a huge incentive to maintain confidentiality.
- Guaranty Funds understand the sensitivity of this information and the need to keep it confidential.
- Guaranty Funds have a proven track record with confidential agreements with Receivers that are standard for every rehabilitation/liquidation.
- NOLHGA and the life funds have been collaborating closely at the troubled company level for several years.
- The role of the property casualty funds (and NCIGF) may differ, but this precedent matters and demonstrates feasibility.

Protecting Communications, Part II

- MOU extends the confidentiality required by the statute to any guaranty fund receiving the information.
- MOU could be an alternative approach where states have this authority under current law.
- Our model MOU can be tailored to address any specific confidentiality concerns.
- Confidential information will NOT be shared with state Board members until such time there is a public court proceeding.
Our Proposal is Consistent With the Public Policy Evolution of P&C Guaranty Funds and NCIGF

2008 Financial Crisis: DFA Title II is still in effect and requires state readiness for companies of any size (not only SIFIs)

Regulators Depend Upon NCIGF’s Coordination of the State Guaranty Fund Response to Multi-State Insolvencies

- Title II Receivership coordination plans adopted by state regulators stress coordination with NCIGF both before and in response to a crisis (Receivers Handbook pp. 629-630).
- NCIGF and coordination between NAIC and NCIGF is cited 44 times in Receiver’s Handbook with numerous references to NCIGF website.
- NCIGF and NOLHGA are invited to participate in the confidential Receivership Financial Analysis Working Group (RFAWG) at the NAIC.

Thank You For Your Time!
This Conversation is Underway

✓ Constructive & collaborative.
✓ Readiness in general, data transfer specifically.
✓ Goal: A near seamless safety net for consumers.
✓ Strengthen state insurance regulation.

We Are on the Same Team!

Roger H. Schmelzer, President & CEO
NCIGF
rschmelzer@ncigf.org
Guideline for Troubled Company Information Sharing and Coordination with Guaranty Associations

Drafting Note: Pre-liquidation information sharing and coordination with guaranty associations has become even more critical in the modern insurance environment. Ideally such sharing and coordination should take place early on when a company becomes a “troubled company.” Regulators should consider involving guaranty funds even before the company is put in a receivership status.¹ It is essential that guaranty funds have usable claims data in order to service claims once a company is found insolvent and ordered into liquidation. (This is when most property casualty funds are “triggered.”) Moreover, complex new products such as cyber security are being written by insurance companies. Older products such as large deductible workers compensation often use complex collateral arrangements and collection protocols. Advance study and information sharing in such cases is essential for a smooth transition into liquidation if a liquidation does occur.

Regulators may have concerns regarding whether there is adequate statutory authority to share information before a receivership. The guideline below offers statutory language that could be used to amend state law to clearly permit sharing and coordination in cases where regulators feel it is appropriate. Confidentiality concerns are paramount and are addressed in the text provided below. Note that amendments to the property casualty guaranty fund model act, the Model Holding Company Act and the Examinations Act may be necessary. Amendments to all of these Models is offered.

In some states, a regulator may determine that current state law and regulatory practice already permits pre-receivership coordination. If this is the case a regulator may want to consider memorializing the terms of information sharing and coordination with a Memorandum of Understanding (MOU). A template for such an MOU is also provided as a separate document.

PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT
NCIGF Suggested Revisions to Section 10

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the

¹ The NAIC Troubled Company Handbook suggests that such coordination begin when a company’s RBC levels are --- or below. (Cite)
determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;

(2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

(1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than $100 per month;

(2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

(4) If the Commissioner determines that any member insurer as defined in Section 5K above may be subject to a future delinquency proceeding under Article XIII of this Code (insert citation to the liquidation section of the Code), then in order to assist in the performance of the Commissioner’s duties, the Commissioner may:

(i) share confidential and privileged documents, material, or information reported pursuant to an enterprise risk filing with the Association regarding that member insurer; and

(ii) share confidential and privileged documents, material, the contents of an examination report, a preliminary examination report or its results, or any matter relating there to, including working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or to any other person in the course of any examination with the Association regarding that member insurer.
(iii) The Commissioner may disclose the information described in this subsection to the Association so long as the Association agrees in writing to hold that information confidential, in a manner consistent with this Code, and uses that information to prepare for the possible liquidation of the member insurer. Access to the information disclosed by the Commissioner to the Association under this subsection shall be limited to the Association’s staff and its counsel. The Board of Directors of the Association may have access to the information disclosed by the Commissioner to the Association once the member insurer is subject to a delinquency proceeding under this Code (insert citation to the liquidation section) subject to any terms and conditions established by the Commissioner.

(iv) The Commissioner may disclose the information described in this subsection with Associations in other states, and with any organization of one or more state Associations of similar purposes, so long as the recipient of such information agrees in writing to hold that information confidential, in a manner consistent with this Code, and uses that information to prepare for the possible liquidation of the member insurer. Access to the information disclosed by the Commissioner under this subsection shall be limited to the Association’s staff and its counsel. The Board of Directors of the Association may have access to the information disclosed by the Commissioner to the Association once the member insurer is subject to a delinquency proceeding under this Code (insert citation to the liquidation section) subject to any terms and conditions established by the Commissioner.

(v) Should the Commissioner determine a liquidation is likely, he or she may cooperate with the Association and with any organization of one or more state Associations of similar purposes to provide for an orderly transition to liquidation in order to minimize any delay in the handling and payment of claims.
Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

NCIGF Recommended Changes to the NAIC Model Holding Company Act

Section 8. Confidential Treatment

A. Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to Section 6 and all information reported or provided to the Department of Insurance pursuant to Section 3B(12) and (13), Section 4, Section 5 and Section 7.1 are recognized by this state as being proprietary and to contain trade secrets, and shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner’s official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(1) For purposes of the information reported and provided to the Department of Insurance pursuant to Section 4L(2), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any NCIGF Recommended Changes to NAIC Model Holding Company Act group capital information received.
from an insurance holding company supervised by the Federal Reserve Board or any U.S. group wide supervisor.

(2) For purposes of the information reported and provided to the [Department of Insurance] pursuant to Section 4L(3), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the Federal Reserve Board and non-U.S. group wide supervisors.

Drafting Note: This group capital calculation and group capital ratio includes confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. Similarly, the liquidity stress test may include confidential information and filings received from insurance holding companies supervised by the Federal Reserve Board. The confidential treatment afforded to group capital calculation filings includes any Federal Reserve Board group capital filings and information.

B. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this Act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to Subsection A.

C. In order to assist in the performance of the commissioner’s duties, the commissioner:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Subsection A, including proprietary and trade secret documents and materials with other state, federal and international regulatory agencies, with the NAIC, and with any third-party consultants designated by the commissioner, with state, federal, and international law enforcement authorities, including members of any supervisory college described in Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(2) Notwithstanding paragraph (1) above, the commissioner may only share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) with commissioners of states having statutes or regulations substantially similar to Subsection A and who have agreed in writing not to disclose such information.
Notwithstanding paragraphs (1) and (2) above, the Commissioner may share confidential and privileged documents, material, or information reported pursuant to Section 4L(1) or otherwise described in paragraph A of this section with the [name of state property casualty insurance guaranty association] by any member insurer defined in [section in guaranty association act defining member insurer] if the Commissioner determines that the member insurer may be subject to a future delinquency proceeding under [provisions related to delinquency proceeding] of this Code. The Commissioner may disclose the information described in this subsection so long as the parties agree in writing to hold that information confidential, in a manner consistent with this Code, and use that information to prepare for a possible delinquency proceeding of the member insurer. Access to the information disclosed by the Commissioner to the [state guaranty fund] shall be limited to the [state guaranty fund’s] staff and its counsel. The Board of Directors of the [state guaranty fund] may have access to the information disclosed by the Commissioner to the [state guaranty fund] once the member insurer is subject to a delinquency proceeding under [provisions relating to delinquency proceeding] of this Code subject to any terms and conditions established by the Commissioner.

The Commissioner may also, pursuant to this subsection, disclose the information described in this subsection with Associations in other states, and with any organization of one or more state Associations of similar purposes, so long as the recipient of such information agrees in writing to hold that information confidential, in a manner consistent with this Code, and uses that information to prepare for a possible delinquency proceeding of the member insurer. Access to the information disclosed by the Commissioner under this subsection shall be limited to the Association’s staff and its counsel. The Board of Directors of the Association may have access to the information disclosed by the Commissioner to the Association once the member insurer is subject to a delinquency proceeding under this Code (insert citation to the liquidation section) subject to any terms and conditions established by the Commissioner.

Should the Commissioner determine that a delinquency proceeding is likely, he or she may cooperate with the Association and with any organization of one or more state Associations of similar purposes to provide for an orderly transition to liquidation in order to minimize any delay in the handling and payment of claims.
MODEL LAW ON EXAMINATIONS

NCIGF Recommended Changes to Section in 5F

Section 5. Examination Reports

F. Privilege for, and Confidentiality of Ancillary Information

(1) (a) Except as provided in Subsection E above and in this subsection, documents, materials or other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under this Act, or in the course of analysis by the commissioner of the financial condition or market conduct of a company shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner’s official duties.

(b) Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:
(i) Created, produced or obtained by or disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries in the course of the National Association of Insurance Commissioners and its affiliates and subsidiaries assisting an examination made under this Act, or assisting a commissioner in the analysis of the financial condition or market conduct of a company; or

(ii) Disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries under Paragraph (3) of this subsection by a commissioner.

(c) For the purposes of Paragraph (1)(b), “Act” includes the law of another state or jurisdiction that is substantially similar to this Act.

(2) Neither the commissioner nor any person who received the documents, material or other information while acting under the authority of the commissioner, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to Paragraph (1).

(3) In order to assist in the performance of the commissioner’s duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Paragraph (1), with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information;

(b) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as
confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to Paragraph (1), with the [name of state property casualty guaranty association] regarding any member insurer defined in [section in guaranty association act defining member insurer] if the commissioner determines that the member insurer may be subject to a future delinquency proceeding under [provisions related to delinquency proceeding] of this Code. The commissioner may disclose the information described in this subsection so long as the parties agree in writing to hold that information confidential, in a manner consistent with this Code, and use that information to prepare for a future delinquency proceeding of a member insurer. Access to the information disclosed by the commissioner to the [state guaranty fund] shall be limited to the [state guaranty fund’s] staff and its counsel. The Board of Directors of the [state guaranty fund] may have access to the information disclosed by the Commissioner to the [state guaranty fund] once the member insurer is subject to a delinquency proceeding under [provisions relating to delinquency proceeding] of this Code subject to any terms and conditions established by the commissioner.

The commissioner may also, pursuant to this subsection (3)(c), disclose the information described in this subsection with Associations in other states, and with any organization of one or more state Associations of similar purposes, so long as the recipient of such information agrees in writing to hold that information confidential, in a manner consistent with this Code, and uses that information to prepare for a possible delinquency proceeding of the member insurer. Access to the information disclosed by the commissioner under this subsection shall be limited to the Association’s staff and its counsel. The Board of Directors of the Association may have access to the information disclosed by the commissioner to the Association once the member insurer is subject to a delinquency proceeding under this Code (insert citation to the liquidation section) subject to any terms and conditions established by the commissioner.
Should the commissioner determine that a delinquency proceeding is likely, he or she may cooperate with the Association and with any organization of one or more state Associations of similar purposes to provide for an orderly transition to liquidation in order to minimize any delay in the handling and payment of claims.

(d) [Optional provision] May enter into agreements governing sharing and use of information consistent with this subsection.

PC-390-5
MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (“MOU”) is among the [state] Department of Insurance (“DOI”), the [Receiver of the insolvent company – if appointed] and the [guaranty fund in the state of domicile of the troubled company, the other insurance guaranty funds which have executed this agreement (collectively “Guaranty Funds”) and the National Conference of Insurance Guaranty Funds (NCIGF).

Definitions:

1.1 “Agreement” or “MOU” refers to this Memorandum of Understanding;

1.2 “Confidential Information” refers to any:
   a) documents, data or other information relating to any domestic insurance company in the State of [state] where the Commissioner has determined that the financial condition of such company creates a material risk of Receivership that are not publicly available or public records, whether written or not, including but not limited to claims files and data; financial analyses, modeling and projections; trade secrets, technical processes and know-how; agency agreements, arrangements, accounts, proposals, lists, and other information; policyholder lists and information; costs and pricing information; internal procedures, strategies and plans; and computer programs;
   b) work product or other information regarding any such Company that is confidential and/or privileged; and
   c) communications between the Parties regarding any potential or pending legal actions involving any such company that is a threat to such companies’ solvency.

1.3 “Evaluation Material” refers to all information, oral or written, including but not limited to Confidential Information as defined herein, that is furnished to Guaranty Funds or NCIGF under the terms of this Agreement, and all analyses, compilations, studies, or other materials prepared by Guaranty Funds or NCIGF containing or based in whole or in part upon such information.

1.4 “Company or Companies” refers to any domestic property and casualty insurance company in the State of [state] where the Commissioner has determined the financial condition of such company creates a material risk of receivership.

1.5 “Commissioner” refers to the Commissioner of Insurance of the State of [state].

1.6 “Party” and “Parties” refer to the Commissioner, the Receiver, if appointed, the signatory Guaranty Funds and the NCIGF.

1.7 “Receivership Court” refers to the [court with jurisdiction over the receivership]

1.8 “Receivership” refers to the rehabilitation or liquidation of any domestic insurance
company in the State of [state].

1.9 “Receiver” refers to [name of deputy receiver if appointed] or any of his or her successors.

1.10 “Covered Claim” shall have the same meaning as contained in the applicable statutes of the Guaranty Funds.

II. Recitals

2.1 The Commissioner is responsible for the financial regulation of Companies. From time-to-time the financial condition of one or more of such Companies creates a material risk of Receivership.

2.2 Should a Receivership occur of a Company, the Commissioner will appoint a special deputy receiver who will be responsible for the handling of such Receivership.

2.3 If the Receivership of a Company includes an order of liquidation with a finding of insolvency, the Guaranty Funds will have the responsibility for the payment of “Covered Claims” arising from such Receivership.

2.4 The Parties agree that in order to properly prepare for any Receivership, to provide for a smooth transition to liquidation should it become required, and in order to avoid delay in the payment of “Covered Claims,” it is essential to share Confidential Information among them with respect to any Company the Commissioner determines is at material risk of Receivership.

2.5 It is agreed by the Parties that, subject to the Commissioner’s discretion, the Commissioner can freely consult with the Receiver (if appointed), the Guaranty Funds, and NCIGF, with respect to any Company, including but not limited to, the dissemination of Confidential Information and Evaluation Material as defined herein. It is understood that such consultations are to be held in strictest confidence and the Commissioner may, in his or her discretion, withhold the name of the Company being discussed from the Guaranty Funds and the NCIGF.

2.6 The Guaranty Funds have determined that in order to protect consumers and to better fulfill their mission (see cite to applicable Guaranty Funds’ statutes) it is necessary and proper for them to enter into this Agreement and likewise it is necessary and proper for the NCIGF, as a membership organization that supports the Guaranty Funds in their mission, to enter into this Agreement. The DOI and Receiver have determined that this Agreement enables them to better serve the insurance consumers in [involved states] and to better protect them from the adverse consequences of a Company liquidation.

III. Use and Treatment of Evaluation Material

3.1 Subject to the terms of this Agreement, the Commissioner and Receiver will grant the Guaranty Funds and NCIGF Evaluation Material as they determine is appropriate. The
Evaluation Material shall be used by the Guaranty Funds and NCIGF to determine potential obligations of the Guaranty Funds, prepare for the possible assumption of such obligations, and to perform such statutory obligations in the event they become obligated to pay “Covered Claims” under policies of insurance issued by a Company. The Guaranty Funds and NCIGF shall be allowed to copy such Evaluation Material for their own use consistent with the terms of this Agreement.

3.2 The Guaranty Funds and the NCIGF agree to maintain the confidentiality of all Evaluation Material provided to them, and of any privileges with respect to such information. The Guaranty Funds and the NCIGF agree not to disclose any Evaluation Material to any person or entity, except as expressly provided herein.

3.3 The Guaranty Funds and the NCIGF may share Evaluation Material with their respective counsel, consultants or agents as it deems necessary, provided that such persons agree to comply with terms of this Agreement, including but not limited to the remedies provided under Part IV. In the event of a breach of this Agreement by any person to whom Evaluation Material has been provided, the Party or Parties providing such information shall also remain liable for the breach.

3.4 The Guaranty Funds and the NCIGF agree that no Evaluation Material shall be provided to any insurance companies or the owners, directors, officers, employees, agents, representatives, or affiliates of any insurance companies, except as necessary to discharge statutory duties, for official action or consideration by the Board of Directors.

3.5 In the event that the Guaranty Funds or the NCIGF are served with process seeking the production of Evaluation Material, including but not limited to a subpoena or order of a court of competent jurisdiction, an investigation by a government entity, or discovery demand issued in connection with any action, the Guaranty Funds and NCIGF, as appropriate, shall notify the Commissioner and Receiver in writing as promptly as practicable. The Guaranty Funds and NCIGF, as appropriate, shall take reasonable actions to protect the confidentiality and, if applicable, the privileged status of such information, unless otherwise requested by the Commissioner or the Receiver. If a protective order or other remedy is not obtained prior to the date that compliance with the request is legally required, the Guaranty Funds and the NCIGF, as appropriate, will furnish only that portion of the Evaluation Material or take only such action as is legally required.

IV. Remedies

4.1 The Guaranty Funds and the NCIGF agree that money damages would not be a sufficient remedy for a breach of this Agreement, and that the Commissioner or Receiver shall be entitled to equitable relief, including injunctive relief, as a remedy for such breach. Such remedy shall be in addition to all other remedies available at law or in equity, and shall not be deemed the exclusive remedy for a breach of this Agreement. Any action to enforce this Agreement shall be brought in the [appropriate court for the proceeding].

4.2 In the event of an action alleging a breach of this Agreement, the prevailing party shall be
entitled to reimbursement for its reasonable attorney’s fees. Any attorney’s fees awarded
to the Guaranty Funds or the NCIGF shall be handled as an administrative expense in the
proceeding, subject to [cite to applicable law]. Any attorney’s fees awarded to the
Commissioner or Receiver shall be paid from the Guaranty funds and NCIGF’s funds, and
shall not be submitted as a claim in the proceeding.

4.3 No failure or delay by any Party in exercising any right, power or privilege shall operate
as a waiver thereof. Any exercise of a right, power or privilege shall not be considered to
preclude any other or further exercise thereof.

4.4 There shall be no liability on the part of the Commissioner or Receiver or the Company(ies)
to the Guaranty Funds or NCIGF relating to or arising from the Evaluation Material or any
other documents, material, information or communications provided under this Agreement.

V. Warranties and Representations

5.1 The Commissioner, the Guaranty Funds, and the NCIGF to the extent consistent with their
statutory and other obligations, shall in good faith cooperate and communicate promptly
with each other with respect to the performance of their duties under this Agreement.

5.2 The Guaranty Funds and the NCIGF represent that they have the authority to enter into this
Agreement and fulfill their obligations under this Agreement.

5.3 Each undersigned person represents that he or she is authorized to sign this Agreement on
behalf of the Party he or she represents.

5.4 The Guaranty Funds and the NCIGF understand and acknowledge that the Commissioner
or Receiver makes no representations or warranties as to the accuracy or completeness of
any Evaluation Material provided under this Agreement.

VI. Termination

6.1 This Agreement may be terminated at any time by agreement among the Parties or by any
single Party in writing with 30 days’ notice, provided that all Evaluation Material obtained
prior to such termination shall remain confidential, unless otherwise agreed by the Parties,
and except as otherwise provided by law. Further, this Agreement shall be terminated upon
a determination in writing by the Commissioner or the Receiver that the Company no
longer presents a material risk of Receivership.

6.2 The Guaranty Funds and the NCIGF are permitted to use Evaluation Material in the manner
and for purposes described herein until delivery by the Receiver or Commissioner of a
written notice specifying the date of termination of this Agreement. Upon a receivership
order wherein one or more Guaranty Funds are triggered this Agreement shall terminate in
all respects without the obligation to destroy Evaluation material or maintain it as
confidential.
DRAFT 3-18-22

6.3 Except as provided in Paragraph 6.2, in the event of a termination of this Agreement, the Guaranty Funds and NCIGF shall immediately undertake to destroy all Evaluation Materials, and all copies, summaries, analyses and notes of the contents or parts thereof, and shall provide an affidavit attesting to the destruction of all such Evaluation Materials being provided to the Receiver, if appointed, and the Commissioner within 30 days after termination, and no part thereof shall be retained by the Guaranty Funds or NCIGF in any form without the prior written consent of the Commissioner or Receiver.

VII. Miscellaneous Provisions

7.1 Nothing in this Agreement shall be deemed to create an attorney-client relationship between any Party’s counsel and any other Party.

7.2 This Agreement shall be governed by and construed in accordance with the laws of the State of [state of domicile of the insolvency].

7.3 This Agreement may be executed in multiple counterparts, each of which shall be deemed an original for all purposes, and all of which together shall constitute one and the same instrument.

7.4 This Agreement shall be effective upon the date signed by each party and shall also apply to any and all Evaluation Material that has previously been shared between the Parties.

7.5 All communications under this Agreement shall be in writing and shall be sent by email to the addresses specified below. A copy of any such notice shall also be personally delivered or sent by either first class registered or certified U.S. Mail, return receipt requested, postage prepaid, or by a bonded mail delivery service, to the address set out below:

The Commissioner:  The Receiver:
[name, address, phone, email address]  [name, address, phone, email address]

Guaranty Funds:
[list of contact information for signatory funds]

7.6 The Parties agree to meet periodically, at least annually, to discuss issues arising under this Agreement and its implementation with respect to any specific Company.

[SIGNATURES OF PARTIES ON FOLLOWING PAGES]
DRAFT 3-18-22

IN WITNESS WHEREOF, the Parties have executed this Agreement on this ____ day of ______________, 2019:

Commissioner

By: ________________________
Its: ________________________
Date: ________________________

Receiver (if appointed)

By: ________________________
Its: ________________________
Date: ________________________

NCIGF:

By: ________________________
Its: ________________________
Date: ________________________

Guaranty Fund:

Separate signature pages may be appropriate.
REINSURANCE (E) TASK FORCE

Reinsurance (E) Task Force March 22, 2022, Minutes ........................................................................................................ 9-621
March 14, 2022, Draft Uniform Checklist for Reciprocal Jurisdiction Reinsurers (Attachment One) ........ 9-624
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law (#785) and the
Credit for Reinsurance Model Regulation (#786); Status as of March 11, 2022 (Attachment Two) ..... 9-630
Implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787);
Status as of March 11, 2022 (Attachment Three) ........................................................................................................ 9-632
Reinsurance (E) Task Force
Virtual Meeting (in lieu of meeting at the 2022 Spring National Meeting)
March 22, 2022

The Reinsurance (E) Task Force met March 22, 2022. The following Task Force members participated: Chlora Lindley-Myers, Chair, and John Rehagen (MO); Chris Niccolopoulos, Vice Chair, represented by Doug Bartlett and Pat Gosselin (NH); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain, represented by Mel Anderson (AR); Ricardo Lara represented by Monica Macaluso (CA); Andrew N. Mais represented by Joel Henry (CT); Trinidad Navarro represented by Ryllyn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen represented by Kim Cross (IA); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by Diana Sherman (NJ); Russell Toal (NM); Adrienne A. Harris represented by Roberto Paradis (NY); Judith L. French represented by Dale Bruggeman (OH); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Cassie Brown represented by Jamie Walker (TX); Jon Pike represented by Jake Garn (UT); Scott A. White represented by David Smith and Doug Stolte (VA); and Nathan Houdek represented by Mark McNabb (WI).

1. **Adopted its 2021 Fall National Meeting Minutes**

Ms. Obusek made a motion, seconded by Mr. Eft, to adopt the Task Force’s Dec. 13, 2021, minutes (see NAIC Proceedings – Fall 2021, Reinsurance (E) Task Force). The motion passed unanimously.


Jake Stultz (NAIC) provided the report of the Reinsurance Financial Analysis (E) Working Group. He stated that the Working Group meets in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. He stated that the Working Group met Dec. 20, 2021, to approve one certified reinsurer and three reciprocal jurisdiction reinsurers for passporting. He stated that the Working Group also met March 3, 2022, and took the following action: 1) approved seven reciprocal jurisdiction reinsurers and one certified reinsurer for passporting; 2) discussed revising the regulator-only Reinsurance Financial Analysis (E) Working Group Procedures Manual; and 3) discussed the revisions to the Uniform Checklist for Reciprocal Jurisdiction Reinsurers (Uniform Checklist). He stated that after its March 3 meeting, the Working Group conducted an e-vote to approve the revisions to the Uniform Checklist.

Mr. Stultz stated that the Working Group has now approved 14 reciprocal jurisdiction reinsurers for passporting and plans to meet several more times in 2022 as more applications are received. He noted that the list of passported reinsurers can be found on the Certified and Reciprocal Jurisdiction Reinsurer web page. He stated that NAIC staff have revised the web page to better meet the needs of state insurance regulators, industry, and other interested parties. He stated that NAIC staff are creating a point-of-contact list to be included on that web page and will include a single best contact for each state for any issues regarding reciprocal jurisdiction reinsurers and certified reinsurers. He requested that each state provide their point of contact person, which will be published publicly on the certified and reciprocal jurisdiction reinsurer webpage.

Ms. Macaluso made a motion, seconded by Mr. Bartlett, to adopt the Working Group’s report. The motion passed unanimously.
3. **Exposed Revisions to the Uniform Checklist**

Dan Schelp (NAIC) stated that the Reinsurance Financial Analysis (E) Working Group met March 3 to discuss revisions to the Uniform Checklist. After that meeting, the Working Group conducted an e-vote and approved sending the revisions to the Task Force for further consideration. Mr. Schelp stated that the Task Force approved the current version of the Uniform Checklist on June 9, 2020, but since that time, the NAIC has adopted the ReFAWG Review Process, which provides updated guidance on the passporting process.

Mr. Schelp stated that the NAIC originally adopted the *Uniform Application Checklist for Certified Reinsurers* in 2014, and it was designed to place uniformity around the state approval process and to assist the Working Group in the review of certified reinsurers for passporting purposes. He stated that it has been amended several times and was the basis for the Uniform Checklist. Mr. Schelp provided a summary of the revisions to the Uniform Checklist and recommended that the document be exposed for a 30-day public comment period.

Mr. Bruggeman suggested a clarification to the Uniform Checklist to provide additional guidance for lead states regarding the ReFAWG Review Process. Mr. Rehagen stated that this clarification may be helpful for the final adopted version of the document and will be considered before the document is adopted.

Mr. Bartlett made a motion, seconded by Mr. Bruggeman, to expose the *Uniform Checklist for Reciprocal Jurisdiction Reinsurers* (Attachment One) for a 30-day public comment period. The motion passed unanimously.

4. **Received a Status Report on the Reinsurance Activities of the Mutual Recognition of Jurisdictions (E) Working Group**

Mr. Wake stated that the Working Group has not met since the 2021 Fall National Meeting but plans to meet later this year to complete its duties related to the group capital calculation (GCC) process and to reapprove the status of the seven existing qualified jurisdictions and the three reciprocal jurisdictions that are not subject to an in-force covered agreement. He stated that NAIC staff established a due diligence review process in 2021 and provided a recommendation to the Working Group that the existing qualified jurisdictions and reciprocal jurisdictions not subject to a Covered Agreement should retain their status, and this recommendation was then adopted by the Working Group. He stated that the Working Group will perform this same review toward the end of 2022 and will report this to the Task Force at the Fall National Meeting. Mr. Wake stated that the Working Group would meet if there were any updates with the qualified jurisdiction review of the Republic of Korea.

5. **Received a Status Report on the States’ Implementation of the 2019 Revisions to Model #785 and Model #786**

Mr. Stultz stated that as of March 11, 48 U.S. jurisdictions have adopted the 2019 revisions to the *Credit for Reinsurance Model Law* (#785), while five jurisdictions have action under consideration. He noted that 34 states have adopted the revisions to the *Credit for Reinsurance Model Regulation* (#786), and seven jurisdictions currently have action under consideration. The maps showing the adoption of the 2019 revisions to Model #785 and Model #786 were included in the meeting materials (Attachment Two).

Mr. Stultz stated that the 2019 revisions to the models must be adopted by the states prior to Sept. 1, 2022, which is the date when the Federal Insurance Office (FIO) must complete its federal preemption reviews under the Covered Agreements. He stated that the Task Force will provide support to the states to meet this deadline. Mr. Stultz recommended that all states and jurisdictions adopt the 2019 revisions to Model #785 and Model #786 as soon as possible and no later than July 1 in order to give the FIO sufficient time for its federal preemption analysis.
Mr. Stultz stated that the current adoption maps can be found on the Task Force’s web page. He noted that he and Mr. Schelp can answer any technical questions during the legislative process, and Holly Weatherford (NAIC) is working directly with the states on the adoption of the 2019 revisions to Model #785 and Model #786.

Mr. Schelp stated that the NAIC has been in contact with all states that have not yet adopted Model #786 and that all are in the process of completing the adoption of the model.

Karalee Morrell (Reinsurance Association of America—RAA) complimented the Task Force and NAIC staff for the work that has been completed at this point and added that the point of contact list will be valuable for the RAA.

6. Received a Status Report on the States’ Implementation of Model #787

Mr. Stultz stated that the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787) becomes an accreditation standard on Sept. 1, with enforcement beginning on Jan. 1, 2023. He noted that as of March 11, 10 jurisdictions have adopted Model #787, with another eight jurisdictions with action under consideration. He stated that the map showing the current adoption status for Model #787 was included in the meeting materials (Attachment Three) and added that the adoption of Model #787 is unrelated to the Covered Agreements and is not potentially subject to federal preemption. Mr. Stultz noted that Model #787 mirrors *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48), and that under the accreditation standards, a state may meet the requirements through an administrative practice, such as an actuarial guideline. He and added that if a state adopts Model #787, it also will need to adopt Section 5B(4) of Model #785.

Having no further business, the Reinsurance (E) Task Force adjourned.
Uniform Checklist for Reciprocal Jurisdiction Reinsurers

<table>
<thead>
<tr>
<th>Reciprocal Jurisdiction Reinsurer Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Primary Contact:</td>
</tr>
<tr>
<td>Domiciliary Jurisdiction / Supervisory Authority:</td>
</tr>
<tr>
<td>Applicable Lines of Business:</td>
</tr>
</tbody>
</table>

I. Filing Requirements for “Lead State” of Reciprocal Jurisdiction Reinsurer

Check appropriate box:

☐ Initial Filing  ☐ Annual Filing

The “Lead State” will uniformly require assuming insurers to provide the following documentation so that other states may rely upon the Lead State’s determination:

<table>
<thead>
<tr>
<th>Citation to State Law / Regulation</th>
<th>Requirements</th>
<th>Y or N</th>
<th>Reference and Supporting Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model #786 § 9A &amp; B</td>
<td><strong>Status of Reciprocal Jurisdiction:</strong> The assuming insurer must be licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction that is listed on the NAIC List of Reciprocal Jurisdictions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model #785 §2F(1)(a)</td>
<td>• A non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States;</td>
<td></td>
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<tr>
<td></td>
<td>• A U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction.</td>
<td></td>
<td>The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.</td>
</tr>
<tr>
<td>Model #786 § 9C(2)</td>
<td><strong>Minimum Capital and Surplus:</strong> The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of</td>
<td></td>
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<td>Model #785</td>
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<tr>
<td>Citation to State Law / Regulation</td>
<td>Requirements</td>
<td>Y or N</td>
<td>Reference and Supporting Documents</td>
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| §2F(1)(b)                         | the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction:  
  • No less than $250,000,000 (USD); or  
  • If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:  
    • Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and  
    • A central fund containing a balance of the equivalent of at least $250,000,000 (USD).  
  
  *The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer complies with this requirement.* |       |                                     |
| Model #786 § 9C(7)                | Minimum Solvency or Capital Ratio:  
  The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio.  
  • The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or  
  • If the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or  
  • If the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a |       |                                     |

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# Uniform Checklist for Reciprocal Jurisdiction Reinsurers

*Approved by the Reinsurance (E) Task Force on June 9, 2020*

<table>
<thead>
<tr>
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<tr>
<td>Model #786 § 9C(7)</td>
<td>Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency.</td>
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<tr>
<td>Model #785 §2F(1)(g)</td>
<td>The assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with this requirement.</td>
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</tr>
<tr>
<td>Model #786 § 9C(4)</td>
<td>Form RJ-1: The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.  [Insert link to copy of form on state web site. ]</td>
<td></td>
<td>Form RJ-1</td>
</tr>
<tr>
<td>Model #785 §2F(1)(d)</td>
<td>Financial/Regulatory Filings: • The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report; • The solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor; • An updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States;—<em>and This is for purposes of evaluating Prompt Payment of Claims.</em> • Information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer. <em>This is for</em></td>
<td></td>
<td>The Reciprocal Jurisdiction Reinsurer shall provide this information if requested by the commissioner consistent with the requirements of Model #785 &amp; Model #786.</td>
</tr>
<tr>
<td>Model #786 § 9C(5)</td>
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<td></td>
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<tr>
<td>Model #785 §2F(1)(e)</td>
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<tr>
<td>Model #786 § 9C(5)(d)</td>
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# Uniform Checklist for Reciprocal Jurisdiction Reinsurers

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<tr>
<td>Model #786 § 9C(6)</td>
<td><strong>Prompt Payment of Claims:</strong> The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:</td>
<td>Y or N</td>
<td>(property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement.</td>
</tr>
<tr>
<td>Model #785 §2F(1)(f)</td>
<td>More than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner;</td>
<td>Y or N</td>
<td>The calculation for Prompt Payment of Claims is based upon the total global claims of the Reciprocal Jurisdiction Reinsurer, and not based solely on U.S. claims. NAIC staff will perform a slow-pay analysis based upon filings of Schedule F by U.S. domiciled ceding insurers with respect to property reinsurance. The level of detail required to perform a slow pay analysis does not exist in Schedule S with respect to life reinsurance. The Lead State should attempt to obtain this information directly from the Reciprocal Jurisdiction Reinsurer and/or its supervisor.</td>
</tr>
<tr>
<td></td>
<td>More than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or</td>
<td>Y or N</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a Covered Agreement.</td>
<td>Y or N</td>
<td></td>
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<tr>
<td>Fee:</td>
<td>[Insert $ amount of the fee applicable in this state.]</td>
<td>Y or N</td>
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II. Filing Requirements for “Passporting State” of Reciprocal Jurisdiction Reinsurer

In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

If an NAIC accredited jurisdiction has determined that the conditions set forth under the Filing Requirements for Lead States have been met, the commissioner has the discretion to defer to that jurisdiction’s determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC. The following documentation must be filed with the Passporting State:

<table>
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<tr>
<td>Model #786 § 9E(2)</td>
<td>Form RJ-1: An assuming insurer must submit a properly executed Form RJ-1 and additional information as the commissioner may require, except to the extent that they conflict with a Covered Agreement.</td>
<td>Y</td>
<td>Form RJ-1</td>
</tr>
<tr>
<td>Model #785 §2F(3)</td>
<td>Lead State: If an NAIC accredited jurisdiction has determined that the required conditions have been met, the commissioner has the discretion to defer to that jurisdiction’s determination. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of this requirement.</td>
<td>Y</td>
<td>The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business. The applicant also should have been reviewed and recommended for passporting by ReFAWG.</td>
</tr>
<tr>
<td></td>
<td>Fee: [Insert $ amount of the fee applicable in this state.]</td>
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III. Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers

Under Section 8A(5) of the Credit for Reinsurance Model Regulation (#786), credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered
Uniform Checklist for Reciprocal Jurisdiction Reinsurers

Approved by the Reinsurance (E) Task Force on June 9, 2020

into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC blanks will be amended to reflect the status of these reinsurers with respect to each type of insurance assumed.
Implementation of the 2019 Revisions to the
Credit for Reinsurance Model Law #785
[status as of March 11, 2022]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Regulation #786 [status as of March 11, 2022]

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Implementation of Model #787 (XXX/AXXX)
Term and Universal Life Insurance Reserve Financing Model Regulation
[status as of March 11, 2022]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
RISK RETENTION GROUP (E) TASK FORCE

The Risk Retention Group (E) Task Force did not meet at the Spring National Meeting.
VALUATION OF SECURITIES (E) TASK FORCE

Valuation of Securities (E) Task Force April 5, 2022, Minutes ........................................................................................................ 9-635


American Council of Life Insurers (ACLI) Comment Letter Regarding the Proposed P&P Manual Amendment to Permit Un-Guaranteed and Unrated Subsidiary Obligors in WCFI Transactions, with SVO Discretion (Attachment Two) ........................................................................................................ 9-647

P&P Manual Amendment to Permit Un-Guaranteed and Unrated Subsidiary Obligors in WCFI Transactions, with SVO Discretion (Attachment Three) ........................................................................................................ 9-650
The Valuation of Securities (E) Task Force met in Kansas City, MO, April 5, 2022. The following Task Force members participated: Doug Ommen, Chair, represented by Carrie Mears (IA); Scott A. White, Vice Chair, represented by Greg Chew and Doug Stolte (VA); Lori K. Wing-Heier represented by David Phifer (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi and Kenneth Cotrone (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Dean L. Cameron represented by Eric Fletcher and Amber Re (ID); Dana Popish Severyinghaus represented by Bruce Sartain (IL); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Melissa Gibson (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Brrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Eric Dunning represented by Lindsay Crawford and Justin Schrader (NE); Marlene Caride represented by Nakia Reid (NJ); Adrienne A. Harris represented by Bob Kasinow and Jim Everett (NY); Cassie Brown represented by Jamie Walker (TX); Jon Pike represented by Jake Garn (UT); Mike Kreidler represented by Steve Drutz (WA).

1. Adopted its 2021 Fall National Meeting Minutes

Mr. Chew made a motion, seconded by Ms. Doggett, to adopt the Task Force’s Dec. 12, 2021, minutes (see NAIC Proceedings – Fall 2021, Valuation of Securities (E) Task Force). The motion passed unanimously.

2. Received and Discussed Comments on a Proposed Amendment to the P&P Manual to Update the Definition of PPS

Marc Perlman (NAIC) said that as explained at the 2021 Fall National Meeting, an amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) is being proposed to update the definition of “principal protected securities” (PPS) because the Securities Valuation Office (SVO) is seeing transactions that pose similar risks to PPS transactions, as currently defined, but they are structured in a way that do not cleanly fit that definition. Currently, the PPS definition covers securities with underlying assets. This includes a traditional bond or bonds and other “performance” assets, such as derivatives, common stock, commodities, equity indices, and even undisclosed assets, which are intended to generate excess return which are typically not securities that would otherwise be permitted on the bond schedule. In each case, the external credit rating provider (CRP) rating is based solely on the component dedicated to the repayment of principal and ignores the risks and statutory prohibitions of reporting the performance asset on Schedule D, Part 1.

The SVO has received proposals for securities that possess many of the same risks as PPS but are structured in a way that they do not cleanly fit the definition in the P&P Manual. They could be described as “synthetic PPS” in that the security is not issued by an special purpose vehicle (SPV), which holds an “underlying” principal protection bond and the performance asset. Instead, the security is the direct obligation of a large financial institution, which is obligated to pay principal at maturity and a premium based on the performance of referenced assets, such as equity, fixed income or futures indices (or a combination thereof), and other financial assets. Though the obligation is solely that of the issuing financial institution, meaning there are no underlying bonds or performance assets (as currently specified in the PPS definition), the structure poses the same risk of exposure to a performance asset because the amount of the issuer’s payment obligation is directly dependent on the performance of the referenced indices or assets. Additionally, unlike a PPS transaction with an underlying bond and performance asset, the likelihood of payment of the performance asset premium, whatever the amount might be, is linked directly to the creditworthiness of the issuer.
Comments have been received from interested parties stating that they agree with the substance behind the proposed amendment but requested that the wording be thoroughly discussed, as was the case with the original PPS definition, to make certain that the amendment does what is intended and does not result in unintended consequences. The SVO requests from the Task Force permission to work with industry for purposes of modifying the language of the current proposal and then re-exposing this amendment for an abbreviated comment period. As deals of this type are currently coming to market, the SVO would like to expedite these discussions and the eventual adoption of this amendment.

Mike Reis (Northwestern Mutual on behalf of the American Council of Life Insurers [ACLI], Private Placement Investors Association [PPiA], and the North American Securities Valuation Association [NASVA]), said they understand the concern and support the change, but they would like to work with the SVO to avoid any unintended consequences.

Ms. Mears directed SVO staff to work with industry on technical modifications to the current proposed language and expose the revised amendment for a 30-day comment period.

3. Exposed a Proposed Amendment to the P&P Manual to Update the Definition of Other Non-Payment Risks Assigned a Subscript “S”

Charles Therriault (NAIC) said this agenda item is closely related to the last one in that PPS are a type of subscript “S” security. Securities that possess “Other Non-Payment Risks” are intended to be reviewed by the SVO, but these investments have not been explicitly included on the list of Specific Populations of Securities Not Eligible For Filing Exemption in Part Three of the P&P Manual. Securities with other non-payment risks are identified through assignment of the Administrative Symbol “S” as a subscript to the NAIC designation. This amendment would add “Securities with Other Non-Payment Risks” to the list of securities that are ineligible for filing exemption.

As noted in Part One, paragraph 90, of the P&P Manual, “An objective of the VOS/TF is to assess the financial ability of an insurer to pay claims. For example, the regulatory assumption is that a fixed income instrument called debt by its originator or issuer requires that the issuer make scheduled payments of interest and fully repay the principal amount to the insurer on a date certain. A contractual modification that is inconsistent with this assumption creates a rebuttable inference that the security or instrument contains an additional or other non-payment risk created by the contract that may result in the insurer not being paid in accordance with the underlying regulatory assumption. The SVO is required to identify securities that contain such contractual modifications and quantify the possibility that such contracts will result in a diminution in payment to the insurer, so this can be reflected in the NAIC Designation assigned to the security through the application of the notching process.”

The proposed amendment clarified through additional illustrations securities that would also be considered as having “Other Non-Payment Risks.” Based on comments received, The SVO requests the Task Force’s approval to work with industry on modifying the language and fine-tuning the amendment to avoid any unintended consequences.

Mr. Reis said this is related to the previous item on PPS. There are more concerns with this amendment as to possible unintended consequences in the additional illustrations, and they appreciate working with the SVO to update the amendment and include a principle-based feature to avoid financial engineering.

Ms. Mears directed SVO staff to work with industry on technical modifications to the current proposed language and expose the revised amendment for a 45-day public comment.
4. **Received and Discussed a Proposed Referral to the Blanks (E) Working Group to Add Fixed Income Analytical Risk Measures to Investments Reported on Schedule D, Part One**

Mr. Therriault said the SVO proposes adding market-data analytical fields for bond investments to the annual statement instructions. This amendment is a first step towards what the former Rating Agency (E) Working Group recommended, and the Financial Condition (E) Committee approved, in 2010 to address lessening the NAIC’s reliance on rating agency ratings by looking at other measures of risk. It also reflects the Investment Analysis Office (IAO) staff’s recent findings regarding the discrepancies between ratings, presented in its Nov. 29, 2021, memo, and recommendation to identify securities with risks that may not be reflected by a rating.

The Rating Agency (E) Working Group made these summary recommendations in its April 28, 2010, report that was adopted by the Financial Condition (E) Committee:

1. Regulators [should] explore how reliance on Approved Ratings Organization (ARO) ratings can be reduced when evaluating new, structured, or alternative asset classes, particularly by introducing additional or alternative ways to measure risk.
2. Consider alternatives for regulators’ assessment of insurers’ investment risk, including expanding the role of the NAIC SVO.
3. When considering continuing the use of ratings in insurance regulation, the steps taken by the nationally recognized statistical rating organizations (NRSROs) in correcting the causes that led to recent rating shortfalls, including the NRSROs’ efforts in implementing the recommended structural reforms, should be taken into account.

As the IAO staff demonstrated with the analysis in its Nov. 29, 2021, memo regarding rating discrepancies, not all CRP ratings reflect a reasonable or consistent assessment of a security’s risk, indicating that rating shortfalls persist today. One step towards introducing alternative ways to measure a bond security’s risk would be to require insurers to report various common analytical measures about each security, including metrics such as its current market yield, interest rate sensitivity, spread relative to risk-free securities such as U.S. Treasuries, duration, convexity, and average remaining life. The more a security’s market yield and spread differ from similarly rated securities, the more likely it is that the implied market-perceived risk of that security differs from the risk indicated by the credit rating assigned to it. The yield difference or spread in basis points can potentially help identify securities whose CRP risk assessment warrants further review by the SVO, examiners, or other regulatory groups. For example, a AAA-rated 10-year security with a market yield of 6.00% appears anomalous when compared to data published by the St. Louis Fed (FRED) indicating a AAA U.S. corporate yield should be 3.00% (as of March 21). Significant differences would highlight a potential risk assessment mismatch. Other fields that measure a security’s price sensitivity to interest rate movements may also help to identify market-perceived risk inconsistent with the assigned credit rating.

The Rating Agency (E) Working Group made similar recommendations to consider market data in its referral to this Task Force and the former SVO Initiatives (EX) Working Group. Their detailed recommendations were as follows:

1. **Referral to the Valuation of Securities (E) Task Force: The Task Force should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending on the specific regulatory process under consideration.**
2. **Referral to the Valuation of Securities (E) Task Force: ARO ratings have a role in regulation. However, since ratings cannot be used to measure all the risks that a single investment or a mix of investments may represent in an insurer’s portfolio, NAIC policy on the use of ARO ratings should be highly selective and incorporate both supplemental and alternative risk assessment benchmarks.**
3. Referral to the former SVO Initiatives (EX) Working Group: The NAIC should evaluate whether to expand the use of SVO and increase regulator reliance on the SVO for evaluating credit and other risks of securities.

The SVO is recommending the addition of these common bond market data fields to the annual statement instructions, through a referral to the Blanks (E) Working Group, for all bonds reported on Schedule D, Part 1 (those within scope of Statement of Statutory Principles (SSAP) No. 26R—Bonds and SSAP No. 43R—Loan-Backed and Structured Securities) with the objective of developing analytical processes to assess investment risk as either a supplement or alternative to ratings. To allow sufficient time for insurers to update their systems, the SVO recommends that the changes be implemented as electronic-only fields effective beginning with the reporting year ending Dec. 31, 2023. The SVO recommends informational referrals to the Capital Adequacy (E) Task Force and the Life Actuarial (A) Task Force to give them the opportunity to include any other market data fields that would assist them in their analysis work.

Ms. Mears said while the Task Force is proposing these new fields for the benefit of analytical procedures by the SVO, they really do align with other initiatives in place and with other groups, including the Capital Adequacy (E) Task Force and the Life Actuarial (A) Task Force. It is anticipated that will be a collaborative effort with those groups to ensure that the new fields are ones that can be used across those various work streams. She said this is a large change and that she agrees that insurers should be given sufficient time to prepare their systems. There are also changes coming from the bond project at the Statutory Accounting Principles (E) Working Group and will be working to align all those efforts across the various groups that are interested in this topic. These are all typical bond analytical fields commonly used to assess a bond risk, and they would be valuable information to be provided to state insurance regulators and the Task Force.

Chris Anderson (Anderson Insights) said what is being discussed is building a model and before a model is built, the purpose of the model needs to be understood. Is the model to get a general idea of insurers assets or is it to identify outliers or anomalies? Once that is addressed, the next question is what data elements are needed to populate the model? He said the suggestions seem reasonable. The question that needs to be addressed is: Are those the right variables? Are there too many, or are there not enough? If the purpose of the model is to identify outliers, then the right variables are needed. He said as another word of caution, if a simple web search is done, it will show how many people try to build models to identify what the proper rating agency rating should be. He said the world is littered with those Ph.D., artificial intelligence (AI), machine learning (ML) people. He said there are 5,000 analysts and supervisors at the nine rating agencies, and they would all love to have a model that would tell what the right rating should be for a bond. Mr. Anderson this is complicated and difficult, and perhaps the NAIC can find resources to build such a model. Before that is attempted, he said the model should be seen and tested. Then decide whether thousands of companies should be required to provide additional data, especially because the model itself that the NAIC develops may not be work properly without additional data.

Mr. Anderson said that last year, 43 anomalies were identified. The tough part, then, is doing attribution. Why do those anomalies exist? He said it is unknown why the 43 anomalies identified last year exist. He said it is hard and difficult. Mr. Anderson said it could be that the NAIC would need to replicate the process of the rating agency. He said a medium size rating agency might have 70–75 methodologies. To replicate the rating, the methodologies need to be understood. For corporate, for example, the NAIC would need to come up with its economic scenario, rely on economists, and then get an industry assessment. If it is autos, if it is aviation, for example, it is important to know how the individual company fits into that structure, both the economic structure and the industry outlook. This is interactive, but the analysts, of course, are looking at history. They are looking at audited financial statements and other things, but they are also actively participating with the company. Rating agency analysts of a corporate issuer has inside information. They meet with the company. They follow the company. They perform their due diligence, and then they go to their committee, which is represented by specialists that are drawn from that industry and who can contribute to the conversation. The analysts’ views are accepted or they are not, and
the analysts just sent back for more work. Mr. Anderson that is the process the rating agencies go through. If there is an anomaly, it needs to be understood now what that anomaly is attributed to.

Mr. Anderson said the SVO has a different process. The SVO looks at history. It looks at three years of audited financials. It looks at secondary information. It looks at the report of the analyst at the insurance company to their investment committee. The SVO may look at other things, but it does not take advantage of the many things that the 5,000 analysts and supervisors at the nine rating agencies do. It is a different process. Even if the SVO had a model and it worked well, there would still be anomalies must be explained. He said that is going to be a challenge.

Mr. Anderson commented on the objective that that the NAIC should reduce reliance on rating agencies for the 315,000 securities that insurers own. He said the idea that the NAIC is trying to reduce reliance is probably not the appropriate objective for this group. That is a blueprint from a dozen years ago. Some of the working groups in that blueprint do not exist anymore. This is not excusing the rating agencies. He said the rating agencies historically did a terrible job a dozen years ago. The U.S. Securities and Exchange Commission (SEC) requires that methodologies and performance be published. The SEC is doing what the SEC does, shining a light on a problem. He said if look at Form NRSRO, you can see the nine exhibits for all the rating agencies in a form that is standardized. It is not only standardized, but the SEC investigates, and it makes sure that a rating agency says what it is doing and does what it says and then those are reported on annually.

Mr. Anderson said that what needs to be done with the R-1 and C-1 bond factors is to come up with reliable factors that can be used to drive the risk-based capital (RBC) model. The RBC model is complicated. He said there are probably not a lot of people who understand the intricacies of that model, but what the model requires is accurate default statistics. That should be the objective of this Task Force in coming up with accurate representations of credit worthiness for R-1 and C-1 that will allow the RBC model to achieve its objective, which is to identify potentially troubled companies. It may be that reducing reliance on rating agencies is something the NAIC winds up doing. In summary, there is the difficulty of developing a model and doing attribution when there are exceptions. The fundamental question of why it is not appropriate to be thinking about the benefit of having accurate C-1 and R-1 factors that drive the RBC model.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) requested a 45-day exposure period for the proposal.

Ms. Mears directed SVO staff to expose this request for a 45-day comment period May 20 and to prepare a referral to the Blanks Working Group with copies to Capital Adequacy (E) Task Force and Life Actuarial (A) Task Force.

5. Received and Discussed Comments on a Proposed Amendment to the P&P Manual to Add Guidance on the Designation of Schedule BA Assets with Fixed Income Characteristics

Mr. Perlman said the SVO recommends updating the instructions in Part Three of the P&P Manual to include guidance related to the assignment of NAIC designations to Schedule BA assets with underlying characteristics of bonds or fixed income instruments. Part One of the P&P Manual currently permits the SVO to assign NAIC designations to Schedule BA assets with underlying characteristics of bonds or fixed income instruments, but there is currently no specific guidance for the SVO in Part Three of the P&P Manual. Including the proposed provisions would enable the SVO to assign NAIC designations to Schedule BA assets that are not expressly covered by other sections of the P&P Manual (such as Schedule BA Funds). Schedule BA assets for life and fraternal insurers would benefit from NAIC designations because they would be eligible for more favorable RBC treatment. The SVO’s authority to assign NAIC designations to certain Schedule BA assets already exists. Part One of P&P Manual states: “The SVO is assigned to assess investment securities reported to state regulators on Schedule D and Schedule BA.”
Additionally, the P&P Manual also explains in Part One that to be eligible for the assignment of an NAIC designation, a Schedule BA asset must have underlying characteristics of a bond or fixed income instrument.

This proposed amendment would potentially make various types of assets eligible for an NAIC designation that currently are not. Each asset would need to be individually assessed by the SVO for bond or fixed income characteristics. At this time, the SVO recommends that SVO staff continue working with industry on this topic.

Mr. Reis said the ACLI, PPIA, and NASVA have had a longstanding shared goal with the SVO to work in getting NAIC designations on fixed income like instruments to right size the RBC charge. That will probably not happen without a referral to Capital Adequacy (E) Task Force. It also ties in with what is happening in the 43-R bond project with the Statutory Accounting Principles (E) Working Group, where certain investments may be moving to Schedule BA. Mr. Reis said this is a supported effort, and they will continue working with the SVO on it.

Ms. Mears directed SVO staff to continue to work with industry on the topic, which will eventually result in a referral to the Capital Adequacy (E) Working Group. She said it will be helpful, for their purposes, if there is a good framework that the Valuation of Securities (E) Task Force can provide to the Capital Adequacy (E) Task Force.

6. **Adopted an Amendment to the P&P Manual to Permit Un-Guaranteed and Unrated Subsidiary Obligors in WCFI Transactions, with SVO Discretion**

Ms. Mears said the Task Force has gone through several iterations of this amendment over the past year. With the current version, exposed at the 2021 Fall National Meeting, the SVO reintroduced a proposal under which the Task Force would give the SVO discretion to notch down from the parent’s rating in certain circumstances. It adheres very closely to an earlier version of the proposal.

Mr. Perlman said as the Task Force is probably aware of by now, the SVO received comments from certain insurers and other interested parties that it should assign NAIC designations to working capital finance investments (WCFI) with unguaranteed and unrated obligors, based on the implied support from an obligor’s NAIC CRP-rated parent even though the SVO found no generally accepted analytical technique or methodology to support the assumption that a parent entity will necessarily support its subsidiary in times of financial distress.

The current draft of the amendment, exposed at the 2021 Fall National Meeting, is substantially like the original amendment and reflects the comments from some Task Force and Statutory Accounting Principles (E) Working Group members that they would like the SVO to retain discretion to notch down, as it deems appropriate (Attachment One). Like the November 2020 amendment, the Task Force would direct the SVO to imply the parent’s support of its subsidiary and would give the SVO discretion to assign an NAIC designation to the subsidiary that is lower than that of the parent based on its assessment of the parent/subsidiary relationship. However, this current proposal clarifies that if the SVO notches the NAIC designation of a subsidiary obligor down from that of its parent, resulting in a credit assessment below an NAIC 2, the WCFI program would not be eligible for an NAIC designation because it would no longer meet the definition of an eligible “obligor” in SSAP No. 105R—Working Capital Finance Investments.

During the exposure period, a comment letter (Attachment Two) was sent to both this Task Force and the Statutory Accounting Principles (E) Working Group with comments related to working capital finance that go beyond the scope of the question of unrated subsidiaries and that affect SSAP No. 105R. It came to this Task Force’s attention that the Financial Accounting Standards Board (FASB) exposure draft regarding disclosure of WCFI or supplier finance programs, as the FASB calls them, which was sent as an attachment to the letter, was not posted in the meeting materials, but it can now be found in the documents tab of the Task Force web page. The Statutory Accounting Principles (E) Working Group has indicated that it does not plan to address these comments at this time, and as such, the SVO proposes adopting this amendment in its current form and revisiting
the other topics in question, depending on Working Group’s position on them, should it revisit them in the future. If this amendment is adopted, SVO staff will monitor WCFI transactions and keep the Task Force informed if the SVO encounters any issues or has any problems with WCFI programs because of these new instructions.

Ms. Mears said this is a narrow application of this direction from the Task Force solely to these WCFIs. And as Mr. Perlman noted, the Task Force would anticipate, in a regulator-to-regulator session, a continued dialog with the SVO on what it is seeing and what types of investments are coming through in case the Task Force would like to alter this in the future.

Mike Monahan (ACLI) said that all the work on WCFI transactions is appreciated and that he agrees with the recommendation to adopt this amendment.

Mr. Kozak made a motion, second by Ms. Doggett, to adopt this P&P amendment by which the Task Force would direct the SVO to assign NAIC designations to WCFIs with unrated subsidiary obligors (Attachment Three). The motion passed unanimously.

7. Heard a Report on the Use of NAIC Designations by Other Jurisdictions in the Regulation of Insurers

Mr. Therriault said the SVO was made aware of regulators or insurers in non-U.S. jurisdictions, such as the Bermuda Monetary Authority (BMA) and Japan’s Financial Services Agency (FSA), either referencing NAIC designations in their regulatory processes or wanting to reference them. The P&P Manual is specific in that NAIC designations are only intended for NAIC members consisting of the chief insurance regulators of the 50 states, the District of Columbia, and five U.S. territories. For example, the P&P Manual says of the intended, proper, and authorized use of NAIC designations, the following:

1. An NAIC designation for quality (NAIC designation) of a security is produced solely for NAIC members who should interpret the designation for quality, in the context of the NAIC Financial Regulation Standards and Accreditation Program, a member’s state insurance laws and regulations, and the regulatory or financial solvency profile of a specific insurance company.
2. Because an NAIC designation is not produced to aid the investment decision-making process, NAIC designations are not deemed to be suitable for use by anyone but NAIC members.
3. NAIC designations are not intended to be and should not be used as if they were the functional equivalent of the credit ratings of NRSROs or other rating organizations whose ratings are intended to be used by investors as predictive opinions of default risk.
4. The use or adoption of NAIC designations by anyone other than NAIC members is improper and is not authorized by the NAIC.
5. NAIC designations and other analytical products of the SVO and Structured Securities Group (SSG) are produced solely for the benefit of NAIC members in their capacity as state insurance department officials for use in the NAIC Financial Regulation Standards and Accreditation Program.

The SVO received this request and support for this change from interested parties who have identified that some U.S. dollar private placement securities could be classified as “unrated” and receive unfavorable treatment if overseas regulators cannot rely on NAIC designations and different legal entities of a single parent could be subject to different capital charges.

Given this would directly affect an NAIC-owned work product and NAIC designations, and it will require the NAIC as an organization to enter into agreements with non-U.S. regulatory groups, the SVO believes the NAIC’s Executive (EX) Committee will need to be involved and approve taking any further steps. The SVO recommends a referral to the Executive (EX) Committee for direction on how it would like to proceed with this matter.
Ms. Belfi said she has concerns about unintended consequences and the SVO being viewed as a rating agency. She asked if the ACLI could discuss what kinds of transactions are involved to require this support, then explain why it is important? She asked if it was maybe a U.S.-based group with a transaction with another jurisdiction, but there is concern with this blossoming into someone just wanting a rating from the SVO, and it has nothing to do with the U.S. group.

Mr. Monahan said to address two jurisdictions, Japan FSA and the BMA, U.S. dollar private placements are currently a core asset class for many U.S. companies operating in Japan, including MetLife, Prudential Financial, Aflac, Protective, and some other large companies. If these assets are considered undesignated after Japan adopts the International Associations of Insurance Supervisors’ (IAIS’) Insurance Capital Standard (ICS), there would be a huge selling pressure for an illiquid asset class, potentially causing market disruption on these U.S. assets. There would be no economic justification for this market’s disruptive, just the inability of global regulators to reach agreement. This is a great opportunity for international regulatory cooperation that is primarily under any NAIC’s control. Bermuda and Japan are extremely willing to use NAIC designations. Those jurisdictions just need to understand exactly what they need to do in a memorandum of understanding (MoU) to qualify for access. The NAIC can help by being very explicit about what Bermuda and Japan are going to use these designations for. They are U.S.-based groups.

Mr. Anderson said this undoubtedly has great merit. He said it is unfortunate when something is rated to not take that into consideration. But on the basic premise, just one observation, one will see in the last agenda item that the SVO designates, either on a first-time basis or on a repeat basis, about a little more than 12,000 securities a year. The notion that there is something special about any designation when the vast majority come from rating agencies is something that that need to be considered. He said he is not saying that this does not have tremendous merit; he said he was questioning the premise that there is a great difference between NAIC designations and rating agency ratings.

Ms. Mears directed SVO staff to forward this proposal to the Executive (EX) Committee requesting direction from it as to whether it supports the NAIC permitting non-U.S. jurisdictions access to and use of NAIC designations for their regulatory purposes if there is an MoU between the NAIC’s governing that use and with an acknowledgement from the requesting regulator that its use of designations may deviate from the NAIC’s intended purposes. She said the Executive (EX) Committee should also consider if guardrails are needed to ensure that usage aligns with the NAIC’s expectations.

8. Heard a Report from the SVO on Carryover Filings

Mr. Therriault said as required in Part Two, Operational and Administrative Instructions Applicable to the SVO, of the P&P Manual, the SVO director must prepare a report for the Spring National Meeting identifying an acceptable annual rate of carryover filings for the year-end reporting period. These carryover filings can be identified with the administrative symbols “IF,” which are initial filings with a self-assigned NAIC designation, and “YE,” which are annual update filings the SVO has not yet reviewed, and the NAIC designation from the prior review was carried forward until the review is complete. There were 828 carryovers filing for 2021 versus 795 in 2020; 310 were “IF,” and 518 were “YE.” This represented a carryover rate of 6.7% for 2021 versus a carryover rate of 6.3% for 2020. Overall, the SVO reviewed 12,258 security filings for 2021. A carryover rate below 10% is manageable for the office given its current staffing. As of March 31, there were only 37 remaining carryover filings to review.

Mr. Therriault said the SVO continues to experience significant resource limitations regarding its technology support that is negatively affecting its ability to make significant or timely improvements to its core systems, VISION, Automated Valuation Service Plus (AVS+), and the Structured Security System (STS). There will be limited ability to intake the private letter (PL) rating rationale reports this year, and the full implementation of the policy in VISION will need to be deferred until 2023 or possibly longer. It has also prevented the SVO for several years
now from being able to use the investment data it licenses, such as the business entity cross reference service and
global instruments cross reference service. Both are necessary to implement investment organizational
relationships and additional security identifiers like ISIN in these applications. He said any help that Task Force
members can provide to increase the SVO’s technology support is greatly appreciated.

Ms. Mears said the technology issues come up again and again and is something to be discussed at the Task Force
in terms of what support it can provide moving forward with the SVO so that it can get the technology and other
resources that they need.

9. Received a Report on Projects of the Statutory Accounting Principles (E) Working Group

Julie Gann (NAIC) said the Working Group met April 4. It addressed several issues during that meeting, but only
five will be included in this update—two adoptions and three exposures. The meeting summary, items that were
adopted, and those that were exposed are on the Working Group’s web page. The Working Group adopted a
proposal to support new reporting related to cryptocurrency. Although it did not result in any actual statutory
revisions, it did support a new general interrogatory, which is up for adoption at Blanks (E) Working Group in May
and will be in effect for a year in 2022. The disclosure will capture information from reporting entities on their use
of cryptocurrency, if they hold it, what reporting schedule it is on, and if they are receiving cryptocurrency as
payment of premium.

The second adoption relates to SSAP No. 43R; the Working Group adopted revisions that were referred from this
Task Force related to financial modeling. The Working Group considered whether to remove the financial
modeling guidance from the SSAP fully or just point to the P&P Manual. After considering comments from
industry, the Working Group decided to retain the guidance in SSAP No. 43R. However, it was identified that it
was easier for preparers to refer to the summary there, but the Working Group did make a point to comment
during the meeting that it is only a summary, and the detailed guidance is in the P&P Manual, if there is a need to
got to the actual detailed level guidance.

For exposures and discussion items, Ms. Gann said there three things to note. First, for the principles-based bond
project, the Working Group exposed a revised bond definition, as well as a draft issue paper in March. The Working
Group noted that comments are due May 6. The Working Group received information through comments received
from industry on the proposed reporting changes. As Ms. Mears mentioned earlier, the Working Group expects
significant reporting changes to Schedule D-1, as well as other satellite schedules, as a result of this project. The
Working Group wants to make sure it communicates that loud and clear so that no one is unaware when those
changes are in effect. NAIC staff were directed at the Spring National Meeting to continue working with industry
on those reporting changes, as well as to draft SSAP revisions so the bond definition gets reflected in SSAP No.
26R and SSAP No. 43R, and then those would be subsequently exposed for comment. The goal is to have more
granularity and transparency on the investments that are held on Schedule D-1. She said it is a big project and if
anyone wants to talk with NAIC staff to get more information, they can reach out and talk to her.

With regards to another item that was up for exposure, the Working Group discussed reporting changes to identify
whether an investment is with a related party, regardless of whether that investment is identified as an affiliated
investment in the reporting schedule. This is a second exposure related to this item, where the Working Group
reflected some interested party comments and re-exposed it for a shortened comment period that ends on May
6. The goal is to have it in effect for year-end 2022. There is a concurrent Blanks (E) Working Group proposal that
was also exposed. There will be new electronic reporting columns for reporting entities that would identify a code
on whether the investment came through a related party. There are five different codes there. One is for direct
credit underlying credit exposure and if there was a related party otherwise involved as a service or manager
again.
Lastly, Ms. Gann said the Working Group exposed a draft interpretation (INT) related to new securities that are referred to as When Issued Freddie Mac Securities. For that investment on day one, the reporting entity acquires a certificate that is backed by cash flows held in a trust. There is a subsequent trust that acquires the mortgage-backed securities within 90 days; it is like a double pass-through. The exposed INT identifies that these securities would be within scope of SSAP No. 43R at the date of acquisition. There would not be any moving between schedules. The securities are guaranteed by Freddie Mac. This was exposed for comment with a shortened comment period deadline of May 6, to get the INT in place.

10. **Heard an Update on New RMBS/CMBS Thresholds and Price Breakpoints**

Ms. Mears said the next item is to hear an update on new residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) thresholds and price breakpoints.

Eric Kolchinsky (NAIC) said the SSG’s plan for the price break-point is to apply the current methodology using the new RBC factor targets for the thresholds and designations. SSG staff will follow the same approach that it currently uses for credit risk transfer (CRT) securities, and those are based on the breakpoint approach. This will be released through the Task Force for comment. SSG staff are closely working with the vendor, BlackRock Solutions, on the scenarios as well and hope to release those scenarios shortly, but it does require a lot more work. The release will include the scenarios and the associated probability. He said SSG staff look forward to getting feedback on them and having a robust discussion with both regulators and industry on these scenarios.

11. **Received an Update on the Ad Hoc Study Group**

Mr. Therriault said the ad hoc group—consisting of regulators, insurers, and NAIC staff—met for the first time on March 11 to discuss objectives for the group:

- Establish a framework of qualitative and quantitative criteria for being a CRP to the NAIC.
- Eliminate/minimize RBC arbitrage opportunities between CRP ratings and asset classes.
- Define a repeatable quantitative process to evaluate rating performance for all rating agencies consistent with NAIC RBC factors.
- Incorporate market data to help identify potential misalignments of risk, as recommended by the former Rating Agency (E) Working Group in 2010.

The ad hoc group also discussed the mapping analysis framework that one rating agency uses to map other rating agency ratings to their rating scale. The ad hoc group plans to meet again after the Spring National Meeting and is currently scheduled to meet monthly thereafter.

Ms. Mears said she anticipates the ad hoc group will have more robust updates once it has more than one meeting under its belt.

12. **Discussed Other Matters**

Mr. Kolchinsky said that there will be a joint NAIC and industry discussion on infrastructure that will be held immediately following Task Force meeting. It covers a report on infrastructure that was jointly written by the Capital Markets Bureau (CMB) and Center for Insurance Policy and Research (CIPR).

Having no further business, the Valuation of Securities (E) Task Force adjourned.
Date: August 26, 2021

To: Kevin Fry, Chair, Valuation of Securities (E) Task Force

From: Dale Bruggeman, Chair, Statutory Accounting Principles (E) Working Group

RE: Referral Response: Unrated Subsidiary Obligors in WCFI transactions

Summary – Pursuant to the referral received July 28, 2021, the Valuation of Securities (E) Task Force exposed a policy change that would direct the SVO to rely upon the NAIC designation of an unrated subsidiary obligor’s parent entity for Working Capital Finance Investments (WCFI), without notching for the subsidiary. A referral was provided to the Statutory Accounting Principles (E) Working Group, as a qualifying NAIC designation of the obligor is a required element for admittance of WCFI receivables under SSAP No. 105R—Working Capital Financial Investments.

The Working Group has considered this exposure and acknowledges that establishment of NAIC designations is within the purview of the Task Force. However, the provisions within SSAP No. 105R were established in accordance with the historical approaches utilized in determining NAIC designations which allowed the SVO to apply its credit substitution methodology as it does for other asset classes. The proposed policy would require the SVO to imply an NAIC designation to an unrated entity based on the parent entity’s credit quality without guarantees or other legally-binding provisions that provide assurance that the parent will be legally or contractually obligated to financially cover the obligations of the unrated entity. Although, for a given program, and not related to the parent/sub relationship, the SVO may notch or otherwise not give a rating to that program.

If the Task Force chooses to move away from the historical application of financial analysis and use of the credit substitution methodology in determining NAIC designations for WCFI programs, the Working Group may deem it necessary to incorporate additional guardrail provisions to SSAP No. 105R as the NAIC designation of the obligor may no longer provide the intended safeguard for WCFI programs. As WCFI are complex arrangements, the credit quality of the obligor – who is ultimately responsible for satisfying the debt owed to the insurance reporting entity – is of paramount importance. Furthermore, the referral and exposure documentation memo seem to understand this dilemma, as it specifically identifies that “no generally accepted analytical technique or methodology supports the assumption that a parent entity will necessarily support its subsidiary in times of financial distress.” Consideration of changes that the Working Group would deem necessary, if any, would be expected to occur after any such edits to the P&P manual are adopted.
If the Task Force chooses to move forward with the issuance of “implied” NAIC designations to unrated entities for WCRI programs, the Working Group offers the following two components for additional consideration:

1. The exposed P&P Manual language seems to contradict with SSAP No. 105R, paragraph 7. Specifically, the Task Force language identifies that the implied approach is an alternative method to obtaining an NAIC designation. If the Task Force is going to permit an implied approach to an unrated sub, then to avoid conflicts with SSAP No. 105R, this implied designation would need to be considered an “NAIC Designation.” If the guidance is adopted with the inconsistency, the guidance in SSAP No. 105R requiring an NAIC designation would be the authoritative guidance. Therefore, the Working Group would recommend coordination to address any inconsistencies.

2. Although the implied designation would need to be considered an “NAIC Designation” to satisfy the requirements of SSAP No. 105R, the Working Group recommends that NAIC designations determined under the implied methodology have a specific identifier so that WCRI programs with rated obligors and unrated obligors can be separately identifiable by state insurance regulators. This is considered necessary as without this identification, regulators could erroneously conclude that an unrated obligor has been individually determined to be of high-credit quality, or that the parent entity has guaranteed or is otherwise legally obligated to pay the obligations of the unrated entity.

The Working Group appreciates the referral from the Task Force and opportunity to provide comments. Please direct any questions or responses to the Chair of the Working Group, or NAIC SAPWG Staff.

CC: Carrie Mears, Vice-Chair, Valuation of Securities (E) Task Force
Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
Julie Gann, Assistant Director, NAIC Financial Regulatory Services
Robin Marcotte, Senior Manager II, NAIC Financial Regulatory Services
James Pinegar, Manager II, NAIC Financial Regulatory Services

January 20, 2022

Ms. Carrie Mears, Chair  Mr. Dale Bruggeman, Chairman
Valuation of Securities Task Force  Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Supply Chain Finance also known as Working Capital Finance Investments

Dear Ms. Mears and Mr. Bruggeman:

ACLI appreciates the opportunity to comment on the Task Force’s Amendment to Permit Un-Guaranteed and Unrated Subsidiary Obligors in WCFI Transactions, with SVO Discretion. We also want to thank the NAIC and staff for engagement and continuing efforts to address various investment and statutory accounting issues and we appreciate the opportunity to call your attention to pending changes to both FASB\(^1\) and IFRS\(^2\) accounting standards. Both bodies have recently issued exposure drafts for comment that cover required disclosures of balance sheet accounts regarding use of what has been termed supply chain finance that in the context of the NAIC are known as Working Capital Finance Investments (SSAP 105).

Attached to this letter is a copy of FASB’s exposure draft which was placed on its agenda from a joint request from the Big 4 accounting firms. All companies preparing financial statements need comply and all disclosures are subject to audit by the filing entity auditor with the FASB exposure draft disclosure requirements summarized below:

405-50-50-3 An entity shall disclose all the following information about its supplier finance programs:
   a. The key terms of the program.

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\(^1\) https://www.fasb.org/jsp/FASB/FASBContent_C/ProjectUpdateExpandPage&cid=1176175475663

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b. The following information about the amount of obligations outstanding at the end of the reporting period that the entity has confirmed as valid to the finance provider or intermediary under the program (that is, the amount of obligations confirmed under the program that remains unpaid by the entity):

1. Where those obligations are presented in the balance sheet. If those obligations are presented in more than one balance sheet line item, then the entity shall disclose the amount outstanding at the end of the reporting period in each line item.
2. A rollforward of those obligations showing, at a minimum, all the following:
   i. The amount of those obligations outstanding at the beginning of the reporting period
   ii. The amount of those obligations added to the program during the reporting period
   iii. The amount of those obligations settled during the reporting period
   iv. The amount of those obligations outstanding at the end of the reporting period.

We want to share several observations about the proposed disclosures and its potential impact on insurance filers as well as on the current SSAP and the remaining open issues and to make several recommendations.

In brief, SSAP 105 was approved in late 2013 with industry as the catalyst for its development. Adoption was low with industry again serving as catalyst for review beginning in 2016 with request for 10 critical revisions in 2017 of which 7 were adopted in 2020. Subsequent adoption of the 2020 revisions also remains low.

The three remaining items not adopted by the NAIC include Schedule BA reporting, restrictions to NAIC 1 and 2 equivalent ratings and limitations of issuers' unrated subsidiaries which is currently the subject of evaluation by both the VOS. Importantly, each of these items are directly addressed through the pending FASB rules:

1. In the case of insurance reporting, FASB requires the corporate entity to disclose specifically where those liabilities are reported in the financial statements likely classified either as either accounts payable or debt. Schedule D is the appropriate insurance reporting schedule for such liabilities and not Schedule BA. The continuing reporting on Schedule BA is inappropriate and is a significant obstacle to adoption by insurers as, and we cannot stress this enough, the extra scrutiny of BA assets is something that many insurance filers avoid.

2. In the case of corporate entities, all companies that utilize supply chain finance will be required to disclose the arrangements, regardless of their NRSRO credit rating. In the case of the SSAP, the restriction to NAIC 2 and higher investments, which is the only investment asset class to have such a restriction, creates a considerable challenge for investment. This restriction is inappropriate as well. As the SVO has discretion to notch a potential filing, in the case of a downward notching below NAIC 2 of a filing, the investment under the existing rules would become non-admitted. There is considerable expense and risk associated with RTAS approval and ratings equivalent assignment. Uncertainty concerning filing creates limitations on the willingness of insurance filers to invest given the increased risk associated with possible downward notching.

3. In the case of subsidiaries and affiliates as part of an organization that is utilizing supply chain finance, its obligations are subject to reporting and audit as consolidated in the accounts under the FASB rules. While this is currently being addressed by the VOS it is also worth noting that there has been significant resistance among staff and some regulators regarding
the perceived risks about unrated subsidiary obligations and suitability for investment. The SSAP restriction offers no meaningful purpose.

ACLI recommends that the remaining restrictions for Schedule BA reporting and for limitations to NAIC 2 or higher obligors be removed from the SSAP. Apt in the context of the pending disclosures is Supreme Court Justice Louis Brandeis statement that “sunlight is said to be the best of disinfectants” from his 1913 Harper’s Weekly article entitled “What Publicity Can Do”, the pending changes will lead to a significant expansion of awareness of the asset class and will also lead to broader opportunities for investment. While the insurance industry has had a head start, given the restrictiveness of the SSAP it has not benefited. Time is of the essence to complete the work and amend the SSAP to resolve the remaining investment issues and request your consideration of resolving these open matters promptly.

If you have any questions in the interim, please do not hesitate to contact me.

Attachments: FASB Exposure Draft - Liabilities—Supplier Finance Programs (Subtopic 405-50)

Sincerely,

Mike Monahan
Senior Director, Accounting Policy

Cc: Julie Gann, Charles Therriault

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2022/2022-04 - Spring National Meeting/06 - WCFI Unrated Sub Obligors/2021-050.03 ACLICommentLetteronWCFI_v012022_v2.docx
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Purposes and Procedures Manual amendment to permit un-guaranteed and unrated subsidiary obligors in WCFI transaction, with SVO discretion

DATE: November 24, 2021

Summary – The SVO has received comments from certain insurers and other interested parties that it should assign NAIC Designations to Working Capital Finance Investments (WCFI) with unguaranteed and unrated obligors, based on the implied support from an obligor’s NAIC Credit Rating Provider (CRP) rated parent.

In November 2020, the Task Force exposed a proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (the “P&P Manual”) to direct the SVO to rely upon the NAIC Designation or NAIC CRP Rating equivalent of the subsidiary obligor’s parent entity, with allowance for the SVO to notch down from the parent’s rating or NAIC Designation due to its assessment of certain factors regarding the parent/subsidiary relationship. In response to feedback from some Task Force members and interested parties, the SVO subsequently presented a revised proposal to the Task Force at the Summer 2021 National Meeting to remove its discretion to notch because, as demonstrated in its memorandum to the Task Force of October 16, 2020, the SVO found no generally accepted analytical technique or methodology to support the assumption that a parent entity will necessarily support its subsidiary in times of financial distress. This revised amendment was also not adopted by the Task Force.

The SVO is now proposing a new clean amendment which is substantially similar to the original and reflects the comments from some Task Force and Statutory Accounting Principles (E) Working Group members that they would like the SVO to retain discretion to notch down, as they deem appropriate. Like the November 2020 amendment, the Task Force would direct the SVO to imply the parent’s support of its subsidiary and would give the SVO discretion to assign an NAIC Designation to the subsidiary which is lower than that of the parent based on its assessment of the parent/subsidiary relationship. However, this new proposal clarifies that if the SVO notches the NAIC Designation of a subsidiary obligor down from that of its parent resulting in a credit assessment below an NAIC 2, the WCFI program would not be eligible for an NAIC Designation because it would no longer meet the definition of an eligible “Obligor” in Statements of Statutory Accounting Principles 105R – Working Capital Finance Investments.
Proposed Amendment – The proposed text changes directing the SVO to assign NAIC Designations to WCFL programs with unguaranteed and unrated subsidiary obligors are shown below with additions in red underline and deletions in red strikethrough, as it would appear in the 2021 P&P Manual format.
PART ONE

POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK FORCE
POLICIES APPLICABLE TO SPECIFIC ASSET CLASSES

WORKING CAPITAL FINANCE INVESTMENTS (WCFI)

Description

118. As described in SSAP No. 105R - Working Capital Finance Investments, WCFI represents a confirmed short-term obligation to pay a specified amount owed by one party (the obligor) to another (typically a supplier of goods), generated as a part of a working capital finance investment program for which an NAIC Designation is assigned by the SVO. Pursuant to the working capital finance investment program, this short-term obligation has been transferred by the entity entitled to payment (typically a supplier of goods) to a third-party investor.

Obligor

119. The Obligor for WCFI transactions is the party that purchases the goods or services that generates the original supplier receivable (which is the payable for that Obligor). The obligor must have an NAIC Designation of “1” or “2” or an NAIC Credit Rating Provider (CRP) Rating equivalent.

Unrated Subsidiaries

120. Many WCFI programs are structured in a way whereby unrated subsidiaries of a rated parent entity are involved as transaction participants, including as the Obligor. Such programs may have strong operational and strategic linkages between the rated parent entity and its unrated subsidiaries.

121. Given (i) the short-term (less than one year) payment terms of each of the underlying receivables arising from the sale of goods or services, (ii) WCFI investors’ option to stop funding a working capital finance program, and (iii) the necessity of working capital finance programs to obligors due to obligors’ reliance on their suppliers, the Task Force has concluded there is a low probability of default of WCFI investments. Accordingly, the Task Force deems it reasonable to establish a principle to direct the SVO, in its assessment of WCFI programs, to rely upon a parent entity’s rating for purposes of determining the NAIC Designation of the overall WCFI program.
122. Solely for purposes of WCFI transactions, the Task Force directs the SVO to rely upon the NAIC Designation or NAIC CRP Rating equivalent of the obligor, subsidiary or affiliate’s parent entity if the obligor, subsidiary or affiliate does not have an NAIC CRP Rating and the SVO cannot assign an NAIC Designation to it.

123. The Task Force authorizes the SVO, based on its analytical judgement and in its sole discretion, to notch such NAIC Designation down or decline to assign an NAIC Designation, based on factors including, but not limited to, whether:
   a) the unrated subsidiaries or affiliates that serve as key transaction participants cannot reasonably perform the functions expected of them; and/or
   b) the rated entity does not have significant documented operational control over the performance of the unrated subsidiaries or affiliates that also serve as obligors in the program; and/or
   c) documentary evidence in the program documents or appended thereto does not sufficiently demonstrate the importance of the inter-relationship between the rated entity and the unrated subsidiaries or affiliates; and/or
   d) the resulting NAIC Designation would, upon application of notching, be lower than an NAIC 2 Designation.

124. For the avoidance of doubt, though the Task Force directs the SVO to use the NAIC Designation or NAIC CRP rating equivalent of the obligor’s parent entity, due to the SVO’s authority to notch such NAIC Designation or rating, the SVO, based on its analytical judgement and in its sole discretion, may assign an NAIC Designation to the obligor which differs from the correlated NAIC CRP rating equivalent of the obligor’s parent entity or choose not to assign any NAIC Designation to the working capital finance program, based on aspects of the working capital finance program which are unrelated to the relationship between the obligor, subsidiary or affiliate and its parent entity.

125. The Task Force acknowledges that reliance upon the NAIC Designation or NAIC CRP rating equivalent of the obligor’s parent entity in the absence of a binding legal obligation for the parent to assume the financial obligations of the obligor, such as a guarantee, is not a generally accepted technique or methodology (as explained in “Use of Generally Accepted Techniques or Methodologies” in Part One of this Manual) and is inconsistent with the credit substitution guidelines detailed in “Credit Substitution” in Part Three of this manual, but it is directing the SVO to so rely.

PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
WORKING CAPITAL FINANCE INVESTMENTS

122. **Obligor** – An entity that purchases the goods or services from the Supplier and thereby generates the original supplier receivable—and which Obligor has, or can be designated, **NAIC 1 or NAIC 2** by the SVO or has been assigned an equivalent credit rating by a NAIC CRP or, if not so designated, the SVO can assign such NAIC Designation, as directed by the VOS/TF pursuant to the “Working Capital Finance Investments (WCFI)” section in Part One of this Manual.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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Memorandum from the Blanks (E) Working Group Regarding Items Impacting Current Accreditation
Standard (Attachment Two)........................................................................................................................................... 10-11

Memorandum from the Capital Adequacy (E) Task Force Regarding Accreditation Standards –
Changes to the Risk-Based Capital (RBC) Formulas and Instructions for Health, Life, and
Property/Casualty (P/C) (Attachment Three).................................................................................................................. 10-14

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(Attachment Four)............................................................................................................................................................ 10-16

Memorandum from the Valuation of Securities (E) Task Force Regarding Revisions to the Purposes
Accreditation Standards (Attachment Five).................................................................................................................... 10-19

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March 2022 Valuation Manual (Attachment Six)........................................................................................................... 10-26

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the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company
System Model Regulation with Reporting Forms and Instructions (#450) (Attachment Seven)................ 10-28

Memorandum from the Financial Condition (E) Committee Regarding Use of Captives to Reinsure
Variable Annuity and Long-Term Care (LTC) Business (Attachment Eight)................................................................. 10-29
Financial Regulation Standards and Accreditation (F) Committee  
Kansas City, Missouri  
April 5, 2022

The Financial Regulation Standards and Accreditation (F) Committee met April 5, 2022. The following Committee members participated: Lori K. Wing-Heier, Chair (AK); Vicki Schmidt, Co-Vice Chair (KS); Sharon P. Clark, Co-Vice Chair (KY); Alan McClain (AR); Andrew N. Mais (CT); Gary D. Anderson (MA); Timothy N. Schott (ME); Mike Causey represented by Jackie Obusek (NC); Eric Dunning (NE); Andrew R. Stolfi (OR); Elizabeth Kelleher Dwyer (RI); Raymond G. Farmer (SC); Larry D. Deiter (SD); Scott A. White (VA); and Jeff Rude (WY). Also participating was: James J. Donelon (LA).

1. **Adopted its 2021 Summer National Meeting Minutes**

Commissioner McClain made a motion, seconded by Director Farmer, to adopt the Committee’s Aug. 14, 2021, minutes (see NAIC Proceedings – Summer 2021, Financial Regulation Standards and Accreditation (F) Committee). The motion passed unanimously.

Director Wing-Heier said the Committee met April 4 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee voted to award continued accreditation to Alabama, Mississippi, and North Carolina.

2. **Adopted Revisions to the 2021 NAIC Publications Referenced in the Accreditation Standards**

   a. **Adopted Revisions Deemed Insignificant**

Director Wing-Heier said there are several NAIC publications currently included in the accreditation standards by reference. At each Spring National Meeting, the Committee is to review revisions made to these publications in the prior year. Each of the applicable groups that developed revisions to the publications in 2021 have provided the Committee with a memorandum discussing the revisions, and they indicated whether the revisions should be considered significant or insignificant for accreditation purposes. This included the following publications: the Accounting Practices and Procedures Manual (AP&P Manual) (Attachment One); the Annual and Quarterly Statement Blanks and Instructions (Attachment Two); Risk-Based Capital (RBC) Formulas and Instructions for Life and Property/Casualty (P/C) Insurers (Attachment Three); the Financial Condition Examiners Handbook (Handbook) (Attachment Four); the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) (Attachment Five); and the Valuation Manual (Attachment Six). The working group or task force responsible for each of these publications has deemed their 2021 changes as insignificant to the accreditation process, except for the item specifically identified as “significant” by the Financial Examiners Handbook (E) Technical Group.

Director Farmer made a motion, seconded by Commissioner Stolfi, to adopt the revisions deemed insignificant to each of the publications immediately by reference to the accreditation standards. The motion passed unanimously.

   b. **Exposed Revisions Deemed Significant**

Director Wing-Heier summarized the Financial Examiners Handbook (E) Technical Group’s memorandum and discussed the items deemed significant for accreditation purposes. The Technical Group identified an
inconsistency between guidance in the Handbook and the accreditation guideline regarding exam coordination. Specifically, the Handbook guidance requires coordination efforts for examinations of holding company groups with insurers domiciled in multiple states; whereas, the accreditation guidance requires the same documentation for holding company groups with multiple insurers. Since the coordination guidance is intended to facilitate work between states, the recommendation is to align the accreditation guideline with the Handbook guidance as outlined in the memorandum.

Director Farmer made a motion, seconded by Commissioner McClain, to expose the Financial Examiners Handbook (E) Technical Group’s memorandum for a 30-day public comment period. The motion passed unanimously.

3. Exposed Receivership Updates to Model #440 and Model #450

Director Wing-Heier stated that at the 2021 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). Because both models are part of the accreditation standards, the Committee needs to consider the impact of any changes. The Task Force has provided its recommendation (Attachment Seven).

Commissioner Donelon, chair of the Task Force, stated that the Executive (EX) Committee and Plenary adopted revisions to Model #440 and Model #450 at the 2021 Summer National Meeting. The revisions help ensure efficient coordination with affiliates and enforce the continuation of essential services by an affiliate to an insurer in the event of insolvency. The Task Force adopted the referral at its Nov. 30, 2021, meeting, which recommends that the receivership revision be considered “acceptable but not required” rather than identifying “substantially similar” provisions that would be required. Commissioner Donelon pointed out that this recommendation is limited to the receivership revisions to these models. It does not include revisions that were adopted by the NAIC in 2020 for group capital or stress testing. While the Task Force does not recommend an accreditation requirement to adopt these revisions, it strongly encourages states to consider them as they are amending their holding company statutes based on the benefits these revisions add to state regulation; the goal is to improve efficiencies in receivership and reduce costs to a receivership estate.

Director Farmer made a motion, seconded by Commissioner Clark, to expose the recommendation from the Receivership and Insolvency (E) Task Force that the 2021 revisions to Model #440 and Model #450 be acceptable for accreditation, but not required, for a 30-day public comment period. The motion passed unanimously.

4. Exposed a Preamble Update for Variable Annuity Captives

Director Wing-Heier stated that captives are generally excluded from the accreditation standards, except for the following: 1) captive risk retention groups (RRGs); 2) captives that reinsure term and universal life with secondary guarantees (ULSGs); 3) captives that reinsure variable annuity business; or 4) captives that reinsure long-term care (LTC) business. Currently, variable annuities and LTC captives have “to be determined” effective dates, as work was ongoing in these areas. Last spring, the Financial Regulation Standards and Accreditation (F) Committee sent a request to the Financial Condition (E) Committee for more information on the extent that variable annuities and LTC captives are used, any relevant trends, and updates on related work. The second paragraph of the Financial Condition (E) Committee response (Attachment Eight) discusses updates to the *Valuation Manual* to alleviate concerns regarding captives that reinsure variable annuity business. The memorandum recommends replacing the “to be determined” effective date with a reference to VM-21: Requirements for Principle-Based Reserves for Variable Annuities. The recommended change to the Accreditation Preamble is on the second page of the recommendation. Since the *Valuation Manual* is already required for accreditation, the proposed revision does not represent a new requirement. Rather, it serves as a reference for how this item is addressed in the

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accreditation standards. This means there is no proposed requirement that would apply directly to captives. Rather, the issue is being addressed through the standards for traditional insurers. If future trends indicate a concern, the Financial Regulation Standards and Accreditation (F) Committee may reconsider this at that time.

Director Farmer made a motion, seconded by Commissioner White, to expose the proposed updates to the Preamble to reference VM-21 regarding variable annuity business for a 30-day public comment period. The motion passed unanimously.

Having no further business, the Financial Regulation Standards and Accreditation (F) Committee adjourned.

https://naiconline.sharepoint.com/sites/NAICSsupportStaffHub/Member Meetings/2022 NAIC Meetings/Spring National Meeting/Committee Meetings/FRS and ACCREDITATION (F) COMMITTEE/Minutes/April 5 F Cmte Minutes.docx
MEMORANDUM

TO:    Director Lori K. Wing-Heier, (AK), Chair, Financial Regulations Standards and Accreditation (F) Committee
         Commissioner Vicki Schmidt, (KS), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee
         Commissioner Sharon P. Clark, (KY), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM:  Dale Bruggeman (OH), Chair, Statutory Accounting Principles (E) Working Group
         Carrie Mears (IA), Vice Chair, Statutory Accounting Principles (E) Working Group

DATE:  February 28, 2022


In 2001, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the Accounting Practices and Procedures Manual – Effective January 1, 2001, Version 1999 (AP&P Manual) as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Statutory Accounting Principles (E) Working Group has made to the AP&P Manual in 2021 up to the 2022 date of submission for publication. This memo is to provide the customary annual update regarding changes to the AP&P Manual.

Attachment A to this memo includes a detailed listing of the changes made to the AP&P Manual in 2021. On behalf of the Working Group, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards.

As outlined in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (SAP Policy Statement), modifications will be made to the AP&P Manual each year. As such, it will be reprinted with an “as of” date associated with it. For example, the next printing of the AP&P Manual, which encompasses the attached modifications, will be titled Accounting Practices and Procedures Manual – as of March 2022. This process allows for an efficient way to update the AP&P Manual and virtually guarantees that users have the latest version. Reprints and updates are necessary because of the evolutionary nature of accounting—in both the statutory accounting principles and the generally accepted accounting principles arenas—and are positive for users of the AP&P Manual.

The Working Group sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the AP&P Manual. We will continue to notify the Committee of any changes to the AP&P Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

cc Becky Meyer, Sara Franson, Sherry Shull, Robin Marcotte, Julie Gann, Jim Pinegar, Jake Stultz and Jason Farr

https://naiconline.sharepoint.com/teams/FRSSStatutoryAccounting/StatAcctg_Statutory_Referrals/2022/2021SAPWGtoAccreditationMemo.doc
Summary of Changes to the  
As of March 2021 Accounting Practices and Procedures Manual  
included in the As of March 2022 Manual

The following summarizes changes made to the As of March 2021 Accounting Practices and Procedures Manual (Manual) and tracked in the As of March 2022 version.

Section 1 summarizes substantive\(^1\) revisions to statutory accounting principles. Substantive revisions introduce original or modified accounting principles and can be reflected in an existing or new SSAP. When substantive revisions are made to an existing SSAP, the effective date is identified in the Status section, and the revised text within is depicted by underlines (new language) and strikethroughs (removed language). This tracking will not be shown in subsequent manuals. New and substantively revised SSAPs are commonly accompanied by a corresponding issue paper that reflects the revisions for historical purposes. If language in an existing SSAP is superseded, that language is shaded and the new or substantively revised SSAP is referenced. Completely superseded SSAPs and nullified interpretations are included in Appendix H.

Section 2 summarizes the nonsubstantive\(^1\) revisions to statutory accounting principles. Nonsubstantive revisions are characterized as language clarifications which do not modify the original intent of a SSAP, or changes to reference material. Nonsubstantive revisions are depicted by underlines (new language) and strikethroughs (removed language) and will not be tracked in subsequent manuals. Nonsubstantive revisions are effective when adopted unless a specific effective date is noted.

Section 3 summarizes revisions to the Manual appendices.

<p>| 1. Substantive Revisions – Statutory Accounting Principles |
| --- | --- | --- |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were no substantive revisions to statutory accounting principles.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| 2. Nonsubstantive Revisions – Statutory Accounting Principles |
| --- | --- | --- |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>2021-12EP</td>
<td>Revisions incorporate paragraph numbers in the statutory hierarchy section.</td>
</tr>
<tr>
<td>Preamble Q&amp;A</td>
<td>2020-40</td>
<td>Revisions clarify that while any state in which a company is licensed can require supplementary financial information, the prescribed practices directed by the domiciliary state shall be reflected in the financial statements filed with the NAIC and are the ones subject to independent audit.</td>
</tr>
</tbody>
</table>

\(^1\) Pending Content Alert – Effective January 1, 2022, references to “substantive” and “nonsubstantive,” which have historically been used to describe statutory accounting revisions, have been updated in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles in Appendix F. Accordingly, where applicable, the concept/term, 1) “substantive” revision is being replaced with the phraseology “new SAP concept” and, 2) “nonsubstantive” revision is being replaced with the phraseology “SAP clarification” on a prospective basis. At the time of publication of the As of March 2022 Accounting Practices and Procedures Manual, conforming editorial revisions which impact the Preamble, Summary of Changes, How to Use this Manual, and NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process were exposed for public comment. When the exposed revisions are adopted, they will be made available as updates to the 2022 AP&P Manual.
<table>
<thead>
<tr>
<th>SSAP No.</th>
<th>Revision Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5R</td>
<td>2020-41</td>
<td>Revisions reject <em>ASU 2020-06, Debt—Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40), Accounting for Convertible Instruments and Contracts in an Entity’s Own Equity</em> for statutory accounting.</td>
</tr>
<tr>
<td>21R</td>
<td>2021-12EP</td>
<td>Revisions improve the readability of paragraph 9 on receivables for securities.</td>
</tr>
<tr>
<td>25</td>
<td>2019-34</td>
<td>Revisions clarify: 1) identification of related parties; 2) a non-controlling ownership over 10% results in a related party classification regardless of any disclaimer of control or affiliation; 3) a disclaimer of control or affiliation does not eliminate the classification as a “related party” and the disclosure of material transactions. Additionally, revisions reject several U.S. GAAP variable interest entities standards.</td>
</tr>
<tr>
<td>26R</td>
<td>2020-22</td>
<td>Revisions clarify that perpetual bonds are within scope of <em>SSAP No. 26R—Bonds</em>. Those with an effective call option shall be amortized under the yield-to-worst concept, and those that do not shall be reported at fair value.</td>
</tr>
<tr>
<td></td>
<td>2020-32</td>
<td>Revisions expand current called bond disclosures to include bonds terminated through a tender offer.</td>
</tr>
<tr>
<td></td>
<td>2021-02</td>
<td>Revisions reject <em>ASU 2020-08, Premium Amortization on Callable Debt Securities</em> for statutory accounting.</td>
</tr>
<tr>
<td>32R</td>
<td>2020-33</td>
<td>Revisions capture publicly traded preferred stock warrants in scope of <em>SSAP No. 32R—Preferred Stock</em> and require the warrants to be reported at fair value.</td>
</tr>
<tr>
<td></td>
<td>2021-10</td>
<td>Revisions clarify that the “effective call price” valuation limitation shall only apply if the call is currently exercisable by the issuer or if the issuer has announced that the instrument will be redeemed/called.</td>
</tr>
<tr>
<td></td>
<td>2021-17</td>
<td>Revisions remove lingering reference to “historical cost” and other minor updates to ensure consistency with prior modifications.</td>
</tr>
<tr>
<td>43R</td>
<td>2020-34</td>
<td>Revisions incorporate minor scope modifications to reflect recent changes to the Freddie Mac Structured Agency Credit Risk (STACR) and Fannie Mae Connecticut Avenue Securities (CAS) programs and allow these credit risk transfer securities to remain in scope of <em>SSAP No. 43R—Loan-Backed and Structured Securities</em>.</td>
</tr>
<tr>
<td></td>
<td>2021-11</td>
<td>Revisions identify that SVO-Identified Credit Tenant Loans are in scope of SSAP No. 43R and also remove examples from paragraph 27.b.</td>
</tr>
<tr>
<td></td>
<td>2021-15</td>
<td>Revisions clarify that residual tranches or interests shall be reported on Schedule BA – Other Long-Term Investments and valued at the lower of amortized cost or fair value.</td>
</tr>
<tr>
<td></td>
<td>2021-19EP</td>
<td>Revisions remove outdated references to guidance which was previously deleted in October 2017 (agenda item 2017-22).</td>
</tr>
<tr>
<td>47</td>
<td>2021-08</td>
<td>Revisions reject <em>ASU 2021-02, Franchisors Revenue from Contracts with Customers (Subtopics 952-606)</em> for statutory accounting.</td>
</tr>
<tr>
<td>48</td>
<td>2021-04</td>
<td>Revisions clarify that the equity method can result in a negative equity valuation regardless of if the investment is supported by an audit.</td>
</tr>
<tr>
<td>SSAP No. 53</td>
<td>2021-06EP</td>
<td>Editorial consistency revision to the statement title.</td>
</tr>
<tr>
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</tr>
<tr>
<td>SSAP No. 55</td>
<td>2021-13</td>
<td>Revisions clarify that subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense (LAE) reserves, depending on the nature of the costs being recovered and updates the related disclosures.</td>
</tr>
<tr>
<td>SSAP No. 71</td>
<td>2019-24</td>
<td>Revisions clarify the guidance regarding levelized commissions with a December 31, 2021, effective date. The revisions affirm the longstanding guidance that acquisition costs, including commissions, shall be expensed when incurred. The revisions also clarify that acquisition costs shall be recognized consistently across insurers, regardless of third-party arrangements, and the obligating event is the writing of an insurance policy.</td>
</tr>
<tr>
<td>SSAP No. 72</td>
<td>2020-41</td>
<td>Revisions reject ASU 2020-06 for statutory accounting.</td>
</tr>
<tr>
<td>SSAP No. 86</td>
<td>2020-33</td>
<td>Revisions capture publicly traded preferred stock warrants in scope of SSAP No. 32R and require the warrants to be reported at fair value.</td>
</tr>
<tr>
<td>SSAP No. 103R</td>
<td>2021-03</td>
<td>Revisions incorporate additional disclosure and a data-capture template. The disclosures are for situations where an entity has transferred assets, but economic interest is retained by the reporting entity, its related parties or another member within the holding company group.</td>
</tr>
<tr>
<td>SSAP Glossary</td>
<td>2021-06EP</td>
<td>Editorial revision removes the footnote reference in the Glossary title and replace it with an updated opening paragraph.</td>
</tr>
</tbody>
</table>

### 3. Revisions to the Appendices

<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>2021-12EP</td>
<td>Revisions update designation codes for preferred stock as noted in section 2 of <em>Appendix A-001: Investments of Reporting Entities.</em></td>
</tr>
<tr>
<td>Appendix B</td>
<td>2021-01</td>
<td>Revisions to <em>INT 20-01: ASUs 2020-04 &amp; 2021-01 – Reference Rate Reform</em> provide temporary (optional) expedient and exception interpretative guidance, with an expiration date of December 31, 2022. This exception will allow for continuation of the existing hedge relationship and thus not require hedge dedesignation.</td>
</tr>
<tr>
<td></td>
<td>2021-05</td>
<td><em>INT 21-01: Accounting for Cryptocurrencies</em> clarifies that directly held cryptocurrencies do not meet the definition of cash in <em>SSAP No. 2R—Cash, Cash Equivalents, Drafts and Short-Term Investments</em> nor the definition of an admitted asset per <em>SSAP No. 4—Assets and Nonadmitted Assets.</em></td>
</tr>
<tr>
<td>Appendix C</td>
<td>AG-25</td>
<td>Revisions to <em>Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index</em> align the guideline with the VM-02, Minimum Nonforfeiture Mortality and Interest, changes to the 2021 <em>Valuation Manual.</em></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>2021-12EP</td>
<td>Updates references in Appendix C and Appendix C-2 to the former Emerging Actuarial Issues (E) Working Group and adds reference to the Valuation Analysis (E) Working Group’s use of included interpretations.</td>
<td></td>
</tr>
<tr>
<td>Appendix D</td>
<td>Rejected as Not Applicable to Statutory Accounting:</td>
<td></td>
</tr>
<tr>
<td>2020-42</td>
<td><em>ASU 2020-07, Presentation and Disclosures by Not-for-Profit Entities</em></td>
<td></td>
</tr>
<tr>
<td>2021-07</td>
<td><em>ASU 2020-11, Financial Services – Insurance Effective Date</em></td>
<td></td>
</tr>
<tr>
<td>Appendix F</td>
<td>2020-39</td>
<td>Revisions clarify the issuance and adoption of accounting interpretations in the <em>NAIC Policy Statement on Maintenance of Statutory Accounting Principles.</em></td>
</tr>
<tr>
<td>2021-14</td>
<td>Revisions to the <em>NAIC Policy Statement on Maintenance of Statutory Accounting Principles</em> modify the terminology used for types of accounting revisions. Beginning January 1, 2022, the phrase “new SAP concept” will reflect instances previously considered to be “substantive,” and the term “SAP clarification” for instances previously identified as “nonsubstantive.”</td>
<td></td>
</tr>
<tr>
<td>Appendix G</td>
<td>Not applicable</td>
<td>Revisions to the <em>Implementation Guide for the Annual Financial Reporting Model Regulation</em>, Section 11, require new information in the annual internal control reporting to facilitate a review of qualification and partner rotation requirements.</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Not applicable</td>
<td>INT 20-03 Troubled Debt Restructuring Due to COVID-19 automatically expired on January 2, 2022. This INT provided exceptions for mortgage loans and banks loans in line with the CARES Act in response to COVID-19.</td>
</tr>
<tr>
<td>2021-11</td>
<td>Not applicable</td>
<td>INT 20-07 Troubled Debt Restructuring of Certain Debt Investments Due to COVID-19 automatically expired on January 2, 2022. This INT provided exceptions for debt securities captured within SSAP No. 36 in response to COVID-19.</td>
</tr>
<tr>
<td>2021-11</td>
<td></td>
<td>INT 20-10: Reporting Nonconforming CTLs, which expired October 1, 2021, was explicitly nullified. The INT is not relevant because of revisions on the definition of CTLs in the Purposes and Procedures Manual of the Investment Analysis Office.</td>
</tr>
<tr>
<td>2021-11</td>
<td>Not applicable</td>
<td>INT 21-02: Extension of Ninety-Day Rule for the Impact of Hurricane Ida provided optional extension from the ninety-day rule under SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers for premium on policies that were directly impacted by Hurricane Ida. This interpretation automatically expired on January 23, 2022.</td>
</tr>
</tbody>
</table>
TO: Director Lori K. Wing-Heier, Chair  
Financial Regulation Standards & Accreditation (F) Committee

FROM: Pat Gosselin, New Hampshire Chief Financial Analyst, Chair 
Blanks (E) Working Group

DATE: February 2, 2022

RE: Items Impacting Current Accreditation Standard

Please find attached a list of items adopted by the Blanks (E) Working Group during 2021. The Blanks Working Group adopts numerous changes to the Annual Statement Blanks and Instructions each year. Most of the changes are made to clarify current requirements or are considered enhancements to existing reporting. The changes adopted in 2021 do not represent a substantive change to any reporting requirements.

I am planning to be present when the Financial Regulation Standards & Accreditation (F) Committee meets in the event any member of the committee wishes to discuss these issues.
Changes to blanks and instructions adopted during 2021

1. Add a new Health Care Receivables Supplement to the Life/Fraternal Annual Statement that adds Exhibits 3 and 3A from the Health Annual Statement to the to the Life/Fraternal annual filings. Add a guidance document reference to Exhibit 3A of the Health Annual Statement (2020-32BWG) Effective Dec. 31, 2021.

2. Modify Annual Statement Lines (ASLs) used on Underwriting and Investment (U&I) Exhibits, State Page and Insurance Expense Exhibit (IEE). Change Health ASL categories used in Property to be consistent with other statement types. Update ASL references used in crosschecks. Update definitions used in the appendix for the Health ASLs. See next page for details (2020-33BWG) Effective Jan. 1, 2022.


4. Expand the number of characters used from seven to 10 in the investment line categories for Schedules D, DA, DL and E excluding Schedule D, Part 6 (Sections 1 and 2) and Schedule E (Part 1 and 3). Add line categories for Unaffiliated Certificates of Deposit and Exchange Traded Funds. Split the line categories for Mutual Funds, Investment Unit Trusts and Closed-End Funds into lines indicating if the fund has been assigned a designation by the Securities Valuation Office (SVO). Make changes to Summary Investment Schedule, Summary by Country and Schedule D, Part 1A (Sections 1 and 2) to reflect the additional line categories (2020-35BWG) Effective Jan. 1, 2022.


6. Add a new Schedule Y, Part 3 to capture all entities with ownership greater than 10%, the ultimate controlling parties of those owners and other entities that the ultimate controlling party controls (SAPWG 2020-34) (2020-37BWG) Effective Dec. 31, 2021.

7. Make changes to the Accident and Health Policy Experience Exhibit by adding new columns, removing lines distinguishing with and without contract reserves, adding some new product lines, eliminating summary tables, changing the date that the exhibit is due and having it reported by state (2020-38BWG) Effective Dec. 31, 2021.


9. Add questions to the General Interrogatories, Part 1 regarding depository institution holding companies as it pertains to the group capital calculation (GCC). Additionally, modify the terminology in the first two questions for consistency with the new questions, which has been modified to consider that many insurers that are part of a depository institution holding company are savings and loan holding companies, which is picked up with the broader terminology compared to the more specific term of bank holding company (2021-02BWG) Effective Dec. 31, 2021.

10. Modify the tables for Interrogatory Questions 1.01, 1.01A, 2.5 and 4.2 in the Separate Accounts General Interrogatories by adding category lines to reflect additional granularity in the reporting on those tables (SAPWG 2020-37 and 2020-38) (2021-03BWG) Effective Dec. 31, 2021.

11. Add interrogatory questions 24.1 and 24.2 to the General Interrogatories, Part 1 “Financial” section asking if the insurer utilizes third parties to pay agent commissions in which the amounts advanced by the third parties are not settled in full within 90 days. Renumber the remaining questions (SAPWG 2019-24) (2021-04BWG) Effective Dec. 31, 2021.

12. Modify the instructions for Note 17B(4)b1(a) – Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities and add a table to the illustrations to data capture some aspects of the disclosure (SAPWG 2021-03) (2021-05BWG) Effective Dec. 31, 2021.

13. Add crosschecks between Long-term Care (LTC) Form 5 and Form 1 for Columns 2, 3, 4, 6 and 7 of Form 5 (2021-06BWG) Effective Dec. 31, 2021.
14. Add additional line categories to the instruction for Column 26 – Collateral Type to capture collateral type data for all residential mortgage-backed securities (RMBS), commercial mortgage-backed securities (CMBS) and loan-backed and structured securities (LBSS) securities regardless of reporting category (2021-07BWG) Effective Dec. 31, 2021.


17. Expand the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. Modify the instructions so they will be uniform between life/fraternal and property (2021-14BWG) Effective Dec. 31, 2022.
MEMORANDUM

TO: Director Lori K. Wing-Heier, Chair
Financial Regulation Standards and Accreditation (F) Committee

FROM: Tom Botsko, Chair
Capital Adequacy (E) Task Force

DATE: February 1, 2022

RE: Accreditation Standards – Changes to the RBC Formulas and Instructions for Health, Life and P/C

Attached please find a brief description of changes to the 2021 Risk-Based Capital Report Including Overview and Instructions for health, life and property/casualty (P/C). These changes were adopted by the Capital Adequacy (E) Task Force and Executive (EX) Committee and Plenary in 2021. Significance of these changes was viewed as it relates to the overall risk-based capital (RBC) standard.

No changes to the RBC formulas or instructions were deemed to be significant for health, life or P/C.

Any questions can be directed to NAIC staff:
P/C – Eva Yeung
Life – Dave Fleming
Health — Crystal Brown

**Health RBC Formula**

Not Significant  Deleted the ACA Fee Sensitivity Test from the XR026.

Not Significant  Added the MAX function to Line 17 – RBC Growth Safe Harbor on page XR022.

Not Significant  Split bonds and miscellaneous assets into separate pages, XR007 and XR008, respectively.

Not Significant  Bond Modification in XR006, XR007 and XR012 included:
1) modified the structure and instructions;
2) revised the factors for 20 bond designations; and
3) reclassified hybrid securities.

Not Significant  Incorporated the term “incentives” into the managed care instructions and blanks as “Bonuses/Incentives.”

Not Significant  Updated the Line 38 receivable for securities factors on page XR008.

Not Significant  Incorporated a 0.5% investment income adjustment into XR013 Underwriting Risk factors for comprehensive medical, Medicare supplement, and dental and vision.

**Life RBC Formula**

Not Significant  Bond factor changes for the expanded NAIC designation categories which also included a bond size adjustment and tax factor changes.

Not Significant  Update the RBC calculation for real estate to reflect the updated experience.

Not Significant  Include factors for a longevity risk charge.
Not Significant  Updated the reinsurance calculation to allow for the inclusion of amounts held for reciprocal jurisdiction reinsurance.

Not Significant  Incorporated the term “incentives” into the managed care instructions and blanks as “Bonuses/Incentives.”

Not Significant  Updated the receivable for securities factors to 0.015.

Not Significant  Incorporated a 0.5% investment income adjustment into the factors on the Underwriting Risk – Experience Fluctuation Risk pages for comprehensive medical, Medicare supplement, and dental and vision.

Not Significant  Deleted the ACA Fee Sensitivity Test from the LR033.

**P/C RBC Formula**

Not Significant  Modified PR027 interrogatories instructions to clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories.

Not Significant  Removed the embedded 3% operational risk component contained in the reinsurance contingent credit risk of Rcat component in PR027A and PR027B.

Not Significant  Deleted the ACA Fee Sensitivity Test from the PR029.

Not Significant  Incorporated the term “incentives” into the PR021 managed care instructions and blanks as “Bonuses/Incentives.”

Not Significant  Incorporated a 0.5% investment income adjustment into PR029 Underwriting Risk factors for comprehensive medical, Medicare supplement, and dental and vision.

Not Significant  Incorporated examples to clarify how the reporting companies should select the designation in the Annual Statement Part 3, Reinsurer Designation Equivalent Rating column if the reporting entities subscribe to one or multiple rating agencies.

Not Significant  Bond Modification in PR006, PR011 and PR015 included:

4) modified the structure;
5) revised the factors for 20 bond designations;
6) modified the bond size factor;
7) reclassified hybrid securities and eliminated the hybrid securities section in PR007.

Not Significant  Updated the Line 1 industry average development factors in PR017 and PR018.

Not Significant  Updated the Line 1 receivable for securities factors in PR009 and PR011.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: Susan Bernard (CA), Chair, Financial Examiners Handbook (E) Technical Group
       John Litweiler (WI), Vice-Chair, Financial Examiners Handbook (E) Technical Group

DATE: Feb. 9, 2022

RE: Consideration for Financial Accreditation Standards
    2022 Financial Condition Examiners Handbook

The Accreditation Program Manual (Manual) includes Review Team Guidelines to be used for financial examinations performed using the risk-focused surveillance approach that is found in the NAIC Financial Condition Examiners Handbook (Handbook). This memorandum is to update the Financial Regulation Standards and Accreditation (F) Committee on changes the Financial Examiners Handbook (E) Technical Group has made to the Handbook in 2021.

Modifications are made to the Handbook each year, and a new edition is printed annually. This process allows for an efficient way to update the Handbook and ensures that users have the latest version. The Technical Group made several changes to the Handbook in 2021, the majority of which it considers non-significant; i.e., having no impact on accreditation guidance.

The Technical Group noted an opportunity to better align the guidance in the Handbook and the Manual as it relates to exam coordination. This change should be considered “significant” for accreditation purposes, which the Technical Group defines as a change that may immediately warrant a change to at least one accreditation standard or the Review Team Guideline(s) for said standard. Although this change is categorized as “significant” by the Technical Group, this is not meant to suggest the modifications are synonymous with the term “significant” within the accreditation context.

During 2021, the Technical Group made the following changes:

**Significant Changes to the Handbook Affecting Accreditation Standards and/or Review Team Guidelines:**

- Revisions to the Coordination Framework to clarify the roles and responsibilities of each state that has a company in a holding company group.

When reviewing the guidance contained in the Coordination Framework, the Technical Group noted that Handbook guidance requires the use of Exhibit Z – Exam Coordination when documenting coordination efforts for examinations of holding company groups with insurers domiciled in multiple states. This is
inconsistent with the guidance in the Manual, which requires the use of Exhibit Z for examinations of holding company groups with multiple insurers.

To ensure a consistent approach to documenting coordination efforts, the Technical Group advises the Committee to consider revising the guidance pertaining to Accreditation Standard B2(e): General Examination Procedures and Accreditation Standard B2(g): Scheduling of Examinations, as well as the related questions on the Accreditation SEG/IAR Form regarding the use of Exhibit Z. The Technical Group suggests incorporating the tracked revisions below to reflect this change in the Manual:

**Accreditation Standard B2(e): Use of Appropriate Guidelines and Procedures, Results-Oriented Guideline 1:**

The examiner should utilize a risk-focused approach and prepare examination documentation in sufficient detail to provide a clear understanding of the work performed. The content and organization of the documentation should support conclusions reached and effective execution of the risk-focused approach. When assessing compliance with this guideline, consideration should be given to the following:

- Utilization of a risk-focused approach in establishing priority of accounts or operational areas.
- The clarity and accuracy of the documentation used to support examination conclusions.
- Extent of involvement with contract examiners if utilized.
- Utilization of audit work when relied upon to support an identified risk.
- Fulfillment of coordination efforts as determined by the state in Exhibit Z – Examination Coordination, and consistent with their role as described in the Examiners Handbook, for companies that are part of a holding company group with insurers domiciled in multiple states that includes more than one insurer.

**Accreditation Standard B2(e): Use of Appropriate Guidelines and Procedures, Process-Oriented Guideline 3:**

If the company being examined is part of a holding company group with multiple insurers domiciled in multiple states, the state should complete the appropriate section of Exhibit Z, Part Two (or similar document) as follows:

- If the state is the exam facilitator conducting a fully coordinated group examination, Exhibit Z, Part Two, Section B (or similar document) should be completed.
- If the state is a participating state in a fully coordinated group examination, the state should complete Exhibit Z, Part Two, Section C (or similar document).
- If the state did not participate in a coordinated group examination or utilized existing work outside of a fully coordinated group examination, the state should complete Exhibit Z, Part Two, Section D (or similar document).

**Accreditation Standard B2(g): Use of Appropriate Guidelines and Procedures, Process-Oriented Guideline 3:**

The department should document the attempt to coordinate examination efforts with departments of other states consistent with the coordinated exam approach prescribed in the Examiners Handbook. Each company that is part of a holding company group that includes more than one insurer with insurers
domiciled in multiple states should include a copy of the coordination plan, documented in Section A of Exhibit Z, Part Two (or similar document), in its examination file.

Accreditation SEG/IAR Form, Standard B2(e), Question 5:

For examinations of companies that are part of a holding company group with insurers domiciled in multiple states that includes more than one insurer, does the department complete the applicable section of Exhibit Z – Examination Coordination based on its role in the examination?

Non-Significant Changes to the Handbook:

- Revisions to the Reserves Repositories (Life, Health and Property/Casualty [P/C]), as well as the Underwriting Repository, to provide additional possible completeness and accuracy procedures for examination teams to consider that align with the testing approach used by external auditors. Additionally, procedures were added to enhance collaboration with the actuary to determine significant lines of business/data elements to focus on for testing purposes.
- Revised guidance related to information technology (IT) in the following areas:
  - Additional guidance for evaluating the accessibility and transferability of policyholder data was incorporated into the following sections of the Handbook: 1) Section 1-3 narrative guidance; 2) Exhibit C, Part Two – IT Planning Questionnaire (ITPQ); and 3) Exhibit C, Part Two – IT Work Program and Instructional Notes.
  - Ransomware guidance was incorporated into the following sections of the Handbook: 1) Section 1-3 narrative guidance; and 2) Exhibit C, Part Two – IT Work Program.

If there are any questions regarding the proposed recommendations, please contact either me or NAIC staff (Bailey Henning at bhenning@naic.org) for clarification. Thank you for your consideration.
MEMORANDUM

TO: Financial Regulation Standards and Accreditation (F) Committee

FROM: Carrie Mears (IA), Chair Valuation of Securities (E) Task Force
Charles Therriault, Director, NAIC Securities Valuation Office

CC: Dan Daveline, Director, NAIC Financial Regulatory Services
Mark Perlman, Managing Investment Counsel, NAIC Securities Valuation Office

DATE: February 28, 2022

RE: Report of the Valuation of Securities (E) Task Force

A. Purpose – This report is presented to assist the Financial Regulation Standards and Accreditation (F) Committee to determine if amendments to the Purposes and Procedures Manual of the NAIC Investment Analysis Office adopted by the Valuation of Securities (E) Task Force in 2021 require corresponding changes in either the Financial Regulation Standards (defined below) or state laws or regulations adopted in conformity with Part A: Laws and Regulations of the Financial Regulation Standards.

B. Financial Regulation Standards – The NAIC Policy Statement on Financial Regulation Standards (SFRS) in the 2022 Accreditation Program Manual consists of four parts: Part A identifies laws and regulations deemed necessary to financial solvency regulation; Part B identifies regulatory practices and procedures that supplement and support enforcement of the financial solvency laws and regulations discussed in Part A; Part C contains three standards related to an insurance department’s organizational and personnel policies; and Part D focuses on Organization, licensing and change of control of domestic insurers. This report is concerned with the financial solvency standards in Part A. Those standards relevant to this report are shown immediately below and can be characterized as NAIC model legislation, codified NAIC guidance (i.e., the Accounting Practices and Procedures Manual): analytical work product of the NAIC staff (including the NAIC Investment Analysis Office) and state laws and regulations that contain substantially the same standards as NAIC model legislation or guidance. A review indicates that the work product of the NAIC Investment Analysis Office is directly or indirectly incorporated into the following Part A standards. For example:

- **Standard 5** requires that insurer owned securities be valued in accordance with the standards promulgated by the NAIC Investment Analysis Office;

- **Standard 2**, the Risk-Based Capital (RBC) for Insurers Model Act (#312) assigns RBC factors for securities based on their credit risk as measured by NAIC Designations;
Standard 3, the Accounting Practices and Procedures Manual uses NAIC Designations produced by the SVO or SSG, or by insurers through the filing exempt process and or Price Grids produced by the SSG to identify valuation rules applicable to an investment and the reserved capital amount the insurer must report;

Standard 8, pertaining to state investment regulations often incorporate NAIC mechanisms that relate asset allocations to credit risk expressed in the form of NAIC Designations; and

Standard 10, the Credit for Reinsurance Model Act identifies insurer owned securities compiled by the SVO into a List of Investment Securities published quarterly in the NAIC AVS + Plus product, and letters of credits issued by the institutions on the NAIC Qualified U.S. Financial Institutions List administered by the SVO, as eligible for use as collateral in reinsurance transactions.

C. Investment Analysis Office Standards Identified in the Purposes and Procedures Manual – All SVO and SSG standards related to the assessment of credit risk in insurer owned securities, identification of additional non-payment risk in securities, classification of certain assets as bonds or as bond-like for reporting purposes, the valuation of insurer owned securities, and other activities conducted by the SVO or the SSG in support of state insurance regulatory objectives, are determined and promulgated by the Valuation of Securities (E) Task Force and published in the Purposes and Procedures Manual. In 2021, the Purposes and Procedures Manual was revised once, in December, with all policies, analytical procedures and instructions adopted during 2021 effective for year-end financial reporting. Amendments to the Purposes and Procedures Manual would automatically be reflected in the SFRS if any or all of the SFRS Standards identified in paragraph A of this memorandum have been adopted by an accredited state or incorporated by reference into the laws or regulations of an accredited state. For example, amendments to the Purposes and Procedures Manual would be directly incorporated by reference if the laws or regulations of an accredited state refer to or incorporate Standard 5 on valuation. Amendments to the Purposes and Procedures Manual would be indirectly incorporated by reference if the law or regulations of a state refers to or incorporates any other Standard that itself uses NAIC Designations or other analytical products of the Investment Analysis Office as a component; for example, Standard 2 in the case of RBC and/or Standard 3 in the case of statutory accounting.

D. Conclusion – In our opinion, reasoning as discussed above, amendments to the Purposes and Procedures Manual adopted by the Valuation of Securities (E) Task Force in 2021 can be characterized as maintenance items consistent with the existing regulatory framework and automatically incorporated into the Part A Standards identified above. The amendments identified in Attachments One did not create processes or practices external to the Purposes and Procedures Manual or other NAIC model legislation, guidance or analysis of NAIC staff that would suggest the need to consider an amendment to NAIC model legislation or guidance or legislative action on the part of an accredited state.

We hope this is responsive to the issues and concerns before the Committee.
Attachment One

RECENT CHANGES TO THE PURPOSES AND PROCEDURES MANUAL
Published in the December 31, 2021 Publication

- Adopted updates to the financial modeling instructions for RMBS/CMBS for non-legacy securities – the changes move away from financial modeling price breakpoints to a single NAIC Designation and NAIC Designation Category for all non-Legacy Securities (those financially modelled RMBS/CMBS securities that closed on or after Jan. 1, 2013). Making this change only effects non-Legacy Securities and preserves the historical treatment for Legacy Securities.

*The Valuation of Securities (E) Task Force adopted this amendment on Mar. 22, 2021*

- Adopted updates to the list of NAIC CRPs to reflect NRSRO changes – these changes reflect the Jul. 2, 2019, Morningstar, Inc. acquisition of DBRS with the new entity being DBRS, Inc., doing business as “DBRS Morningstar Credit Ratings” or “DBRS Morningstar” along with other updates to the rating agency names on the List of NAIC Credit Rating Providers and the CRP Credit Rating Equivalents to NAIC Designations and NAIC Designation Categories tables to match those on the U.S. Securities and Exchange Commission’s Office of Credit Ratings list of Current NRSROs.

*The Valuation of Securities (E) Task Force adopted this amendment on Mar. 22, 2021*

- Adopted additional instructions for the review of funds to clarify guidance for fund leverage and the use of derivatives - a fund’s exposure to: (i) derivatives under which a fund is or may be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payments or otherwise, (ii) short sale borrowings and (iii) reverse repurchase agreements or similar financing, would be limited to 10% of the fund’s net assets in normal market conditions. Exposure would be calculated based on the gross notional amounts of derivatives, the value of assets sold short for short sale borrowings, and the proceeds received by the fund but not repaid for reverse repurchase agreements. Certain currency and interest rate derivatives that hedge currency or interest rate risk associated with one or more specific equity or fixed-income investments of the fund would be exempt from the 10% exposure calculation. For derivatives under which a fund shall not be required to make any payment or delivery of cash or other assets during the life of the instrument or at maturity or early termination, whether as margin or settlement payments or otherwise, exposure would be calculated based on the derivative’s market value. As defined in the P&P Manual, “Predominantly Hold” means, in part, “The fund will hold at least 80% of its assets in bonds if the fund is a bond fund or at least 80% of its assets in preferred stock if the fund is a preferred stock fund, in normal market conditions.” This existing requirement, therefore, limits total derivatives, short sale borrowing and reverse repurchase agreement exposure in any fund to 20%, exclusive of the currency and interest rate derivatives mentioned above.

*The Valuation of Securities (E) Task Force adopted this amendment on Jul. 15, 2021*

- Adopted changes to permit securities that are Credit Tenant Loan-like (CTL-like) and Ground Lease Financing-like (GLF-like) transactions to use NAIC credit rating provider (CRP) ratings through the Filing Exempt (FE) process if they are structured as securities – the amendment clarifies the difference between Credit Tenant Loans and Ground Lease Financings, and real estate lease-backed securities for purposes of amending the Filing Exemption eligibility for each. The amendment modifies the P&P definition of CTL and GLF by clarifying that CTLs and GLFs only refer to “mortgage loans in scope of SSAP No. 37,” and, by default, not “securities,” which would be in scope of SSAP Nos. 26R or 43R. Real estate lease-backed securities would include CTL-like and GLF-like transactions which meet all the CTL or GLF guidelines in the P&P Manual but for a feature making it a security, such as a trust issued certificate. Only CTLs or GLFs with mortgage loans in scope of SSAP No. 37 need to be filed with the SVO for review and potential assignment of an NAIC Designation. All other real estate lease-backed transactions which meet the definition of a “security”, including those with balloon payments in excess of 5%, would be eligible for Filing Exemption, and have the option to file with the SVO.

*The Valuation of Securities (E) Task Force adopted this amendment on Jul. 15, 2021*
• Adopted guidance to conform to the Statutory Accounting Principles (E) Working Group’s adopted change to Statement of Statutory Accounting Principles (SSAP) No. 105R—Working Capital Finance Investments - The Statutory Accounting Principles (E) Working Group adopted updates to SSAP No. 105R Working Capital Finance Investments on May 20, 2020. Key revisions are summarized as follows: Functionally Equivalent Foreign Regulators - Removed the requirement that the Securities Valuation Office (SVO) determine if the International Finance Agent is the functional equivalent of the U.S. regulator; Commingling Prohibitions - Removed the finance agent prohibitions on commingling; Investor Rights Edit - Removed duplicative text regarding exercising of investor rights; Requirements for filer to Certify Perfected Interest – Removed requirements, with revisions allowing the SVO to determine if a first priority perfected interest has been obtained; Finance Agent Validation Requirements – Broadened the independent review requirements to allow independent review of the finance agent by either audit or through an internal control report; Default Date - Changed the default provisions from 15 to 30 days so the default date and the cure period are consistent; Possible Domestic Regulator Approval – Removed the statement that the reporting entity may need to seek approval from the domestic regulator. This amendment removes inconsistencies between the P&P Manual and SSAP No. 105R Working Capital Finance Investments.

The Valuation of Securities (E) Task Force adopted this amendment on Jul. 15, 2021

• Adopted instructions to add back Zero Loss Criteria for Legacy Modeled RMBS and CMBS - modeled Legacy Security RMBS or CMBS tranches that have no expected loss under any of the selected modeling scenarios would be assigned an NAIC 1 Designation and NAIC 1.A Designation Category regardless of the insurer’s book/adjusted carrying value.

The Valuation of Securities (E) Task Force adopted this amendment on Sep. 30, 2021

• Adopted the addition of Spanish GAAP to the list of Countries and Associated National Financial Presentation Standards - financial statements submitted to the Security Valuations Office (SVO) for analysis must be audited and prepared in accordance with either a Global Financial Presentation Standard (U.S. Generally Accepted Accounting Principles (U.S. GAAP) or International Financial Reporting Standards (IFRS) or a Reconciled Financial Presentation Standard (local GAAP reconciled to U.S. GAAP or IFRS) unless the SVO has been specifically authorized to use a National Financial Presentation Standard. The amendment permits filings presented on the basis of Spanish GAAP, subject to the presentation of additional documentation as specified and annually thereafter.

The Valuation of Securities (E) Task Force adopted this amendment on Sep. 30, 2021

• Adopted the addition of Bank Loans - Since 2018 the Accounting Practices and Procedures Manual (AP&P Manual) has included bank loans issued directly by a reporting entity or acquired through a participation, syndication or assignment in SSAP No. 26R – Bonds. Pursuant to SSAP No. 26R, bank loans means fixed-income instruments, representing indebtedness of a borrower, made by a financial institution. In order to maintain consistency with the bond definition in SSAP No. 26R - Bonds, this amendment clarifies that the SVO can assess and assign NAIC Designations to bank loans. The filing instructions and methodology would follow that of other corporate obligations.

The Valuation of Securities (E) Task Force adopted this amendment on Nov. 17, 2021
• Adopted the addition of the United States International Development Finance Corporation to the U.S. Government Full Faith and Credit – Filing Exempt List - In October 2018 the Better Utilization of Investments Leading to Development (“BUILD”) Act was signed into law. The BUILD Act reorganized and merged existing United State government development finance and aid programs, the U.S. Overseas Private Investment Corporation (“OPIC”) and the Development Credit Authority of the United Stated Agency for International Development (“USAID”), into a new agency called the U.S. International Development Finance Corporation (“DFC”). Pursuant to the BUILD Act, the support provided by the DFC shall, and existing support provided by OPIC and USAID shall continue, to constitute obligations of the United States, and the full faith and credit of the United States is thereby pledged for the full payment and performance of such obligations. The DFC is authorized to borrow from the U.S. Treasury to fulfill such obligations of the United States. Based on this express full faith and credit, the DFC was added to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part One. However, for the avoidance of doubt, as noted in this Manual, any security issued by an entity on the “U.S. Government Full Faith and Credit – Filing Exempt” list shall be filed with the SVO if the security is not fully guaranteed by the U.S. government. For certain entities on the list, statute may require parties other than the U.S. government full faith and credit guarantor to bear a risk of loss equal to a specified percentage of the guaranteed support. For example, the BUILD Act requires parties to a project to bear the risk of loss in an amount of at least 20 percent of the guaranteed support of the DFC. If an insurance company, as investor, is the party bearing that risk of loss, meaning the securities it purchased are not fully guaranteed by the DFC or another entity on the list, it would need to file those securities with the SVO.

The Valuation of Securities (E) Task Force adopted this amendment on Nov. 17, 2021

• Adopted technical corrections for Private Letter Rating Securities and the corresponding NAIC Designation Category for NAIC 5GI - At the May 24, 2021 Task Force meeting, an amendment was adopted to the P&P Manual requiring the submission of Private Rating Letter Rationale Reports with certain Private Rating Letters filed with the SVO. In the May amendment certain language, currently in the printed December 2020 version of the P&P Manual, which clarifies that an NAIC 5GI Designation is the equivalent of an NAIC 5.B Designation Category, was erroneously omitted. This non-substantive technical amendment re-inserts the omitted language.

The Valuation of Securities (E) Task Force adopted this amendment on Dec. 12, 2021

• Adopted clarify instructions to exclude Residual Tranches and Interests from Schedule D-1 reporting and to provide temporary NAIC Designation instructions - The Statutory Accounting Principles (E) Working Group (the “Working Group”) identified inconsistencies in how residual tranches and interests were being reported with some entities reporting them on Schedule BA – Other Long Term Invested Assets and others reporting them on Schedule D-1: Long-Term Bonds with either self-assigned NAIC 5GI or NAIC 6 Designations. To prevent further inconsistency and direct appropriate reporting, at its Nov. 10, 2021 meeting, the Working Group adopted an amendment to SSAP No.43R – Loan Backed and Structured Securities to clarify that residual tranches and interests shall be report on Schedule BA and made a referral to the Valuation of Securities (E) Task Force requesting a similar change to the P&P Manual. The amendment creates a December 31, 2022 effective date for all residual tranches and interests to be reported on Schedule BA without an NAIC Designation with a provision which permits residual tranches and interests currently reported on Schedule D-1 to continue to be reported on Schedule D-1 for reporting year 2021 but only with an NAIC 6* Designation.

The Valuation of Securities (E) Task Force adopted this amendment on Dec. 12, 2021
• Adopted instructions to require the filing of private rating letter rationale reports with the Securities Valuation Office (SVO) beginning Jan. 1, 2022 - for a private letter rated (PLR) security to receive an NAIC Designation the SVO must receive, along with the private rating letter, a related private rating letter rationale report providing a more in-depth analysis of the transaction, the methodology used to arrive at the private rating, and, as appropriate, discussion of the transaction’s credit, legal and operational risks and mitigants. With both the private rating letter and the private rating letter rationale report the SVO would be able to determine whether the privately rated security is eligible to receive an NAIC Designation with an NAIC CRP Credit Rating. A private rating letter rationale report should mirror the work product that a CRP would produce for a similarly rated security. The amendment has provisions for delayed submission and waived submission PLR securities, depending upon their issuance date.

The Valuation of Securities (E) Task Force adopted this amendment on May 24, 2021

END NOTES

1 “...The purpose of the Part A: Laws and Regulations standards are to assure that an accredited state has sufficient authority to regulate the solvency of its multi-state domestic insurance industry in an effective manner. ... A state may demonstrate compliance with a Part A standard through a law, a regulation, an established practice, which implements the general authority granted to the state or any combination of laws, regulations or practices, which achieves the objective of the standard ...” 2014 Accreditation Program Manual. “...For those standards included in the Part A ... where the term “substantially similar” is included, a state must have a law, regulation, administrative practice or a combination of the above that addresses the significant elements included in the NAIC model laws or regulations. ... Accreditation Interlineations (Substantially Similar)

2 “...Part B sets out standards required to ensure adequate solvency regulation of multi-state insurers ... In addition to a domestic state’s examination and analysis activities, other checks and balances exist in the regulatory environment. These include ... analyses by NAIC’s staff, ... and to some extent the evaluation by private rating agencies ...” 2014 Accreditation Program Manual

3 The SFRS requires that securities owned by insurance companies be valued in accordance with standards promulgated by the NAIC’s Capital Markets and Investment Analysis Office approved by VOS TF while other invested assets should be valued in accordance with procedures promulgated by the Financial Condition (E) Committee. The Investment Analysis Office refers to two independent staff functions: i.e., that of the SVO and that of the NAIC Structured Securities Group (SSG). The SSG was formally established as an NAIC staff function in 2013 and assumes responsibility for the conduct of the year-end financial surveillance of insurer owned residential mortgage backed securities (RMBS) and commercial mortgage backed securities (CMBS), conducted by the SVO since 2009. The SSG is also presumptively the segment of NAIC professional staff that would lead assessment of structured finance products generally.

The financial modeling process administered by the SSG generates intrinsic price values (referred to as Price Grids) for RMBS and CMBS instead of an NAIC Designation. These standards are contained in Part Four of the Purposes and Procedures Manual. Price Grids are used by insurers to generate NAIC Designations in accordance with procedures specified in Statement of Statutory Accounting Principles (SSAP) No. 43R Loan Backed and Structured Securities of the NAIC Accounting Practices and Procedures Manual. Accordingly, to the extent that the NAIC Accounting Practices and Procedures Manual is incorporated by reference in any standard, Price Grids and NAIC Designations derived by reference to them would also be incorporated.

4 The SFRS requires the adoption of the Risk Based Capital (RBC) for Insurers Model Act (#312) or a substantially similar law or regulation. RBC factors are tied to NAIC designations assigned by the SVO or in certain cases, for example in the case of Mortgage Referenced Securities, by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…This standard does not articulate a threshold level for minimum capital and surplus required for insurers to transact business ... Risk-based capital will, however, effectively require minimums when adopted by states.” Accreditation Interlineations - Financial Regulation Standards

5 The SFRS requires the use of the codified version of the Accounting Practices and Procedures Manual. Valuation procedures applicable to long-term invested assets are determined by the nature of the insurer (life or property/casualty) and the NAIC designation assigned to the security by the SVO or SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…To satisfy this standard, ... specific adoption of the NAIC Annual Statement Blank, NAIC Annual Statement Instructions, and the NAIC Accounting Practices and Procedures Manual [is required]. … Accreditation Interlineations - Financial Regulation Standards

6 The SFRS requires a diversified investment portfolio. Although the Investment of Insurers Model Act (Defined Limits or Defined Standards) is not specifically identified, portions of one or the other model acts have been adopted by many of the states and these relate specific asset allocations to NAIC designations provided by the SVO or in some cases by the SSG; NAIC Designations assigned by insurance companies pursuant to the filing exempt rule contained in the Purposes and Procedures Manual or NAIC Designations derived by insurance companies for RMBS and CMBS from Price Grids produced by the SSG pursuant to SSAP No. 43R. “…This standard ... [will require] that statutes, together with related regulations and administrative practices, provide adequate basis ... to prevent, or correct, undue concentration of investment by type and issue and unreasonable mismatching of maturities of assets and liabilities. The standard is not interpreted to require an investment statute that automatically leads to a fully diversified portfolio of investments. Accreditation Interlineations - Financial Regulation Standards

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The NAIC Investment of Insurers Model Act (Defined Limits Version) (# 280) imposes a 3% limit on the amount an insurer can invest in a single person (the threshold diversification limit) and also imposes a percentage limit on total investments of a defined credit quality, expressed by reference to NAIC Designation categories (the threshold credit quality limit). An additional percentage limit is then assigned to specific asset categories, which may or may not be subject to adjustment with the two threshold requirements. The limits identified in the Model Act are what would guide portfolio allocation decisions. Once made the insurer would shift to monitoring changes in the portfolio and rebalancing the allocations accordingly. Assuming a process for the identification of concentrations caused by indirect exposures, the insurer would aggregate such exposures with similar risks across all activities.

The SFRS requires the adoption of the Credit for Reinsurance Model Act (#785), Credit for Reinsurance Model Regulation (#786) and Life and Health Reinsurance Agreement Model Regulation (#791) or substantially similar laws. The SVO maintains a list of banks that meet defined eligibility criteria to issue letters of credit in support of reinsurance obligations or that are eligible to serve as trustees under various arrangements required by state insurance law.
MEMORANDUM

TO: Director Lori K. Wing-Heier (AK), Chair, Financial Regulations Standards and Accreditation (F) Committee, Commissioner Vicki Schmidt, (KS), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee and Commissioner Sharon P. Clark, (KY), Co-Vice Chair, Financial Regulations Standards and Accreditation (F) Committee

FROM: Mike Boerner (TX), Chair, Life Actuarial (A) Task Force, Craig Chupp (VA), Vice Chair, Life Actuarial (A) Task Force

DATE: March 8, 2022


In 2017, the Financial Regulation Standards and Accreditation (F) Committee approved a motion to adopt the Valuation Manual – Effective January 1, 2020 as an accreditation standard. The intention of this memorandum is to update the Committee on changes the Life Actuarial (A) Task Force made to the Valuation Manual in 2021. The changes were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer Meeting.

Attachment A to this memo includes a detailed listing of the changes made to the Valuation Manual in 2021. On behalf of the Task Force, it is our opinion that none of these items, either individually or collectively, should be considered “significant” as defined by the financial solvency accreditation standards.

As outlined in the Valuation Manual, amendments will be adopted annually by the Executive (EX) Committee and Plenary at each NAIC Summer Meeting. As such, the Valuation Manual will be reposted with an effective date of January 1 of the year following Executive Committee and Plenary adoption. For example, the current Valuation Manual, which encompasses the attached modifications, is titled the 2022 Edition - Valuation Manual. This process allows for an efficient way to update the Valuation Manual and ensures that users have the latest version.

The Task Force sincerely requests that the Committee consider the items listed in Attachment A as “insignificant” changes to the Valuation Manual. We will continue to notify the Committee of any changes to the Valuation Manual and to advise if, in our opinion, those changes are “significant” by financial solvency accreditation standards.

It should be noted that revisions have been made to the Life PBR Exemption through adoption of amendment proposal 2019-33, which provides for the inclusion of individually underwritten group life business in the calculation of premium volume to become effective in 2024. The accreditation standard provides as follows: “Although not required for accreditation, a state’s laws and regulations may allow an exemption from the reserving requirements of the Valuation Manual similar to that provided in the Valuation Manual. For such cases, do the laws and regulations contain provisions that are similar to those provided in the Valuation Manual?” [Emphasis added]. We are aware of several states that have adopted the Life PBR Exemption directly into their statutes, and that it may be necessary for those states to amend their statutes by 2024 in order to make them consistent with the updated Life PBR Exemption.
The individual amendment proposals reside on the Industry tab on the NAIC website and are accessible by following the link below:

[LATF Adopted Amendments for the 2022 VM](#)
Date: November 30, 2021

To: Superintendent Elizabeth Kelleher Dwyer (RI), Chair of Financial Regulation Standards and Accreditation (F) Committee

From: Commissioner Cassie Brown (TX), Chair of Receivership and Insolvency (E) Task Force

Re: 2021 Amendments to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)

On August 17, 2021, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The revisions help ensure efficient coordination with affiliates and to enforce the continuation of essential services by an affiliate to an insurer in the event of insolvency.

These revisions were drafted by the Receivership Law (E) Working Group under charges assigned by the Receivership and Insolvency (E) Task Force. These revisions, referred to as the “receivership revisions” do not include recent revisions to Models #440 and #450 for group capital calculation or liquidity stress test. The receivership revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership by: 1) bringing affiliate service providers deemed “integral” or “essential” to an insurer’s operations under the jurisdiction of a rehabilitator, conservator, or liquidator for purposes of interpreting, enforcing, and overseeing the affiliate’s obligations under the service agreement and give the commissioner authority to require that “integral” or “essential” affiliate service providers consent to such jurisdiction; 2) further clarifying the ownership of data and records of the insurer that are held by the affiliate; and 3) clarifying that premiums of the insurer held by the affiliate are the property of the insurer and rights of offset are determined by receivership law. See attachment A for a copy of the amendments.

The recommendation for Part A Accreditation Standards is that these receivership revisions be considered acceptable, but not required to be adopted by states. However, the revisions are considered important and all states are encouraged to adopt them. States may consider adoption of the changes in conjunction with opening their holding company laws to consider adoption of the Group Capital Calculation and Liquidity Stress Test revisions.

The Task Force will continue to encourage states to adopt these revisions based on the benefits these revisions add to state regulation, and to the goal of improving efficiencies in receivership and reducing costs to a receivership estate.
MEMORANDUM

TO: Superintendent Elizabeth Kelleher Dwyer, Chair of the Financial Regulation Standards and Accreditation (F) Committee

FROM: Commissioner Scott A. White, Chair of the Financial Condition (E) Committee

DATE: Nov. 19, 2021

RE: Use of Captives to Reinsure Variable Annuity and Long-Term Care Business

I received your April 14 memo requesting information on the extent the referenced captives are used, any trends on the use of the captives, reasons for such trends, and any relevant updates on work done in the areas of variable annuities and long-term care insurance (LTCI). Upon receiving your memo, I referred the information to the Financial Analysis (E) Working Group. Since the Working Group ultimately collected the information on the use of captives by surveying domestic states using the states’ confidentiality standards, the Working Group’s response memo will be submitted to the Financial Regulation Standards and Accreditation (F) Committee as a separate regulator-only document. However, for the purposes of this memo, I would note that one of the key takeaways from the Working Group is that the current impact to the risk-based capital (RBC) of the domestic insurers utilizing these captives is minimal.

I would also like to provide you with updates on work done on variable annuities and LTCI. In 2018, the Financial Condition (E) Committee adopted a revised framework for variable annuities, which became effective Jan. 1, 2020. The changes were specifically designed to remove the non-economic volatility within the previous framework, therefore removing the major reason for the use of captives for variable annuities. The Committee believes it is an appropriate time to remove the to be determined (TBD) effective date in the Accreditation Preamble and replace it with a reference to VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

For LTCI, the Financial Condition (E) Committee has not developed any new standards that could be used to justify the removal of the TBD status. Although the impact of the use of captives for LTCI still appears to be minimal, the Committee recommends that this aspect of the Accreditation Preamble be retained and that the Financial Regulation Standards and Accreditation (F) Committee continue to monitor the use of captives for LTCI.

In summary, the Financial Condition (E) Committee recommends a replacement of the TBD in the Accreditation Preamble for variable annuities with VM-21 and retaining the TBD for LTCI.
Captive Reinsurers

The following Part A standards apply to the regulation of a state’s domestic insurers licensed and/or organized under its captive or special purpose vehicle statutes or any other similar statutory construct (captive insurer) that reinsure business covering risks residing in at least two states, but only with respect to the following lines of business:

1) Term and universal life with secondary guarantee policies that are applicable under Section 3 of the *Term and Universal Life Insurance Reserve Financing Model Regulation (#787)* (commonly referred to as XXX/AXXX policies). The application of this provision is intended to have a prospective-only effect, so that regulation of captive insurers, special purpose vehicles and any other entities that reinsure these types of policies will not be subject to the Part A standards if the policies assumed were both (1) issued prior to Jan. 1, 2015, and (2) ceded so that they were part of a reinsurance arrangement as of Dec. 31, 2014. [Drafting Note: This paragraph of the Preamble became effective Jan. 1, 2016]

2) Variable annuities valued under Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43) or VM-21: *Requirements for Principle-Based Reserves for Variable Annuities*. [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.] This paragraph of the Preamble was addressed through revisions to VM-21 of the *Valuation Manual.*

3) Long term care insurance valued under the *Health Insurance Reserves Model Regulation* (Model #10). [Drafting Note: This paragraph of the Preamble is not yet effective. Effective date for compliance to be determined.]

With regard to a captive insurer, special purpose vehicle, or any other entity assuming XXX/AXXX business, regulation of the entity is deemed to satisfy the Part A accreditation requirements if the applicable reinsurance transaction complies with Model #787.

[Drafting Note: The Part A standards with respect to entities assuming variable annuities and long term care reinsurance business are intended to be effective with respect to both currently in-force and future business. However, the effective dates for variable annuities and long term care insurance are is not yet determined, and their its application to in-force business need further discussion].
The International Insurance Relations (G) Committee met in Kansas City, MO, April 7, 2022. The following Committee members participated: Gary D. Anderson, Chair (MA); Eric Dunning, Vice Chair (NE); Andrew N. Mais (CT); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Troy Downing (MT); Marlene Caride (NJ); Alexander S. Adams Vega (PR); and Raymond G. Farmer (SC).

1. **Adopted its Jan. 18, 2022, and 2021 Fall National Meeting Minutes**

Commissioner Caride made a motion, seconded by Director Dunning, to adopt the Committee’s Jan. 18, 2022 (Attachment One) and Dec. 15, 2021 (see NAIC Proceedings – Fall 2021, International Insurance Relations (G) Committee) minutes. The motion passed unanimously.

2. **Discussed International Efforts on Sustainability and Climate**

Commissioner Anderson explained that the purpose of this agenda item was to highlight the topic of sustainability and climate and hear about international efforts to bring insurance supervisors together to strengthen their understanding of and responses to sustainability issues facing the insurance sector. He noted that the Committee would first hear more about the work of the Sustainable Insurance Forum (SIF), as several individual states and the NAIC are members. He noted that after hearing about the SIF, the Committee would hear from an insurer on how it is addressing sustainability and climate issues.

William Harding (SIF) gave an overview of the composition and creation of the SIF and its intended near-future and long-term goals. He addressed work being done or planning to be done as it relates to sustainability and climate. He reviewed the highlights of the SIF’s work over its first five years, including several key projects done in partnership with the International Association of Insurance Supervisors (IAIS). He noted that though the SIF has not met in person recently, there is strong engagement with its membership, and the SIF is looking forward to new members joining soon. Lastly, he said the SIF continues to dialogue with experts, both external and internal in relation to the membership, to share insights during active participation workshops.

Commissioner Anderson invited Committee members whose states are part of the SIF to offer their thoughts on how the SIF helps inform domestic efforts and activities related to sustainability and climate. Commissioner Birrane commented that the Solvency Workstream of the Climate and Resiliency (EX) Task Force is researching how to enhance tools to address climate-related financial risk more directly. The Task Force has reviewed international supervisory frameworks as part of this research and released a survey on where U.S. surveillance tools should be enhanced. That analysis led to requests for revisions to the Financial Condition Examinations Handbook (Handbook) and the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual (ORSA Guidance Manual). Commissioner Birrane noted that the Task Force is waiting for comments and plans to hold a public session before deciding to adopt any changes to the Handbook or the ORSA Guidance Manual. She then noted that public panel discussions, a deeper dive into scenario analysis, and stress testing are all part of this discussion. She commended the SIF for its generous assistance to state department staff in providing resources, and she foresees utilizing the SIF’s expertise again to help in future deeper scenario analysis and stress testing work. Lastly, she said being an SIF member provides an incredible opportunity for Maryland’s insurance department staff to have sophisticated, global training on these issues.
Commissioner Mais highlighted the findings of the United Nations (UN) Intergovernmental Panel on Climate Change’s (IPCC’s) recent report on climate and its importance to the discussion of the Committee. He noted that Connecticut has the second highest number of uninsured coastal properties, and that was an agenda topic at Connecticut’s inaugural conference on climate, which included participants from the Committee, the Federal Insurance Office (FIO), and the SIF. He said the Connecticut Insurance Department will be issuing a bulletin to insurers on managing climate risk that considers current and future risk, with a draft for comment to be released in a few days. He also highlighted an upcoming release of Connecticut’s first legislative report that addresses climate risks. He noted that more innovative insurance products are needed, raising awareness for mitigation dollars and maintaining open dialogues with industry. He concluded his comments by noting that Connecticut’s application to join the SIF has been approved.

Rakhi Kumar (Liberty Mutual) presented on sustainability and climate from Liberty Mutual’s perspective. She highlighted how Liberty Mutual approaches sustainability and its importance to the company’s business, and she shared insights around climate scenario work. She outlined the way sustainability and climate are embedded in the workings of Liberty Mutual, explaining its environmental, social, and governance criteria. She provided detailed insights on scenario analysis, including how it provides a better understanding of transition risks affecting companies, coordination—not just commonality in the way forward—and how energy dependency influences policy design.

3. **Heard an Update on 2022 Activities of the IAIS**

Commissioner Anderson reported that due to time constraints, the update on recent IAIS activities would be circulated via email to the Committee. This update covered the following:

- IAIS committee meetings were held virtually in the latter part of February, as well as in person at the beginning of March in Basel, Switzerland.
- Work continues on developing criteria to assess whether the aggregation method (AM) provides comparable outcomes to the insurance capital standard (ICS). The ICS and AM data collections templates for this year of the monitoring period are expected to be released later this spring.
- On the holistic framework, the on-site portion of the targeted jurisdictional assessments is wrapping up, and work will next move to writing the reports. The U.S. on-site assessment took place in mid-January, which included Connecticut, New Jersey, and New York as state volunteers.
- This year’s global monitoring exercise (GME) kicked off earlier this month.
- The Climate Risk Steering Group delivered its recommendations on how the IAIS should: 1) address any gaps in its supervisory material; 2) support members on sharing best practices on climate scenario analysis; and 3) integrate climate-related data elements into the GME.
- On diversity, equity, and inclusion (DE&I), IAIS members are being surveyed as a stock-take on DE&I initiatives currently underway that will eventually lead to a public report expected in the fourth quarter of this year. The survey also intends to help identify possible areas for future work by the IAIS in this area.
- The IAIS has launched a new logo and website as part of its brand modernization process.

4. **Heard an Update on International Activities**

   a. **Regional Supervisory Cooperation**

Director Dunning reviewed the three topics of focus in 2022 for the European Union (EU)-U.S. Insurance Dialogue Project: 1) climate risk financial oversight, including climate risk disclosures, supervisory reporting, and other financial surveillance; 2) climate risk and resilience, including innovative technology, pre-disaster mitigation, and adaptation efforts, and modelling; and 3) innovation and technology, which will include topics such as big data, artificial intelligence (AI), and supervisory technology (SupTech) as a regulatory tool. He noted that the project’s
working groups have met several times and will be producing a summary report of the discussions by the end of this year.

Director Dunning reported that upcoming bilateral discussions are planned with Bermuda, Japan, and Taiwan, among others, and the NAIC will utilize the in-person IAIS June committee meetings and Global Seminar as an opportunity to connect with several colleagues from around the globe. Next, he noted upcoming virtual speaking engagements: 1) Director Cameron will be speaking on supervision in the new normal at a high-level event hosted jointly by the Latin American Association of Insurance Supervisors (ASSAL), the Financial Stability Institute (FSI), and the IAIS; and 2) Commissioner Birrane will be presenting at the Taiwan Insurance Institute’s (TII’s) East Asia Pacific Insurance Forum in May on regulation and practices of insurtech and consumer protection in the U.S.

Director Dunning reported that the 2022 NAIC Spring International Fellows Virtual Program will take place May 16–20. He said to plan for the in-person Fall 2022 Fellows Program scheduled to begin Oct. 10, any state interested in hosting a Fellow should contact NAIC staff.

b. OECD

Director Dunning reported that since the last meeting of the Organisation for Economic Co-operation and Development’s (OECD’s) Insurance and Private Pensions Committee (IPPC) in early December, work continues on a variety of projects. He said the NAIC recently contributed on three of the IPPC’s initiatives in particular: 1) the Global Insurance Statistics framework; 2) a survey on improving health, wellbeing, and care through digital tools in insurance; and 3) a state insurance regulator survey on leveraging emerging technologies for risk management.

5. Discussed Other Matters

Commissioner Anderson reminded attendees about the NAIC’s 2022 International Insurance Forum to be held in Washington, DC, May 12–13.

Commissioner Ommen commented on the importance of state insurance department staff involvement in international discussions and activities, as it helps ensure informed NAIC decision making on and influence over IAIS and other international work. Commissioner Anderson followed up on this by noting that building up a “U.S. bench” is consistent with that approach, and NAIC staff will further explore how to get state department staff more involved.

Commissioner Anderson ended the meeting by congratulating Director Farmer on his retirement and thanking him for his dedicated service to the NAIC and its international work.

Having no further business, the International Insurance Relations (G) Committee adjourned.
The International Insurance Relations (G) Committee met Jan. 18, 2022. The following Committee members participated: Gary D. Anderson, Chair (MA); Raymond G. Farmer, Vice Chair (SC); Evan G. Daniels represented by Scott Persten (AZ); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon (LA); Kathleen A. Birrane (MD); Anita G. Fox represented by Steve Mayhew (MI); Chlora Lindley-Myers (MO); Eric Dunning represented by Jill Gleason (NE); Marlene Caride (NJ); Andrew R. Stolfi represented by TK Keen (OR); and Jessica K. Altman (PA).

1. **Discussed NAIC Comments on the IAIS Public Consultation on the Development of Liquidity Metrics: Phase 2**

   Commissioner Anderson explained that the International Association of Insurance Supervisors (IAIS) Public Consultation on the Development of Liquidity Metrics: Phase 2 will serve as a tool to facilitate the IAIS’s monitoring of the global insurance industry’s liquidity risk. He noted that it will allow the IAIS to assess insurers’ liquidity exposure, which may be critical, as insurers have been exposed to liquidity shortfalls in previous crises.

   Tim Nauheimer (NAIC) gave an overview of the NAIC’s comments on the public consultation, noting that since the NAIC was part of the initial drafting group within the IAIS, the comments address a few questions rather than respond to the full list. He explained that the NAIC’s comments serve as a general statement of support for this phase of the work. On the topic of additional metrics to be considered, he said while exploring the option of additional liquidity metrics is important for the IAIS to consider, a separate publication on this is too premature at this stage. In terms of a preference for a single or a set of metrics for liquidity risk monitoring purposes, he noted that the NAIC prefers the company projection approach (CPA), but it is not opposed to other types of metrics that fit with other jurisdictions’ systems.

   Steve Broadie (American Property Casualty Insurance Association—APCIA) spoke about the APCIA’s general comments on the consultation document, and he said the comments are still being finalized. He highlighted that property/casualty (P/C) insurers generally pose limited, if any, liquidity risk, and to the extent that there is some risk, it is not of systemic importance. Thus, the APCIA’s comments will urge the IAIS to use this for the purposes of macroprudential surveillance only, and jurisdictions should not use these metrics for the supervision of groups or companies at this point. Mr. Broadie noted that an aggregate basis of results released on an anonymized basis should be the approach taken by the IAIS. Mr. Nauheimer said the NAIC generally agrees with these points and that any data published by the IAIS would be anonymized.

   Robert Neill (American Council of Life Insurers—ACLI) said the ACLI is also finalizing its comments on the public consultation for submission to the IAIS. He noted that the ACLI will encourage the IAIS to establish an approach that leverages the results of jurisdictional level analysis, such as the NAIC’s liquidity stress test (LST) framework, rather than make additional data requests on the industry. He requested insight into further field-testing expectations, and he asked: 1) whether it would require additional information from U.S. firms beyond what is being provided for the NAIC’s LST work; and 2) whether it would be driven by the IAIS or jurisdictional supervisors. Mr. Nauheimer noted that the IAIS would conduct the field testing, but the NAIC would leverage the data for domestic purposes for LST purposes to limit the burden on domestic reporting companies. In terms of timing, he said the calendar is not set but would most likely begin in mid-2022 after the IAIS global monitoring exercise data collection.
Director Farmer made a motion, seconded by Commissioner Caride, to approve submission of the NAIC comments on the Liquidity Metrics: Phase 2 consultation document (Attachment One-A).

Having no further business, the International Insurance Relations (G) Committee adjourned.
### Question

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<td>1 Do you agree with the IAIS’ general objective and contemplated usage for the liquidity metrics? If not, please explain your rationale.</td>
<td>A liquidity risk indicator should be considered along with other risk indicators to develop an overall risk profile of individual insurers and the sector. We support development of the CPA approach as a better risk indicator to assess liquidity risk. With respect to contemplated usage, we would prefer to see how the development of the CPA approach progresses prior to deciding on any publication of results as an ancillary indicator. A separate publication may not be necessary as it may be prudent to keep the results within the IIM and SWM exercises.</td>
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<td>4 Is there a need to develop supplementary liquidity metrics solely for separate accounts for both EA and CPA? If not, provide suggestions how the IAIS should monitor liquidity related to separate accounts (united-linked products) for both EA and CPA?</td>
<td>Whether this is needed should be explored in the future; the NAIC plans to research this domestically in the future as well.</td>
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<td>65 Do you prefer a set of liquidity metrics for liquidity risk monitoring purposes? If not, provide clarification.</td>
<td>While we feel the CPA is the best indicator of liquidity risk, we would not be opposed to having a set of liquidity metrics from which jurisdictions could choose to use based on which metric(s) works best for their system.</td>
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<td>66 Do you prefer a single liquidity metric (eg. ILR or CPA metrics) for liquidity risk monitoring purposes? If not, provide clarification.</td>
<td>The NAIC prefers the CPA because we feel it is a better indicator of liquidity risk. The CPA is more dynamic capturing the cash flow generated by insurance premiums versus the static point in time balance sheet metrics historically used as liquidity risk indicators. The NAIC supports field testing both ILR and CPA to provide insights and comparison that may allow for some improvements.</td>
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INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

Innovation, Cybersecurity, and Technology (H) Committee April 5, 2022, Minutes ........................................... 12-2
Revised 2022 Proposed Structure and Charges (Attachment One) ........................................................................... 12-8
Big Data and Artificial Intelligence (H) Working Group April 5, 2022, Minutes (Attachment Two) .......... 12-12
Cybersecurity (H) Working Group March 23, 2022, Minutes (Attachment Three) ................................. 12-16
Innovation, Cybersecurity, and Technology (H) Committee
Kansas City, Missouri
April 5, 2022

The Innovation, Cybersecurity, and Technology (H) Committee met in Kansas City, MO, April 5, 2022. The following Committee members participated: Kathleen Birrane, Chair (MD); Evan G. Daniels, Co-Vice Chair (AZ); Dana Popish Severinghaus, Co-Vice Chair (IL); Karima M. Woods (DC); John F. King (GA); Amy L. Beard (IN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Troy Downing (MT); Adrienne A. Harris represented by My Chi To (NY); Jon Godfread (ND); Judith L. French (OH); Elizabeth Kelleher Dwyer (RI); Carter Lawrence (TN); Michael S. Pieciak represented by Kevin Gaffney (VT); and Mike Kreidler represented by Michael Walker and Molly Nollette (WA). Also participating were: George Bradner (CT); and Eric Slavich (WA).

1. ** Adopted Proposed Revisions to the Innovation, Cybersecurity, and Technology (H) Committee Structure and its Working Group Charges

Commissioner Birrane said with the retirement of former Superintendent Eric A. Cioppa (ME), there have been some changes to the leadership and membership of the Innovation, Cybersecurity, and Technology (H) Committee (Committee). She said Director Popish-Severinghaus will replace Superintendent Cioppa as the co-vice chair, and Director Lindley-Myers will replace Maine as a member of the Committee.

Commissioner Birrane reviewed the proposed changes to the structure and the charges and proposed a new Committee working group, the Innovation in Technology and Regulation (H) Working Group. She said the structure changes propose moving the Speed to Market (H) Working Group to the Market Regulation and Consumer Affairs (D) Committee and moving the Privacy Protections (D) Working Group to this Committee. She said the proposal also includes a clarifying amendment to the Privacy Protections (D) Working Group charge.

Commissioner Birrane said the new Working Group will be the platform through which the Committee will evaluate and provide educational opportunities for state insurance regulators and others to investigate evolving and new developments on the innovation and technology front. She said this Director Daniels will serve as Working Group chair, and Director Popish Severinghaus and Director French will serve as co-vice chairs. Director Daniels said this Working Group will signal some new ways to educate and facilitate learning amongst state insurance regulators and presents an opportunity for many stakeholders to be part of that. He said he would summarize the charges in two ways. He said first, the objective is to facilitate discussion between all stakeholders—not just technology stakeholders, but also with state insurance regulators who are facilitating innovation in their states. He said many states have produced ways to talk about this area openly and that this Working Group can serve to identify issues affecting the insurance marketplace in the near future.

Mr. Bradner asked about the reasoning behind moving the Speed to Market (H) Working Group to the Market Regulation and Consumer Affairs (D) Committee. He said the charges to the Working Group appeared to include the System for Electronic Rates & Forms Filing (SERFF) Modernization Project, which might be considered something under the purview of the Committee. Commissioner Birrane acknowledged the charges speak to the SERFF Modernization Project, but she said the Working Group has been more focused on edits to the Product Filing Review Handbook, and the scope of that work is more granular and specific to rates and forms and not the broader NAIC. Director Daniels said the proposed move should not be considered any signal that the Committee is not interested in following this work, but that it is a touchpoint similar to others identified with other NAIC committees that the Committee will continue to coordinate with like the Health Innovations (B) Working Group. Commissioner Birrane said how state insurance regulators use technology will be a focus of the Committee, but
that does not mean specific and more granular work will be done outside of the Committee where the subject
matter expertise (SME) exists.

Commissioner Downing made a motion, seconded by Director Daniels, to adopt the proposed revisions to the
Innovation, Cybersecurity, and Technology (H) Committee’s structure and charges (Attachment One). The motion
passed unanimously.

2. **Adopted the Reports of its Working Groups**

   a. **Big Data and Artificial Intelligence (H) Working Group**

      Superintendent Dwyer said the Big Data and Artificial Intelligence (H) Working Group met April 5 and focused on
      four workstreams. She said the first workstream, led by Mr. Gaffney, is to continue the survey work begun in 2021.
      She said the workstream will continue to look at the private passenger auto (PPA) artificial intelligence
      (AI)/machine learning (ML) survey results and use that experience to inform the development of a homeowners
      and a life insurance survey scheduled to be issued in June and August, respectively. She said the work will
      culminate in a white paper to be published by the Fall National Meeting. She said the second workstream, led by
      Commissioner Ommen, will focus on review of third parties providing data and models to determine the
      appropriate regulatory format for monitoring and overseeing this use. She said this work should be completed by
      the Fall National Meeting as well. She said the third workstream, led by Superintendent Harris, will gather and
      evaluate information on governance models and frameworks, software tools and resources from various sources
      that could assist state insurance regulators in overseeing and monitoring use of data, and AI/ML to eliminate
      unintended bias. She said the final workstream, led by Commissioner Beard, is focused on how to implement the
      expectations outlined in the NAIC AI Principles and provide suggestions on next steps, which could include
      regulatory guidance, such as model governance. She said the Working Group will be holding an open meeting in
      45 to 60 days to receive a public update on these workstreams. Lastly, she said the Working Group received an
      update on the review of the PPA AI/ML survey results.

   b. **Cybersecurity (H) Working Group**

      Ms. Amann said the Cybersecurity (H) Working Group met March 23 to kick off its work for the year. She said that
during this meeting, the Working Group reviewed its charges and discussed projects that may be taken on based
on its charges and the needs of state insurance regulators. She said the discussion covered the following five
items:

      1. Consider the development of a cybersecurity response plan to assist state insurance regulators with
         situations where cybersecurity events take place within the insurance industry intended to leverage the
         strength of the U.S. system of regulation and allow state insurance regulators to share expertise and to
         develop a valuable resource to aid states managing complicated responses to cybersecurity events.
      2. Consider the development of a cybersecurity survey to better understand cybersecurity practices by
         insurers and look at controls, working closely with the Center for Insurance Policy and Research (CIPR)
         and learn from the NAIC’s experience with surveys.
      3. Develop advice and guidance related to training that would be beneficial to state insurance regulators,
         and put together training to be offered at the NAIC Insurance Summit.
      4. Review and refine the Working Group charges and related topics.
      5. Monitor state, federal, and international cybersecurity efforts.
c. **E-Commerce (H) Working Group**

Commissioner Downing said the E-Commerce (H) Working Group met March 30. He said the Working Group heard a presentation and summary from NAIC staff on the recent surveys sent to the states regarding their adoption and various exceptions to the federal Uniform Electronic Transactions Act (UETA), as well as the various steps and other actions taken by the states regarding e-commerce both during and because of the COVID-19 pandemic. He said 20 states responded to the survey, and their results gave the Working Group a good sense of what kinds of orders and bulletins have now either expired or been rescinded, as well as what other actions taken by the states have now become permanent either through legislation or regulation.

The NAIC also presented and summarized the various industry concerns that were received in response to the survey as well. Four industry trade associations provided responses to the survey in which they discussed various concerns and what they consider to be impediments to e-commerce. He said the trades also provided recommendations on how they would like to see state insurance regulators and legislators proceed with respect to e-commerce.

He said going into the meeting, the original intent was to assign issues to buckets and set discreet delivery dates and prioritization based on the survey results and the Working Group analysis. He said that sparked a conversation on whether that would be premature prior to spending time thoughtfully identifying themes and problem statements for each theme. He said at a high level, the industry surveys identified issues related to identifying consumer protection concerns such as opt-in/opt-out for electronic delivery of notices and other overarching themes. He said a small group of state insurance regulators volunteered to further analyze the states’ survey results to identify the various overarching themes and issues contained in the survey results and to further clarify the Working Group’s work plan. He said the Working Group plans to meet again in May to further discuss its work plan, as well as timelines for any deliverables that may be developed as a result of this work.

d. **Speed to Market (H) Working Group**

Commissioner Birrane said the Speed to Market (H) Working Group did not meet prior to the Spring National Meeting but is currently chaired by Rebecca Nichols (VA). She said the Working Group leadership and NAIC staff plan to review and discuss edits to the *Product Filing Review Handbook* and present any proposed changes to the Working Group, as needed. She said the Working Group plans to meet April 20 to continue work on its goals.

Commissioner Godfread made a motion, seconded by Director French, to adopt the reports of the Big Data and Artificial Intelligence (H) Working Group (Attachment Two), the Cybersecurity (H) Working Group (Attachment Three), the E-Commerce (H) Working Group, and the Speed to Market (H) Working Group. The motion passed unanimously.

3. **Received an Update on the Casualty Actuarial and Statistical (C) Task Force Predictive Model Review Process**

Commissioner Birrane said that consistent with the Committee’s efforts to coordinate and ensure collaboration with other related NAIC workstreams, Mr. Slavich, the current the chair of the Casualty Actuarial Statistical (C) Task Force, would provide an update on its Predictive Model Review Process.

Mr. Slavich said the Task Force has been concentrating on predictive modeling activities for the past few years. He provided a description of those activities and charges. Mr. Slavich then provided an update about the NAIC rate model review team’s activities. He said first, states are approving rates filed and the rate models are used in support of those rates; therefore, this group is not actually approving the models themselves, as the states are approving the rates. He said second, the rate models evaluated today are for risk classification and not the overall rate levels, so the company determines its overall rate needs, determines changes to rating variables not included...
in the modeling process, and then uses the model as the main support of allocation of the remaining overall rate needed for individual classes.

Mr. Slavich said the Task Force completed its first predictive modeling product in 2020 with its adoption of the NAIC white paper titled *Regulatory Review of Predictive Models*; meets in regulator-to-regulator session to discuss rate filing issues; and facilitates training and the sharing of expertise through predictive analytics webinars, which is referred to as the Book Club. He said the Task Force received a new charge this year to: “Review the completed work on artificial intelligence (AI) from other Committee groups and to coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues, in as far as these issues contain a Task Force component.”

Mr. Slavich said Task Force members have also been working closely with the NAIC staff hired to form the NAIC rate model review team, including Dorothy L. Andrews (NAIC), a senior behavioral data scientist and actuary, and Sam Kloese (NAIC) and Roberto Perez (NAIC), who are property/casualty (P/C) rate model actuaries. He said this team of experts is led by Kris DeFrain (NAIC), Director of Research and Actuarial Services, and has made considerable progress over the last few years. He said the team has reviewed 54 rate models and produced 127 reports to assist state insurance regulators with their reviews of these models. Mr. Slavich said these reports are stored in a P/C rate model database designed by Task Force regulators and NAIC staff and accessible by the 31 states that have signed the Rate Review Support Services Agreement with the NAIC.

4. Received an Update on the Privacy Protections (D) Working Group 2022 Work Plan

Ms. Johnson provided the report of the Privacy Protections (D) Working Group. She said the Working Group met April 4 and adopted its minutes from previous meetings. She said the Working Group adopted the final exposure draft of the report on consumer data privacy protections and detailed the changes. She said during its meeting, the Working Group heard updates from Jennifer McAdam (NAIC) and Brooke Stringer (NAIC) on federal privacy legislation and received comments from the American Council of Life Insurers (ACLI) and the Health Coalition on the exposure draft of the Working Group’s work plan, which was adopted by the Working Group.

5. Discussed the Coordination of Related Workstream Activity in Other NAIC Committees

Commissioner Birrane said one of the highest priority charges to the Committee is to facilitate appropriate levels of coordination and collaboration among NAIC working groups with respect to topics that relate to innovation, technology, cybersecurity, and privacy in the insurance sector. She said the charge was a foundational element in the decision to form the Committee—the goal being to assure, to the extent appropriate, that the NAIC’s activities in these areas are identified, coordinated, and transparent. She said the first task was to operationalize that charge and determine what coordination and collaboration means along a continuum that ranges from awareness and monitoring the activities of a particular working group, to the absorption of that working group under the Committee and determine what the appropriate level of interface is between that NAIC working group and the Committee. She said the first step was to identify the working groups within the NAIC that include within their current charges or work focus topics that overlap with the work of the Committee referred to as “related groups.” She said that effort was undertaken by NAIC Committee staff, working across all the NAIC committees, and then the leadership of the Committee met with the leadership of each of the other committees to discuss coordination and collaboration in general and with respect to specific related groups. She said this led to an operational approach and framework that depends on the related group and the ongoing and iterative discussions. She said at a high level the categories are:

- Awareness and monitoring of work focus – This approach applies to groups whose work has no obvious overlap with the Committee but whose work can inform the Committee.
• Overlapping representation – This approach applies to groups whose work is more directly related and where each should be aware of the work of the other.
• Joint products/projects – This approach applies to circumstances in which the related group is working on a project that very clearly overlaps with the Committee, and it makes sense for the groups to share the work product.
• Absorption into the Committee – The only example of this currently is the Privacy Protections (D) Working Group.

Commissioner Birrane said that is the outline of how the Committee intends to interface with related groups. In addition, however, there are topics that cut across many related groups and that are of broad significance, such as the detection of unfair bias in AI/ML decisional systems or complex predictive models. She said that is an example of something that many working groups are addressing and for topics such as these, the Committee is establishing a Collaboration Forum that will serve as the platform for multiple NAIC working groups to come together to identify and address foundational issues and develop a common framework that, when adopted, can inform the area specific work of those groups.

Commissioner Birrane said that when such a topic is identified, there will be a meeting of the working groups involved and, if consensus exists, a project within the Collaboration Forum will be created. She said that project will be undertaken by a group consisting of each of the related working groups and any other state that wishes to participate, and each will have its own chair and vice chairs, determine the common issues to be addressed, and establish a work plan, deliverables, and time frames. She said the objective of each project within the Collaboration Forum will be to create the common framework and foundational elements of important regulatory issues that are of broad concern and impact to assure that those issues are fully discussed and vetted with the involvement of many disciplines and areas of expertise and focus, moving forward from a firm foundation built on consensus. She said the first project of the Collaboration Forum will be the algorithmic bias project.

Commissioner Birrane said one additional way in which the Committee will facilitate coordination and collaboration is to facilitate awareness and communication around what related groups are working on supported by the launch of the Innovations, Cybersecurity and Technology (ICT) Hub, which will:

• Provide a “portal” or library of resources related to innovation, cybersecurity, data privacy and consumer privacy, and technology, where the user can easily identify various workstreams and work products developed or being developed by different committees and groups at the NAIC.
• Primarily be led by NAIC staff but with significant input from committee members around the look and feel and the practicality of it.
• List related groups with links to their work and allow users to query and identify working groups and work product from a topic driven perspective.

Commissioner Birrane asked if any Committee members, interested state insurance regulators or interested parties wanted to comment. David Snyder (American Property and Casualty Insurance Association—APCIA) asked what the opportunities would be for stakeholder input on these large-scale projects like algorithmic bias. Commissioner Birrane said the group may meet in regulator-to-regulator session for organizational purposes but would then have public meetings to develop a common understanding and to identify appropriate tools for identifying algorithmic bias within certain AI/ML models. She said the objective would be to listen to SMEs and that the work product of the Collaboration Forum would be open for comment. Scott Harris (American InsurTech Council—AITC) said he applauds the efforts being made. He said finding the right balance between appropriate oversight and encouraging innovation, while keeping up with the pace of innovation, is challenging and that the AITC welcomes the opportunity to comment.
6. **Discussed Other Committee-Level Projects**

Director Daniels said that while the new Innovation in Technology and Regulation (H) Working Group is more outward-focused on what is happening in the marketplace, the Committee will also take on an inward focus as well to look at how state insurance regulators are using innovation and technology to do their jobs. He said there will be a forum for state insurance regulators to discuss concerns or share information about specific technologies or use cases, as well as what might be available in the future, or what SupTech and state insurance regulators will leverage or are leveraging to do their jobs better and more efficiently. Commissioner Birrane said this may have a similar look to what the Casualty Actuarial and Statistical (C) Task Force group is currently doing with its Book Club.

7. **Discussed Other Matters**

Commissioner Birrane asked Denise Matthews (NAIC) to provide an update on innovation, cybersecurity, and technology-related model law implementation. Ms. Matthews said 19 jurisdictions have passed the *Insurance Data Security Model Law* (#668), and it is pending in six jurisdictions with one state, New York, having passed related legislation. Commissioner Birrane noted that this legislation is close to being passed in Maryland, which will bring the number to 20. Ms. Matthews also said that two states have passed legislation related to the rebating revisions in the *Unfair Trade Practices Act* (#880), and legislation is pending in seven.

Birny Birnbaum (Center for Economic Justice—CEJ) asked if it would be possible for states to report the types of rebates they are finding companies are using and whether they are finding any issues with those rebates. He also said that while states are considering Model #880, some states took action by bulletin such as Maine, and he asked if the NAIC could track those.

Having no further business, the Innovation, Cybersecurity, and Technology (H) Committee adjourned.
Draft: 2/28/22

Adopted by the Executive (EX) Committee and Plenary, xx/xx/22

Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, xx/xx/22

Draft 2022 Revised Proposed Structure and Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

The mission of the Innovation, Cybersecurity, and Technology (H) Committee is to: 1) provide a forum for state insurance regulators to learn and have discussions regarding: cybersecurity, innovation, data security and privacy protections, and emerging technology issues; 2) monitor developments in these areas that affect the state insurance regulatory framework; 3) maintain an understanding of evolving practices and use of innovation technologies by insurers and producers in respective lines of business; 4) coordinate NAIC efforts regarding innovation, cybersecurity and privacy, and technology across other committees; and 5) make recommendations and develop regulatory, statutory or guidance updates, as appropriate.

Ongoing Support of NAIC Programs, Products or Services

1. The Innovation, Cybersecurity, and Technology (H) Committee will:

   A. Provide forums, resources, and materials for the discussion of insurance sector developments in cybersecurity and data privacy to educate state insurance regulators on how these developments affect consumer protection, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.

   B. Discuss emerging issues related to cybersecurity, including cybersecurity event reporting, and consumer data privacy protections. Monitor and advise on the cybersecurity insurance market, including rating, underwriting, claims, product development, and loss control. Report on the cyber insurance market, including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.

   C. Coordinate with various subject matter expert (SME) groups on insurer and producer internal cybersecurity. Discuss emerging developments; best practices for risk management, internal control, and governance; and how state insurance regulators can best address industry cyber risks and challenges. Work with the Center for Insurance Policy and Research (CIPR) to analyze cybersecurity related information from various data sources.

   D. Provide forums, resources, and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers, producers, and state insurance regulators; as well as new products, services, and distribution platforms. Educate state insurance regulators on how these developments affect consumer protection, data privacy, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.

   E. Discuss emerging technologies and innovations related to insurance; and insurers, producers, state insurance regulators, licensees, or vendors; and the potential implications of these technologies for the state-based insurance regulatory structure—including reviewing new products and technologies affecting the insurance sector, and associated regulatory implications.
F. Consider and coordinate the development of regulatory guidance and examination standards related to innovation, cybersecurity, data privacy, the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance, and technology, including drafting and revising model laws, white papers, and other recommendations as appropriate. Consider best practices related to cybersecurity event tracking and coordination among state insurance regulators, and produce guidance related to regulatory response to cybersecurity events to promote consistent response efforts across state insurance departments.

G. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity including the Insurance Data Security Model Law (#668), the NAIC Insurance Information and Privacy and Privacy Protection Model Act (#670), the Privacy of Consumer Financial and Health Information Regulation (#672), and the Unfair Trade Practices Act (#880) rebating language and providing assistance to state insurance regulators as needed.

H. Coordinate with other NAIC committees and task forces, as appropriate, and evaluate and recommend certifications, continuing education, and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.

I. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.

2. The Big Data and Artificial Intelligence (H) Working Group will:

A. Research the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommendations to the Innovation, Cybersecurity, and Technology (H) Committee including potential recommendations for development of model governance for the use of big data and AI including ML for the insurance industry.

B. Review current audit and certification programs and/or frameworks that could be used to oversee insurers’ use of consumer and non-insurance data, and models using intelligent algorithms, including AI and in alignment with the NAIC AI Principles. If appropriate, issue recommendations and coordinate with the appropriate subject matter expert (SME) committees on the development of or modifications to model laws, regulations, handbooks, and regulatory guidance, regarding data analysis, marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.

C. Assess data and regulatory tools needed for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data, algorithms, and machine learning, including AI/ML in underwriting, rating, claims and marketing practices. This assessment shall include a review of currently available data and tools, as well as recommendations for development of additional data and tools, as appropriate. Based on this assessment, propose a means to include these tools in existing and/or new regulatory oversight and monitoring processes to promote consistent oversight and monitoring efforts across state insurance departments.
3. The **Speed to Market (H)** Working Group (**move to D Committee**) will:

   A. Consider proposed System for Electronic Rates and Forms Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board (SAB), likely originating from the SERFF Product Steering Committee (PSC). Upon approval and acquisition of any needed funding, direct the SAB to implement the project. Receive periodic reports from the SAB, as needed.

   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.

   C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
      1. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
      2. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
      4. Facilitate the review and revision of the **Product Filing Review Handbook**, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the **Product Filing Review Handbook**.

   D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.

   E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
      1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states’ participation in, and the industry’s usage of, the Compact.
      2. Receive periodic reports from the Compact, as needed.

4. The **E-Commerce (H)** Working Group will:

   A. Examine e-commerce laws and regulations; survey states regarding federal Uniform Electronic Transactions Act (UETA) exceptions; and work toward meaningful, unified recommendations. The Working Group will also examine whether a model bulletin would be appropriate for addressing some of the identified issues and draft a proposed bulletin if determined appropriate.
5. **The Cybersecurity (H) Working Group** will:

   A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices and breaches with the potential to affect the insurance industry.
   B. Interact with and support state insurance departments responding to insurance industry cybersecurity events.
   C. Promote communication across state insurance departments regarding cybersecurity risks and events.
   D. Oversee the development of a regulatory cybersecurity response guidance document to assist state insurance regulators in the investigation of insurance cyber events.
   E. Coordinate NAIC committee cybersecurity work including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology Examination (E) Working Group.
   F. Advise on the development of cybersecurity training for state insurance regulators.
   G. Work with the Center for Insurance Policy and Research (CIPR) to analyze publicly available cybersecurity related information.
   H. Support the states with implementation efforts related to the adoption of *Insurance Data Security Model Law* (#668).
   I. Engage with federal and international supervisors and agencies on efforts to manage and evaluate cybersecurity risk.

6. **The Privacy Protections (HD) Working Group** (*move to H Committee from D Committee*) will:

   A. Review state insurance privacy protections regarding the collection, data ownership and use rights, and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as Model #670 and Model #672.

7. **NEW: The Innovation in Technology and Regulation (H) Working Group** will:

   A. Develop forums, resources, and materials for discussing innovation and technology regarding companies, producers, state insurance regulators, and licensees relevant to the state-based insurance regulatory structure, including new products, services, business models, and distribution mechanisms.
   B. In conjunction with NAIC staff, explore developing a forum that provides insurers or third parties working with insurers the opportunity to confidentially brief state insurance regulators regarding innovation and technology applications, tests, use cases, and results.
   C. Identify and discuss regulatory models or programs that may assist state insurance regulators identify and better understand innovation taking place within the insurance industry.
   D. Monitor innovation work occurring in other NAIC letter committees, task forces, and working groups, and identify areas of possible coordination for the Innovation, Cybersecurity, and Technology (H) Committee.

NAIC Support Staff: Denise Matthews/Scott Morris

SharePoint/NAIC Support Staff Hub/Member Meetings/Spring 2022 National Meeting/Committee Meetings/INNOVATION CYBERSECURITY and TECHNOLOGY (H) COMMITTEE\2022 Charges\H Cmte Charges Revised040522.docx
The Big Data and Artificial Intelligence (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met in Kansas City, MO, April 5, 2022. The following Working Group members participated: Elizabeth Keller Dwyer, Chair (RI); Amy L. Beard, Co-Vice Chair (IN); Doug Ommen, Co-Vice Chair (IA); Adrienne A. Harris, Co-Vice Chair, represented by My Chi To and Kaitlin Asrow (NY); Kevin Gaffney, Co-Vice Chair (VT); Lori K. Wing-Heier (AK); Ken Allen (CA); Peg Brown (CO); Andrew N. Mais (CT); Frank Pyle (DE); Nicole Altieri Crockett (FL); Erica Weyhenmeyer (IL); Kathleen A. Birrane (MD); Timothy N. Schott and Benjamin Yardley (ME); Karen Dennis (MI); Cynthia Amann (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Christian Citarella (NH); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready and Teresa Green (OK); Doug Hartz (OR); Michael Humphreys (PA); Raymond G. Farmer and Michael Wise (SC); Frank Marnell (SD); Bill Huddleston (TN); Mark Worman (TX); Eric Lowe (VA); Molly Nollette and John Haworth (WA); Nathan Houdek and Jennifer Stegall (WI); and Juanita Wimmer (WV).

1. Discussed its Work Plan

Superintendent Dwyer said the 2022 work plan builds on the Working Group’s discussions last year and the three themes of: 1) artificial intelligence (AI)/machine learning (ML) surveys; 2) tools for monitoring AI/ML; and 3) AI/ML regulatory frameworks and governance. She said third-party data and model vendors, while included in the survey work last year, will be a new workstream in 2022. Superintendent Dwyer said the workstreams tie back to the Working Group’s charges. The first charge is to research the use of big data and AI/ML in the business of insurance, and evaluate existing regulatory frameworks for overseeing and monitoring their use. This charge includes the potential recommendation for the development of model governance for the use of big data and AI/ML. Superintendent Dwyer said the second charge is to review current audit and certification programs and/or frameworks, and assess data and regulatory tools needed for state insurance regulators to appropriately monitor the marketplace that could be used to oversee insurers’ use of consumer and non-insurance data and models using intelligent algorithms. She said the third charge focuses on the assessment of data and regulatory tools needed, which will include, as appropriate, recommendations for the collection of additional data and the development of additional tools.

Superintendent Dwyer said the work plan provides a summary of these charges and the following four workstreams: 1) survey work; 2) third-party data and model vendors; 3) evaluation of tools and resources for monitoring industry’s use of data; and 4) regulatory framework and governance. She said the first workstream will continue the analysis of the AI/ML private personal auto (PPA) survey data, use the PPA survey data and experience to inform the development of an AI/ML homeowners (HO) survey, and develop an AI/ML life insurance survey. The second workstream will determine the appropriate regulatory evaluation of third-party data and model vendors and produce a recommended regulatory framework for monitoring and overseeing industry’s use of third-party data and model vendors. The third workstream will gather data and evaluate information on governance models and software tools, which could assist state insurance regulators in overseeing and monitoring industry’s use of data and AI/ML and eliminate any bias in such use. The fourth workstream will evaluate how best to implement the expectations outlined in the NAIC AI Principles and provide suggestions on next steps, which could include regulatory guidance such as model governance.
2. **Discussed 2022 Workstreams**

Mr. Gaffney said Workstream One will build on the survey work completed in 2021 and will continue the analysis of the PPA survey data. As noted by Superintendent Dwyer, Mr. Gaffney said the subject matter experts (SMEs) will use the lessons learned from the PPA survey to develop the HO survey and life insurance survey. Mr. Gaffney said he anticipates the HO survey will be issued in June, and the life insurance survey will be issued in August, with company responses being collected on a confidential basis. Finally, Mr. Gaffney said the HO survey will be similar to the PPA survey, but the life insurance survey will be developed by a different group of regulatory SME. Mr. Gaffney said the survey results and white paper to completed by the Fall National Meeting will support the other workstreams, especially Workstream Two and Workstream Four.

Commissioner Ommen said Workstream Two is focusing on third-party data and model vendors. As noted in the work plan, a group of state insurance regulator SMEs will evaluate the activities of third-party data and model vendors and produce a recommended regulatory framework for monitoring and overseeing industry’s use of these vendors. Commissioner Ommen said the findings and insights will be reported to the Working Group for public discussion and recommendation to the Innovation, Cybersecurity, and Technology (H) Committee. As these efforts proceed, future work will likely be referred to other NAIC committees, task forces, and working groups. To provide a little more context to these efforts, Commissioner Ommen said the first area of focus is to identify new entities operating in the marketplace, better understand their operating practices, and identify whether and how states are currently licensing these entities. While this work will be broader than rating, he said the Casualty Actuarial and Statistical (C) Task Force’s recent survey identifying the types of licenses states issue may help inform these initial discussions. These licenses include Advisory Organizations, Rating Organizations, Rate Service Organizations, Statistical Agent, Statistical Organizations, and Insurance Service Organizations. He said Workstream Two will address all vendors that provide nontraditional data and models to insurers, such as vendors providing data for marketing, fraud detection, and claims settlement. Commissioner Ommen said this is one of the reasons why future work will likely be referred to other NAIC committees, task forces, and working groups. He said the second area of focus is to develop examination standards or questions that states can use for engaging with third-party data vendors and insurers regarding their use of third-party data vendors. Because this work is broader than advisory organizations and rating issues, Commissioner Ommen said the current examination standards for advisory organizations do not provide the right focus but that these standards will be kept in mind as examination standards are developed for third-party data and model vendors.

Superintendent Dwyer said Superintendent Harris is leading Workstream Three with Ms. To and Ms. Asrow. Ms. Asrow said this Workstream will review existing trends, tools, and approaches that can be deployed, or are being deployed, by supervisors to monitor the use of AI/ML by insurance companies. Ms. Asrow said these tools are referenced as SupTech and will include discussion of statistical methods that allow state insurance regulators to better identify disparate impact or unfair discrimination. This Workstream will also discuss tools and vendors the insurance industry is using directly to detect discrimination or bias that might result from the use of data or new processes. Ms. Asrow said the goal is to produce a summary of the supervisory approaches and processes that state insurance regulators can use. This summary will also identify best practices in the regulation of AI/ML, such as relevant model governance frameworks that have been used by state insurance regulators for insurance, banking, or other financial services. Ms. Asrow said one potential option is focus on the mitigation practices of insurance companies rather than directly reviewing for bias using technical tools. Ms. Asrow said this Workstream will primarily coordinate with Workstreams Two and Workstream Four.

Commissioner Beard said Workstream Four will focus on how to implement the expectations outlined in the NAIC’s AI Principles and provide suggestions on the appropriate regulatory framework for monitoring AI/ML, which could include model governance. She said this Workstream will be dependent upon the efforts of the other three workstreams.
Birny Birnbaum (Center for Economic Justice—CEJ) said the work plan is comprehensive and requested the Working Group review potential antitrust issues arising from insurers’ use of third-party data and model vendors. Mr. Birnbaum recommended the Working Group confirm insurers have responsibility for the outcomes that arise from their use of third-party data and model vendors. He also recommended the issues of consumer transparency and avoidance of unfair discrimination and racial bias be addressed. Regarding Workstream Four addressing the regulatory framework/governance, Mr. Birnbaum stressed the need for modernized data collection and market regulation. In addition, he said this Workstream should examine the actual consumer impacts because there are limitations to front-end reviews and model governance procedures. Mr. Birnbaum said these types of regulatory reviews do not guarantee positive consumer outcomes.

Scott Harrison (American InsurTech Council—AITC) said he thinks the work plan is well thought out and appropriately recognizes the impact this work will have on every line of insurance and committee across the NAIC. Matthew Smith (Coalition Against Insurance Fraud) said the Coalition will issue a study in September addressing the use of data and AI/ML to identify insurance fraud. Mr. Smith said the Coalition is beginning this work through a survey and encouraged the Working Group members to contact him if there are questions that they would like to be considered for the survey. David Snyder (American Property Casualty Insurance Association—APCIA) said the work plan looks logical and encouraged the Working Group not to lose sight of how AI/ML has extreme value for consumers, in terms of delivering the kind of products consumers expect and promoting market competition. Regarding Workstream Three, Mr. Snyder said he hopes this Workstream will be completed within the context existing state laws on unfair discrimination.

Superintendent Dwyer said she would review the comments made today and work with the SME lead for each Workstream to make any necessary changes to the work plan. She then requested each Workstream to provide an update on their work in 45 to 60 days during an open Working Group meeting.

3. Received a Presentation on AI/ML Survey Work

Mr. Gaffney said Workstream Three has five key objectives: 1) learn directly from the industry about what is happening in this space; 2) get a sense of the current level of risk and exposure and how the industry is managing or mitigating that risk; 3) develop information for trending, such as how the risk is evolving over time, and the industry’s responsive actions; 4) become more informed to develop a meaningful and useful regulatory approach for overseeing and monitoring AI/ML in the insurance market; and 5) learn from prior surveys to inform and improve future surveys. He said the initial surveys will allow state insurance regulators to document what the industry reports is happening in the PPA, HO, and life insurance markets regarding use of data and AI/ML and get a good sense of the current level of risk and exposure, as well as explore what companies might be doing to mitigate and/or manage its risk and exposure. Mr. Gaffney then reviewed in detail the additional, preliminary results of the PPA.

Mr. Gaffney said the PPA survey was conducted under the market conduct examination authority of nine states—Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin—and was sent to only larger companies, defined as those PPA writers with more than $75 million in direct premium written. The nine states received 193 responses, and almost 90% of the companies responding indicated they are using AI/ML in some manner. He said the largest use of AI/ML models is in claims, then fraud detection, marketing, rating, underwriting, and loss prevention. Mr. Gaffney said state insurance regulators are surprised by the results for the rating and underwriting categories as some of the companies that reported no use of AI/ML in these areas have filed rate models in support of their rates. Because of this, the analysis includes an evaluation of the accuracy of reporting.
Mr. Gaffney said 155 of the 193 respondents are using AI/ML in their claims processes, with 113 companies using AI/ML to evaluate images for the claim. He said no companies reported using AI/ML to automatically deny a claim.

Mr. Gaffney said 111 companies indicated they are or will be using AI/ML for fraud detection, and almost all these companies are using AI/ML to refer claims for fraud review. He said only 29 companies use AI/ML to fast-track claims in a determined non-fraud situation. Mr. Gaffney said companies reported using fraud detection models for claims triage, medical provider fraud detection, fraudulent quote detection, organized crime ring identification, and social network analysis.

Mr. Gaffney said about half the companies are using AI/ML models for marketing, with 75% of the companies using their own models and 25% of the companies using third-party vendors. Marketing models are most often used for targeted online advertising. Mr. Gaffney said other marketing models are used to identify potential customers, decide what advertising to do via mail or in print ads, and implement natural language processing for customer interactions.

Mr. Gaffney said 77 companies reported using AI/ML for rating, with 52 companies implementing rating models in production. He said the survey results also reflect that the use of telematics data was prevalent among companies with rating models in production. Mr. Gaffney said around 80% of models being used are developed internally by the companies, which highlights a regulatory need for continued preparation in the states to review independently developed rate models.

Mr. Gaffney said the use of AI/ML in underwriting is similar to its use in rating, with 59 companies indicating they are using or plan to implement AI/ML models for underwriting purposes, with 34 of the 59 companies indicating they are implementing underwriting models in production. He said an important aspect regarding the use of AI/ML in underwriting is the prevalence of externally sourced data elements, with more than 60% sourced from third-party providers. Mr. Gaffney said underwriting models are used for tiering and company placement, input into denials and approvals, renewals and reinstatements, and policy anomaly detection. He said only three companies are currently using AI/ML to identify high-risk customers for loss prevention.

Mr. Gaffney said the goal is to finalize the PPA survey analysis this summer and to present a report to Big Data and Artificial Intelligence (H) Working Group by the Fall National Meeting. He said the report is expected to include recommendations for regulatory guidance to better monitor the use of AI/ML. One idea is to potentially outline some type of risk hierarchy and describe company governance of risks and best practices that support the NAIC’s AI Principles.

Having no further business, the Big Data and Artificial Intelligence (H) Working Group adjourned.
The Cybersecurity (H) Working Group of the Innovation, Cybersecurity, and Technology (H) Committee met March 23, 2022. The following Working Group members participated: Cynthia Amann, Co-Chair (MO); Wendy Erdly, Co-Chair (NY); C.J. Metcalf, Co-Vice Chair (IL); Michael Peterson, Co-Vice Chair (VI); Sian Ng-Ashcraft (AK); Evan G. Daniels (AZ), Mel Anderson (AR); Damon Diedrich (CA); Wanchin Chou (CT); Matt Kilgallen (GA); Lance Hirano (HI); Shane Mead (KS); Troy Smith (MT); Martin Swanson (NE); Keith Briggs (NC); Colton Schulz and Chris Aufenthie (ND); Don Layson and Todd Oberholtzer (OH); Dan Petterson (VT); John Haworth (WA); and Nathan Houdek (WI).

1. **Heard Opening Remarks and Updates**

Ms. Amann welcomed the state insurance regulators to the Working Group’s first meeting. She said that the goal of the meeting is to discuss the group’s charges and, in the process, lay out a plan for the group’s work for the year. Although the hope was to cover all the charges, she said the focus of the discussion is going to be on the projects associated with two of the Working Group’s charges: 1) to interact with and support state insurance departments responding to insurance industry cybersecurity events; and 2) work with the Center for Insurance Policy and Research (CIPR) to analyze publicly available cybersecurity-related information.

In addition, the new Working Group will work to compliment the work of others with an increased focus on cybersecurity.

2. **Received an Update on the Macroprudential Risk Assessment Process**

Ms. Amann then led a discussion of the Working Group’s charges starting with the charge to interact with and support state insurance departments responding to insurance industry cybersecurity events. She noted that the Working Group could support state insurance regulators with the development of a repository of procedures/controls to assist them in responding to cyber security events. Mr. Peterson noted that he looks forward to working on this project given the complexity of cybersecurity discussions. There are many stakeholders that get involved in cybersecurity events, including law enforcement officials, so he said a response plan resource could help states understand their communication expectations.

Miguel Romero (NAIC) noted that although the financial exam and market conduct exam processes have been updated to better incorporate cybersecurity concepts, there remains a need for a response plan type of document to assist state insurance regulators responding to cybersecurity events. Over the years, state insurance regulators have asked for assistance responding to security events, and a cybersecurity response plan focused on the regulator’s role could be beneficial in meeting that need. The response plan could help states take a lead role in responding to security events. Such a response plan could be viewed as an optional practice aid that states use only as needed.

Mr. Peterson noted that he looks forward to working on this project given the complexity of cybersecurity discussions. There are many stakeholders that get involved in cybersecurity events, including law enforcement officials, so he said a response plan resource could help states understand their communication expectations.

Mr. Haworth asked if there would be a training component for insurance companies as part of this project. Ms. Amann indicated openness to the idea. Mr. Romero noted that state insurance regulators could continue the discussion on training insurers. He said the Working Group does have a charge to train state insurance regulators, but the regulators would have to evaluate if they would be the best body to train insurance companies specifically.
Ms. Amann, Mr. Peterson, and Mr. Romero next talked about the possibility of partnering with the CIPR to collaborate on a survey of insurance company cybersecurity practices. This work would be the practical implementation of the Working Group’s charge to work with the CIPR to analyze publicly available cybersecurity-related information. Mr. Romero noted that a good survey could give state insurance regulators meaningful information that would then help them prioritize future projects. Ms. Erdly also talked about the role that data could play in helping to identify control best practices.

Beyond these two charges, Ms. Amann talked about the importance of working with Market Regulation and Consumer Affairs (D) Committee and Financial Condition (E) Committee subject matter experts (SMEs) to avoid duplication and leverage expertise. Ms. Amann also expressed a desire to see more in the way of cybersecurity-related training. Ms. Amann and Mr. Romero further talked about the need to have a group that monitors international and federal work and also considers whether corresponding efforts are relevant and/or necessary domestically.

Mr. Chou requested that because of the wide-ranging topics the Working Group will cover, it should take steps to make sure the agenda provides enough detail to allow state insurance regulators to understand the expertise that should participate in the Working Group’s meetings. Mr. Chou also referred to the American Academy of Actuaries (Academy), which recently published insights on cybersecurity via its Cyber Risk Task Force. He said that might be beneficial to state insurance regulators on the Working Group’s projects. Richard Gibson (Academy) noted that the Cyber Risk Task Force also prepared a Cyber Risk Toolkit that could be useful to state insurance regulators. Additionally, Mr. Hirano commented on the importance of controls and reviewing third-party work in any cybersecurity risk discussion. Mr. Romero said that there may be training on reviewing third-party work at the NAIC’s Insurance Summit.

Having no further business, the Cybersecurity (H) Working Group adjourned.
NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee April 8, 2022, Minutes................................................................. 13-2
NAIC/American Indian and Alaska Native Liaison Committee April 6, 2022, Minutes (Attachment One)...... 13-7
The NAIC/Consumer Liaison Committee met in Kansas City, MO, April 8, 2022. The following Liaison Committee members participated: Andrew R. Stolfi, Chair (OR); Grace Arnold, Vice Chair (MN); by Lori K. Wing-Heier (AK); Jim L. Ridling represented by Mark Fowler and Reyn Norman (AL); Alan McClain represented by Jennifer Bruce (AR); Peni Itula Sapini Teo (AS); Ricardo Lara (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida represented by Melissa Hamada (HI); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); James J. Donelon (LA); Kathleen A. Birrane represented by Alexander Borkowski (MD); Anita G. Fox and Karin Gyger (MI); Chlora Lindley-Myers (MO); Mike Causey represented by Kathy Shortt (NC); Jon Godfread represented by John Arnold (ND); Eric Dunning (NE); Chris Nicolopoulos represented by David Bettencourt (NH); Barbara D. Richardson represented by David Cassetty (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French and Jana Jarrett (OH); Michael Humphreys represented by Katie Merritt (PA); Cassie Brown (TX); Jon Pike (UT); Scott A. White represented by Don Beatty (VA); Mike Kreidler (WA); and Allan L. McCey (WV). Also participating were Michael Conway (CO); John F. King (GA); Michelle B. Santos (GU); Doug Ommen (IA); Dana Popish Severinghaus (IL); Doug Hartz (OR); and Tregenza A. Roach (VI).

1. **Heard Opening Remarks**

Commissioner Stolfi welcomed the 40 NAIC consumer representatives selected for 2022, indicating that their names and the organizations represented were included on the agenda following the names of the Liaison Committee members. He said as the vice chair of the NAIC Consumer Board of Trustees, he wants to report that the Board: 1) works in conjunction with the Liaison Committee; 2) comprises six state insurance regulator members and six consumer representative members; and 3) meets in closed, confidential sessions because it administers the NAIC Consumer Participation Program, which may require discussions of a confidential nature concerning personal information. He said the Board met April 7 to discuss suggested revisions to the Plan of Operation for the NAIC Consumer Participation Program and the surveys of Liaison Committee members and consumer representatives on how to enhance the level of participation during future Liaison Committee meetings.

2. **Adopted its 2021 Fall National Meeting Minutes**

Commissioner Stolfi said the Liaison Committee met Dec. 13, 2021.

Commissioner Arnold made a motion, seconded by Commissioner Lara, to adopt the Liaison Committee’s Dec. 13, 2021, minutes (see NAIC Proceedings – Fall 2021, NAIC/Consumer Liaison Committee). The motion passed unanimously.

3. **Heard a Presentation from the AEPI on the Demise of the Auto Insurance Appraisal Clause**

Erica Eversman (Automotive Education & Policy Institute—AEPI) said the appraisal clause is vanishing from private passenger automobile (PPA) insurance policies, and this is important because it is used to determine property loss claims values that are non-binding. She said the Road Traffic Act 1988 (RTA) requires insurers to provide umpire awards exclusively for personal injury but not for property loss resolutions. She said it also allows insurers to avoid using the Inter-American Commercial Arbitration Commission (IACAC), including no penalty for bad actors; however, she said it is not in all PPA policies. She said the appraisal is $5,500 and $96 for an arbitration for a policy that has an appraisal clause for a claim settlement projected to be under $10,000. She said the consumer success
rate is extremely high at 98% when arbitration is utilized. She said recent insurer changes include insurers: 1) using their own employees or claims adjustors to serve as arbitrators; 2) rejecting most umpires suggested by consumers; and 3) refusing to pay the umpire’s award. She said consumers are then forced to sue insurers to force them to pay contracts as written and approved by state insurance departments, which is contrary to standard insurance regulation. She said other changes insurers are making to appraisal clauses include removing them entirely or covering partial losses only where the clause used to cover a full or partial loss. She said many consumers have called her looking for an attorney to use but cannot find any, so insurers can pay less because small claim limits are much lower and can be moved to lower general court.

Ms. Eversman said her recommendations for state insurance regulators are to: 1) mandate full and partial evaluation of automobile property loss; 2) alert insurers to notify consumers that the RTA exists if they disagree with their claim offer; 3) require the use of independent evaluators and umpires; 4) establish a time frame for RTA completion and the maximum amount the consumer expects to be permitted; and 5) include the use of RTA use, results, and dollar value; and 6) change data elements for market conduct analysis to reflect it. She said a company told her she did not follow insurance regulations so she could not collect on her claim.

Commissioner Stolfi said Oregon implemented a consumer education process and hoped that when consumers came to it, they would understand that if the cost after the final decision is higher, the state requires companies to pay the difference. Amy Bach (United Policyholders—UP) said the UP is seeing insurers using fewer appraisals. Ms. Eversman asked companies why these changes are being made and whether companies have a good reason to do it. Commissioner Stolfi said Ms. Eversman could submit a request for NAIC action following the meeting.

4. Heard a Presentation from the CEJ on Modernizing Market Regulation Data Collection

Birny Birnbaum (Center for Economic Justice—CEJ) said there is little to no public market regulation data available for consumers or states to use, and the type of data the NAIC has today is on workers’ compensation so state insurance regulators can track COVID-19-related data by state and severity. He said mortgage lending is available on a monthly and annual basis by race and geography. He said on March 10, the NAIC announced a 2.2% increase from 2018 to 2019; an anachronism in property/casualty (P/C) data collection (not workers’ compensation) through the Market Conduct Annual Statement (MCAS) is highly flawed and untimely. He said most of the reporting comes from a statistical data agency system that has not been updated in 40 years. He said for workers’ compensation, the National Council on Compensation Insurance (NCCI) is only one of many statistical organizations that base analysis on transactional data reported monthly. He said for personal lines, the data is outdated and used to produce industry aggregate statistics, which results in reporting that is of no use to state insurance regulators for market regulation, except for that which is COVID-19-related or racially biased.

Mr. Birnbaum said statistical agents appointed by states refuse to provide data. He said one straightforward solution would be to use their existing authority to designate one singular statistical company through a bid process for all states to use like the NAIC did for statutory reporting, and it should include individual company data. He said there was historic precedence by the Texas Department of Insurance (TDI) when it implemented Request for Information and Qualifications (RFIQ) in 1995. He said its first expectation was that the designated statutory agent is to report to the TDI as the state’s agent. He said a second solution would be to use an Open Interactive Data Language (IDL) Blockchain Network for the insurance industry. He recommended that state insurance regulators move to a more timely, granular, uniform, and responsive market regulation data collection through a modernized statutory agent framework.

Commissioner Arnold asked Mr. Birnbaum if he has any concerns because workers’ compensation insurance has more structure than other P/C insurance. Mr. Birnbaum said he does not have any concerns because the historical evidence was tied to rating, which is not needed today, but the underwriting and pricing attributes are needed. Mr. Cassetty asked if the bid process was used by the TDI in 1995. Mr. Birnbaum said the bid process was done
from outside the TDI with one statutory agent designated for each major line. He said when the agent did credit scoring, data they already had was used because it had continually been collected, so there was no need for specific data calls. Commissioner Stolfi said this is intriguing to him, and he asked if anyone knows of other states that may have done this that could be contacted. Mr. Birnbaum said California, Illinois, and Pennsylvania have looked at this with special data calls from time to time because this would eliminate the need for special data calls. He suggested that the NAIC compare workers’ compensation to other lines’ data calls and ask statutory companies, such as the Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS), what they can provide. Mr. Chou asked if, given the proactive and reactive resource constraints for most state insurance departments, the NAIC could encourage workers’ compensation to get more meat in their data reporting. Mr. Birnbaum said some resources are needed up front, and less being needed later. Executive Deputy Superintendent To said the Innovation, Cybersecurity, and Technology (H) Committee would provide supervisory or regulatory technology being considered.

5. Heard a Presentation by the NCTE, the DREDF, and the HIV + Hepatitis Policy Institute on the Role of State Insurance Regulators in Addressing Discriminatory Benefit Design

Carl Schmid (HIV + Hepatitis Policy Institute) said the proposed 2023 Notice of Benefit Payment Parameters (NBPP) Rule on Benefit Design, Section 156.125 Prohibition on discrimination would “… explicitly prohibit discrimination on the basis of sexual orientation and gender identity, as had been the case prior to 2020.” He said the Center for Consumer Information and Insurance Oversight (CCIIO) recently proposed adding clinically based, relevant, peer reviewed medical journal guidelines in six areas where presumptive discrimination exists: 1) the limitation on hearing aid coverage based on age; 2) Autism spectrum disorder (ASD) coverage limits based on age; 3) age limits for infertility treatment coverage when treatment is clinically effective for the age group; 4) limitation on foot care coverage based on diagnosis, whether diabetes or another underlying medical condition; 5) coverage of Essential Health Benefits (EHB) for gender-affirming care; and 6) access to prescription drugs for chronic health conditions through adverse tiering. He said there should be no adverse tiering, and tiering should not rely on cost alone. He said it must be clinically based and balanced, as well as allow reasonable medical management. He said there are other practices that also constitute discrimination, so attention to enforcement is needed in accordance with Qualified Health Plan (QHP) certification for prescriptions that is available online now with additional tools coming soon, many of which have zero cost sharing.

D. Ojeda (National Center for Transgender Equality—NCTE), who uses the pronoun they, said there are high levels of unmet health care needs among the transgender community. They said providers and plans need to mitigate harmful health care encounters and damaged trust. They said gender-affirming care is medically necessary and saves lives by improving mental health and quality of life overall. They said providers and plans found that in 2015, one in four experience a problem with being denied health care insurance coverage. They said there is a need to mitigate harmful health care encounters, such as the fear of being mistreated and that they could not afford the care needed, especially those that are higher within the ranks of people of color. They said state insurance regulators could provide clear guidance on nondiscriminatory coverage and outreach. They said states that have already provided explicit guidance include Colorado, Montana, Nevada, and Virginia. They encouraged all state insurance regulators to take the lead in this area of need.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said discriminatory benefit design also exists within the proposed 2023 rule regarding rehabilitation and habilitation services and devices. She said there are critical medical needs for people with chronic conditions, such as medically needed therapies for pain management that are not fixes or cures, but rather slow progressive symptoms and restore functional capacity (e.g., long COVID); therapies needed for children and adults to achieve functions for the first time; mental health services and therapy that include in-patient and out-patient care; and durable medical equipment. She said some people need a wheelchair elevator, which for them is not a luxury item due to their debilitating condition, but rather, it is a medical necessity. However, she said insurers would not be covering it or certain contraception
services due to benefit design discrimination. She said they need help from state insurance regulators and recommended that they issue clear examples of discriminatory benefit design, explain what this type of discrimination means, and rotate a deep dive review of key benefit categories.

Commissioner Arnold said Workstream Five under the Special (EX) Committee on Race and Insurance would be a good place to give this presentation as well, and it might include how policies are affected. Ms. Merritt asked if the draft QHP template would have any federal definition of gender-affirming care. D. Ojeda said the template had a definition as well as standards.

6. Heard a Presentation from the NWLC and Georgetown University CHIR on the Urgency of Now: Mental Health Parity and an Ongoing Pandemic

Dorianne Mason (National Women’s Law Center—NWLC) said the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) referred to a covered condition, not a mandate. She said forty-three state parity laws were in effect in 2008, and the MHPAEA contains no state preemption. She said the MHPAEA did not affect existing state mandates to offer or cover behavioral health benefits, and legislative activity at the state level continues to focus on compliance and enforcement. Since the pandemic began, she said 106,000 Americans have died of overdoses, with 36.8% per 100,000 of those reporting as black and 41.4% reporting as Indian. She said every two years, the Employee Benefits Security Administration (EBSA) and the federal Centers for Medicare & Medicaid Services (CMS) issue an MHPAEA Report to the U.S. Congress (Congress). She said the 2022 report indicated that none of the plans were found to be sufficient, and compliance assistance was not enough, but what was needed was more active enforcement by states using their full authority. She said the report also indicated that the pandemic had a negative impact and increased mental health needs, especially in women due to the lack of childcare, the isolation of remote work, and required home schooling. She said one in seven women and 12.3% of men reported feeling overwhelmed.

Maanasa Kona (Georgetown University Center on Health Insurance Reforms—CHIR) said questions state insurance regulators could ask as they move forward with plans to improve MHPAEA compliance by insurers are: 1) what type of information the state needs to collect; 2) whether the state has the authority to collect this information; and 3) what format the state should use in requesting and collecting this information. She said the MHPAEA requires plans to document and report internal as well as external practices. She said under the Consolidated Appropriations Act enacted on Feb. 10, 2021, plans must make comparative analyses of design and application of non-quantitative treatment limitations (NQTLs) available to state departments of insurance (DOIs) upon request. She said state legislation as of the Legal Action Center (LAC) Report of July 2020 included: 1) 15 states and Washington, DC required plans to submit compliance reports and/or quantitative data to DOIs; 2) nine states and Washington, DC required plans to conduct parity compliance analysis modeled after the Kennedy Forum’s six-step analysis and report findings to DOIs; and 3) Washington, DC required health plans to report on quantitative data needed for an “in operation” analysis of parity compliance.

Ms. Kona said Pennsylvania developed its own quantitative treatment limitations (QTLs) compliance tool for assessing QTLs that included time limits, the need for granularity, and use of the tool by insurers during future product development. She said assessing NQTLs included finding the right tool; issues with NQTL compliance due to the large amount of data and consistency across carriers; recommendations that included reaching out to providers, which New Mexico did via provider survey and Nebraska did via presentations for providers; and using claims review. She said looking forward, state insurance regulators could: 1) require submission of compliance reports and quantitative data to monitor MHPAEA compliance by leveraging federal law; 2) adopt or develop the right tool for QTL and NQTL compliance data submission; 3) ensure high quality submissions by carriers; and 4) identify issues in submitted information. She concluded by saying that Georgetown University will be doing its own MHPAEA survey and report.
Commissioner Stolfi said Oregon passed some of these laws recently and acknowledged that putting such legislation together takes a lot of work by a state insurance department.

7. Heard a Presentation from the LLS and the Colorado Children’s Campaign on Standard Plan Design: Federal Developments and Lessons Learned in States

Erin Miller (Colorado Children’s Campaign) said there has been a lot of interest in being able to compare health care plans to help consumers choose the right plan for their personal needs. One way to improve a consumer’s ability to select would be to clarify the choices so the plans could be compared on an “apples to apples” basis. She said standardized plans would meet this challenge while improving health equity and providing other health coverage improvements. She said it would also provide the potential for cost-reduction strategies by targeting rate setting. She said states that already require standardized individual market health plans are on both coasts and in Colorado. She said Colorado required extensive stakeholder involvement in the process, including those from the health care industry and communities that are diverse regarding race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic regions of the state and are affected by higher rates of health disparities and inequities. She said the standardized plans are designed to improve racial health equity and decrease racial health disparities through a variety of means, which are identified collaboratively with consumer stakeholders, such as improving prenatal health care, and through a culturally responsive network.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) said recommendations for state insurance regulators include: 1) improving regulatory tools that would improve health equity through plan design, limit the number of plans offered, provide meaningful difference standards, and improve naming display; 2) additional consumer education with an emphasis on the benefits of standard plans, explanations of how to compare standard and non-standard plans, and education about new plans at re-enrollment; and 3) monitoring the marketplace as to the trends in consumer choices and consumer satisfaction.

Commissioner Arnold asked how requiring standardized plans affected the value of health care plans. Ms. Culp said most states see standard plans affected mostly in the way plans are named and referred to. She said this is where consumer education is needed the most. Ms. Miller said plan display comes in handy, especially in the early years.

Commissioner Stolfi said Oregon has had standard plans since the federal Affordable Care Act (ACA) was enacted.

8. Discussed Other Matters

Commissioner Stolfi said these presentations are very valuable, and the discussions following each were even more so. He said it is possible that changes may be determined for future meetings based on the results of the state insurance regulator and consumer surveys completed just prior to this meeting. He said a full discussion of all will follow to find good solutions for enhancing presentations and discussions going forward.

Michael DeLong (Consumer Federation of America—CFA) asked that consumer representatives be encouraged to help at the state level, and he asked what the NAIC is doing to ensure that the letter from the CFA on antifraud is being addressed. Commissioner Stolfi said he believes this issue is being addressed by another committee.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
Draft: 4/26/22

NAIC/American Indian and Alaska Native Liaison Committee
Kansas City, Missouri
April 6, 2022

The NAIC/American Indian and Alaska Native Liaison Committee met in Kansas City, MO, April 6, 2022. The following Liaison Committee members participated: Troy Downing, Chair (MT); Russell Toal, Vice Chair (NM); Lori K. Wing-Heier (AK); Trinidad Navarro (DE); Dean L. Cameron represented by Randy Pipal (ID); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Mike Causey represented by Kathy Shortt (NC); Jon Godfread represented by Colton Schulz (ND); Glen Mulready (OK); Andrew R. Stolfi (OR); Larry D. Deiter represented by Frank Marnell (SD); Mike Kreidler represented by Todd Dixon (WA); and Jeff Rude (WY). Also participating were Frank Pyle (DE); and Bob Biskupiak (MT).

1. Adopted its 2021 Fall National Meeting Minutes

Commissioner Downing said the Liaison Committee met Dec. 11, 2021.

Director Wing-Heier made a motion, seconded by Superintendent Toal, to adopt the Liaison Committee’s Dec. 11, 2021, minutes (see NAIC Proceedings – Fall 2021, NAIC/American Indian and Alaska Native Liaison Committee, Attachment Two). The motion passed unanimously.

2. Heard a Presentation on Communication and Outreach Within the American Indian Culture

Commissioner Downing said he met Pastor Bruce Plummer (Montana Indian Ministries) during an outreach meeting in Helena, MT, and he had a good conversation with Pastor Plummer regarding issues of cultural awareness that may facilitate or hinder communications with members of native populations. Although there is not one sweeping statement than can be made for every unique community, he said he found this experience valuable, and he asked Pastor Plummer to speak to the Liaison Committee about his insights into communications and awareness in Indian Country.

Pastor Plummer began his presentation with a prayer over the Liaison Committee. He said the focus of his presentation is on “Being an Indian,” and he said he lives on the Fort Belknap Indian Reservation in Montana, which is a closed, domestic, protected reservation that is a federally recognized tribe. He said the Fort Belknap Indian Reservation is located 40 miles south of the Canadian border and 20 miles north of the Missouri River. He said it is home to two tribes, i.e., the Assiniboine, or Nakoda, and the Gros Ventre. He said the reservation is not subject to Montana, which is a good thing and a bad thing. He said there is a desperate need to make communication work with Montana, as the American Indian tribes are dying. When asked who they are, he said they are a tribal nation that emphasizes “we,” not “I.” However, he said there is a lot of water under the bridge to quote an old proverb between states and Native Americans, so there are more than 500 years of roadblocks to overcome. He said to start with, he is a spiritual chief who was made by his tribe, rather than an ancestry chief. He said in 2022, Native Americans are American citizens; however, this was not always the case. He said there are less than five million Native Americans left, and they consider themselves caretakers of the land. While he said there are no do-overs in history because the past exists always and Native Americans have an excellent memory, now it is time for everyone to move on. He said when he is asked about what can be done to help preserve his people and his culture, he says education is an issue, as his parents only had a sixth-grade education. He said it is important to remember that there are many differences between American Indians and Alaska Natives, so outreach and communication efforts need to be customized according to tribe and area. To assist with this, he referred to the handout posted on the Event App that shows the strengths and differences between Native
American and white American cultures. He said in collaborating with the best leaders, they need a hand up, not a handout, and they need education. Then, he said they need more education.

Commissioner Downing said he understands that Pastor Plummer’s daughter is trying to solve housing problems in tribal communities. When asked about programs promoting “saving for your future”, Pastor Plummer rhetorically asked “why would those with resources not share? Because tribal members share rather than save.” Superintendent Toal asked what type of health services are available in Montana. Pastor Plummer said Montana did a survey that emphasizes the differences between federal Affordable Care Act (ACA) health care and Indian Health Service (IHS) health care. It found that the average age at death for a male in the U.S. is 75, but the average age at death for a Native American male is 55. He said that is because illness and chronic health conditions are ranked one to five; however, the amount budgeted for this care in the federal budget is enough to cover those ranked one only.

3. Heard a Presentation on Montana’s Experience with the ACA and its COVID-19/Pandemic Response

Commissioner Downing said Lesa Evers (Montana Department of Public Health and Human Services—DPHHS) would discuss responses to the COVID-19 pandemic in tribal communities. He said she would discuss successes, hurdles, and lessons learned in vaccinating tribal members.

Ms. Evers said she is proud to say that the flags of all the tribal nations are flown at the entrance to the building she works in, and the state cares for the flags and protects them. She said she was born on a reservation but now lives outside of the reservation. She said there are seven reservations in Montana that cover 1,500 miles and eight jurisdictions, all of which are federally recognized. She said the Little Shell Tribe is trying to become the 754th tribe recognized by the federal government. She said in the governor’s state of the state report said cardiovascular disease was the top reason for Native American deaths in Montana. She said Native Americans die at age 56 for men and 62 for women, while throughout the U.S., men die at age 75 and women at age 82. She said during a tour a few years ago, former Montana Insurance Commissioner Monica Lindeen traveled to all the tribes to educate them about the ACA. She said outreach was done via flyers, which were placed on bulletin boards at the grocery stores and clinics, as well as public service ads through tribal radio stations and via Facebook and other social media. She said they feed people and always bring food even if only one person shows up; it was worth it because that one person represented a whole group of people or a whole tribe, and that one person took the food as well as the message about the ACA back to that whole group of people or the whole tribe. She said one must build relationships to do this.

Ms. Evers said most Native Americans believe the IHS is a health insurance plan, but it is not; it is an extremely complicated health care system. She said it might cover the costs of health care provided, and it might not. She said Montana expanded Medicaid, which helped, but access to health care for the most critical is the number one issue. She said the IHS has five priority categories, but it only has funding for one—i.e., the very top level—so there is no preventative care, only care for the most critical cases, which is a problem. She said COVID-19 accelerated this problem due to the required isolation with some communities having checkpoints to control those who were able to enter reservations. She said it was difficult to track the spread because the state collects information by county, and there are 56; however, Native Americans want to hear about it by tribe. She said within six weeks, all tribes had been tested, with three of the tribes deciding to go through the state and the other three going elsewhere or providing their own. She said a total of 12,000 vaccinations were given, and the state did 8,000 of those. She said the Montana DPHHS has created good partnerships with the tribes by taking actions and providing home kits; however, COVID-19 has been devastating, with tribes having 19% of the cases and 32% of the deaths in Montana. She said lessons learned include: 1) commit to action; 2) remember that you are a guest on reservations; 3) do not expect large crowds; 4) bring food that you paid for and bring to-go boxes; and 5) do not overpromise.
Superintendent Toal gave a shout out to New Mexico tribes and pueblos who did so well in getting vaccines delivered, and he said he really appreciates their efforts. Commissioner Rude asked if any ongoing partnerships had been formed through their efforts in Montana. Ms. Evers said some tribes did, and others did not.

4. **Heard a Presentation on Consumer Outreach and Education About Fraud Within the American Indian Culture**

Matthew Smith (Coalition Against Insurance Fraud—CAIF) said he has been working with Alaska as they take steps to include fraud in their mission statement. He said fraud always targets the most vulnerable parts of consumers. He said American Indians and Alaska Natives are very trusting people, which is why fraudsters prey on them. He asked the Liaison Committee members to check out the graph in his slides for more information about how to protect tribes from fraudsters and educate tribal members on what is good insurance so they can recognize bad insurance when fraudsters try to thrust it upon them. He said 78% of tribes are not hearing from their state insurance department. He referred state insurance regulators to the public information and outreach templates on the CAIF’s website. He said customized videos and advertising are also available for any insurance department to use. He said the CAIF will train antifraud staff and teams on how to report and be protected from fraud. Director Wing-Heier said elders with cell phones are the most vulnerable sector of the country.

5. **Discussed Other Matters**

Commissioner Downing said he would like to address a few deliverables and time frames for the Liaison Committee. He said the first deliverable for consideration would be to produce a document on communication and cultural awareness with American Indian and Alaska Native communities. To gauge interest in an ad hoc group to define this tool to help bridge communications gaps between members of native communities and non-native industry and regulatory representatives, he asked members of the Liaison Committee to volunteer to be on the first ad hoc group.

Commissioner Downing said the second deliverable he would like to suggest is an ad hoc group to explore access to non-IHS health plans. He said this second ad hoc group would investigate issues with access and navigation of ACA Exchange Programs for American Indians and Alaska Natives.

Finally, Commissioner Downing said he would like to suggest an ad hoc group to explore deficits in access to coverage and put together suggestions for closing any market gaps. He said he would like any member of the Liaison Committee who is interested in being on one of the three ad hoc groups just noted to contact Lois E. Alexander (NAIC) and him so ad hoc group meetings can be scheduled. He said each group will have two to three members and will meet for a limited time to produce a specific product or deliverable.

Commissioner Downing said he would like to note that the Liaison Committee has two presenters from the Blue Cross Blue Shield of New Mexico lined up for an interim meeting that will be scheduled sometime before the Summer National Meeting at a date and time yet to be determined.

Commissioner Downing said he would like to use the rest of the meeting time to recommend that Liaison Committee members review the results of the two surveys—i.e., one for state insurance regulators and one for NAIC consumer representatives—about the goals of the Liaison Committee for 2022 in their head table member packets.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.