

Amendments for the 2022 Valuation Manual
for the Consideration of
the Life Insurance and Annuities (A) Committee
July 19, 2021

Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
1	3	2019-33	Sect II, VM-20, VM-51	Clarify the definition of individually underwritten life insurance and the applicability of PBR requirements for group contracts with individual risk selection issued under insurance certificates.	7/1/2021
2	11	2020-02	VM-20 Section 2.H and new Section 2.I	Provide clearer guidance on the boundaries of a company's latitude in following VM-20 steps	10/29/2020
3	15	2020-03	VM-20 Section 3.B.3	Clarify NPR calculation requirements	8/27/2020
4	19	2020-08	VM-20 Section 9.C.2.d.vi.	Clarify and introduce a third permissible technique for the calculation of company experience rates.	12/3/2020
5	22	2020-09	VM Section II, Subsection 1.D	Modify Life PBR Exemption	11/5/2020
6	25	2020-10	VM-20, VM-31	Mortality improvement	6/10/2021
7	35	2020-11	VM Section II, Subsection 1.D.4	Modify Life PBR Exemption-Part 2	2/11/2021
8	37	2020-13	VM-20, Sec 7.D.3	Asset Collar	4/8/2021
9	38	2021-03	VM-21, Section 6.C.5:	Update the reference to required minimum distribution age	5/6/2021
10	41	2021-04	VM-02 Section 3.A	Clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.	4/29/2021
11	43	2021-05	VM-01, VM-20 7.E, VM-21 4.D, VM-31 3.D.6, 3.F.6	Clarify modeled company investment strategy and comparison to the alternative investment strategy	5/20/2021
12	48	2021-06	VM-50, VM-51	Revise VM-50/VM-51	5/27/2021
13	91	2021-07	VM-20 Section 2.A.3, 3.A, 3.B 3.C and 6.B	Clarify ULSG NPR Calculation Requirements	6/24/2021
14	99	2021-09	VM-21 Section 1.E (new), 3.H (new), VM-31 Section 3.E.1, 3.F.2.e	Update VM-31 materiality language to be consistent new section of VM-21 addressing materiality.	7/1/2021
15	102	2021-10	VM 51 App 4	Remove "at issue" from Smoker Status data element name to allow for use of the smoker status at the time of data submission	6/24/2021

**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.

American Academy of Actuaries, Life Reserves Work Group

Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

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, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF on 2/11/21) shown in blue text.

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 Appendix

All proposed changes specific to this amendment proposal are shown in red text.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

* 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:

Dates: Received	Reviewed by Staff	Distributed	Considered
3/19/19			
Notes: APF 2019-33			

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Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the *Valuation Manual* to bring these individual certificates into scope of VM-20.

Six changes are recommended:

- 1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);
- 2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);
- 3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;
- 4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;
- 5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;
- 6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.

VM Changes 1, 2 and 3 – II. Reserve Requirements

II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

- (1) Life Insurance Products
- (2) Annuity Products
- (3) Deposit-Type Contracts
- (4) Health Insurance Products
- (5) Credit Life and Disability Products
- (6) Riders and Supplemental Benefits
- (7) Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the *Valuation Manual*. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the *Valuation Manual*.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.

Subsection 1: Life Insurance Products

- A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the *Valuation Manual* that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.
- B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in ~~paragraph D below~~ **subsection 1.G** are provided by VM-20, *Requirements for Principle-Based Reserves for Life Products*, except for election of the transition period in ~~paragraph C below~~ **subsection 1.F.2** below. For this purpose, joint life policies are considered individual life.
- C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the *Valuation Manual*.
- D. **Minimum reserve requirements for individual certificates under group life contracts (regardless of the issue date of the master group life contract) which meet all the requirements in VM-20 Section 1.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.**
- E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, *Mortality Tables* (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, *Minimum Nonforfeiture Mortality and Interest*.

F. A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the *Valuation Manual* and prior to 1/1/2024.
2. Business not described subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the *Valuation Manual*.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners' Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company ~~during the three years~~ elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting ~~the at least one of the conditions in D~~subsection 1.G.2 below may file a statement of exemption for individual ~~ordinary life insurance policies or certificates, except for policies or certificates in D~~subsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. ~~If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D~~subsection 1.G.2 was met ~~and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.~~

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies or certificates covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in Dsubsection 1.G.2 below, 2) the policies or certificates contain those in ~~D~~subsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies or certificates. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter "SEE EXPLANATION" in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

~~a—~~The company has less than \$300 million of ~~ordinary life~~exemption premiums[†], and if the company is a member of an NAIC group of ~~life insurers~~which includes other life insurance companies, the group has combined ~~ordinary life~~exemption premiums[†] of less than \$600 million; or

The only new policies or certificates that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies or certificates valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:

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- a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus
- b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus
- c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus
- d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus
- e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:

- (i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
- (ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies and Certificates Excluded from the Life PBR Exemption:
 - a. Universal life with secondary guarantee (ULSG) policies or certificates, or policies or certificates – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”
4. Each exemption, or lack of an exemption, outlined in ~~D~~-subsection 1.G.1 – ~~D~~-subsection 1.G.3 above applies only to policies or certificates issued or assumed in the current year, and it applies to all future valuation dates for those policies or certificates. However, if policies or certificates did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies or certificates. The minimum reserve requirements for the ordinary life policies, including individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B, subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

- A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the *Valuation Manual* and subject to a principle-based valuation with an NPR floor under Model #820. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.

B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant's issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

Guidance Note: Coverage amount does not imply a requirement for banding of premiums or charges but rather rates or charges that are multiplied by number of units of coverage of face amount (or net amount at risk) per \$1,000 to obtain the actual premium or charge.

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the *Valuation Manual* except election of the transition period in Section 2, subsection 1.F.1.

VM Change 5 - VM-20: Requirements for Principle-Based Reserves for Life Products

Section 2: Minimum Reserve

- A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:

VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.

Life PBR Exemption as defined in the NAIC adopted Valuation Manual (VM)						
1.	Has the company filed and been granted a Life PBR Exemption from the reserve requirements of VM-20 of the Valuation Manual by their state of domicile?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="checkbox"/>
2.	If the response to Question 1 is "Yes", then check the source of the granted "Life PBR Exemption" definition? (Check either 2.1, 2.2 or 2.3)					
2.1	NAIC Adopted VM	<input type="checkbox"/>				
2.2	State Statute (SVL)	<input type="checkbox"/>	Complete items "a" and "b", as appropriate.			
a.	Is the criteria in the State Statute (SVL) different from the NAIC adopted VM?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="checkbox"/>
b.	If the answer to "a" above is "Yes", provide the criteria 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	<input type="checkbox"/>	Complete items "a" and "b", as appropriate.			
a.	Is the criteria in the State Regulation different from the NAIC adopted VM?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="checkbox"/>
b.	If the answer to "a" above is "Yes", provide the criteria 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).					

**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.

Joint submission by NAIC staff and Staff of Office of Principle-Based Reserving, California Department of Insurance – Clarify areas of confusion relating to the topic of materiality.

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:

Valuation Manual (January 1, 2021 edition), VM-20 Section 2.H, new Section 2.I, and Section 7.E.1.g

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 Appendix.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

See attached Appendix.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
09/21/20	RM		
APF 2020-02 rev. 09/21/20			

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Appendix

ISSUE:

Skipping steps in VM-20 is not allowed on grounds of immateriality. Some companies are skipping some VM-20 requirements altogether, without providing a simplification, approximation, or modeling technique that satisfies the VM-20 Section 2.G requirement that such simplifications neither materially understate nor downwardly bias the reserves. Simply skipping portions of the requirements, such as not computing an NPR, or not computing the DR and/or SR when exclusion tests have not been performed, inherently bias the reserve downward since their omission can only be neutral or decrease the resulting reserve. Without computing even a simplified model for Section 2.G analysis that shows there is not a decrease in the final reserve, this makes the skipping of the step violate Section 2.G. This APF clarifies that these types of omissions are not allowed. This has always been the case, but perhaps needs more emphasis in the *Valuation Manual*.

SECTION:

VM-20 Section 2.H and new Section 2.I, and VM-20 Section 7.E.1.g

REDLINE:

VM-20 Section 2.H

H. The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks under VM-20 Section 9.B.1. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

Guidance Note:

For example, the standard may be expressed as an impact of more than X dollars or Y% of the reserve, whichever is greater, where X and Y are chosen in a manner that is meant to stand the test of time and not need periodic revision.

The standard is based on the impact relative to the size of the NPR, DR and SR as opposed to the impact relative to the overall financial statement (e.g., total company reserves or surplus). Reviewing items that may lead to a material misstatement of the financial statement in the current year is appropriate in its own context, but it is not appropriate for identifying material risks for PBR, which itself is an emerging risk.

Note that the criteria apply to the NPR, DR and SR, and not just the final reported reserve. For example, if the DR is less than the NPR, the criteria still apply to the DR.

The standard also applies to exclusion tests, as they are an element of the principle-based valuation.

(new) VM-20 Section 2.I

- I. Section 2.G and Section 2.H provide companies some flexibility in assumption setting and modeling methodologies, but they do not allow for skipping mandated steps without providing a valid approximation, simplification, or modeling technique under Section 2.G that neither materially understates nor downwardly biases the reserve.

Examples of omissions that would not satisfy VM-20 Section 2.G: not computing even a simplified NPR, not computing even a simplified DR or SR without having passed the relevant exclusion test(s), omitting prescribed mortality margins, not establishing any lapse margins, not building even a simplified asset model for the DR, using the alternative investment strategy without first determining that it produces a higher reserve than the company investment strategy, and ignoring post-level term losses.

Guidance Note: The issue here is not the use of approximations; it is about skipping mandated VM-20 requirements. Thus, for example, this does not rule out the use of a relatively simple asset model that is acceptable pursuant to VM-20 Section 7.E.1.a, nor the judicious use of the previous year's assumption development work to save time and effort.

VM-20 Section 7.E.1.g Guidance Note

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the model investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the model investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance. Or, the company may be able to rely on a previous year's determination as to which strategy produces a higher reserve, if the assets and strategy have not changed very substantially since then.

REASONING:

Some companies have mistakenly believed that it was permissible to skip certain significant steps outlined in VM-20, without using a valid approximation or simplification that they have shown does not materially understate or bias reserves in a downward direction.

Note: Comment letters were received on an earlier draft of this APF, in response to which this newer version has eliminated any mention of PIMR and has made it clearer that a simplified asset model may in some circumstances be acceptable and that a full-blown run of both the actual investment strategy and the alternative investment strategy is not necessarily something that has to be done every year.

Dates: Received	Reviewed by Staff	Distributed	Considered
2/18/20	RM		
Notes: APF 2020-03 revised 2/26/20 Exposed 2/27/20, Revised 3/31/20			

**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

Title of the Issue:

Clarify NPR calculation requirements.

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 3.B.1 – 3.B.3, and VM-20 Section 3.B.6.d.i

January 1, 2020 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.)

Clarify any confusion on whether more direct calculations of the NPR to reflect non-annual premium modes, etc., are allowed. The current guidance note in Section 3.B.3 states that these may be reflected **either** “directly or through adjusting accounting entries”. However, due to some confusion on this point, I suggest emphasizing that more direct calculation methods are not prohibited. This is consistent with SSAP 51R, Paragraph 24:

24. Since terminal reserves are computed as of the end of a policy year and not the reporting date, the terminal reserve as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date.

This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in paragraphs 25-28. Other appropriate methods, including an exact reserve valuation, may also be used.

For re-exposure, to address both the question posed in the initial exposure of clearly reflecting both mean and mid-terminal adjustments, as well as to address comments received, I recommend language consistent with SSAP 51R, paragraph 24. SSAP 51R paragraphs 25-28 are referenced by paragraph 24. They are provided below for completeness, and specific references for policies subject to the *Valuation Manual* are highlighted.

Mean Reserve Method

25. Under the mean reserve method, the policy reserve equals the average of the terminal reserve at the end of the policy year and the initial reserve (the initial reserve is equal to the previous year's terminal reserve plus the net annual valuation premium for the current policy year). When reserves are calculated on the mean reserve basis, it is assumed that the net premium for a policy is collected annually at the beginning of the policy year and that policies are issued ratably over the calendar year.

26. However, as premiums are often received in installments more frequently than annually and since the calculation of mean reserves assumes payment of the current policy year's entire net annual premium, the policy reserve is overstated by the amount of net modal premiums not yet received for the current policy year as of the valuation date. As a result, it is necessary to compute and report a special asset to offset the overstatement of the policy reserve.

27. This special asset is termed "deferred premiums." Deferred premiums are computed by taking the gross premium (or premiums) extending from (and including) the modal (monthly, quarterly, semiannual) premium due date or dates following the valuation date to the next policy anniversary date and subtracting any such deferred premiums that have actually been collected. Deferred premium assets shall also be reduced by loading. Since the calculation of mean reserves assumes payment of the current policy year's entire net annual premium, deferred premium assets are considered admitted assets to compensate for the overstatement of the policy reserve. For policies subject to the Valuation Manual requirements, the deferred premium asset will continue to be calculated for the net premium reserve component of the total principle-based reserve.

Mid-Terminal Method

28. Under the mid-terminal method, the policy reserves are calculated as the average of the terminal reserves on the previous and the next policy anniversaries. These reserves shall be accompanied by an unearned premium reserve consisting of the portion of valuation premiums paid or due covering the period from the valuation date to the next policy anniversary date. For policies subject to the Valuation Manual requirements, the adjustment to the unearned premium reserve will continue to be calculated for the net premium reserve component of the total principle-based reserve.

Since the guidance note at the end of Section 3.B.3 contains requirements and not just guidance, it should be taken out of a guidance note. This requires moving the four terms to Section 3.B.1 and updating two cross references in VM-20 Section 3.B.6.d.i.

* 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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VM-20 Section 3.B.1 – 3.B.3

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:

- a. A policy with “multiple secondary guarantees” is one that: a) simultaneously has more than one shadow account; b) simultaneously has more than one cumulative premium type of guarantee; or c) simultaneously has at least one of each. A single shadow account with a variety of possible end dates to the secondary guarantee, depending on the policyholder’s choice of funding level, constitutes a single—not multiple—secondary guarantee.

Guidance Note:

Policy designs that are created simply to disguise guarantees or exploit a perceived loophole must be treated in a manner similar to more typical product designs with similar guarantees. If a policy contains multiple secondary guarantees, such that a subset of those secondary guarantees in combination represent an implicit guarantee that would produce a higher NPR if that implicit guarantee were treated as an explicit secondary guarantee of the policy, then the policy should be treated as if that implicit guarantee were an explicit guarantee. For example, if there were a policy with a “sequential secondary guarantee” where only one secondary guarantee applied at any given point in time but with a series of secondary guarantees strung together with one period ending when the next one began, the combined terms of the secondary guarantees would be regarded as a single secondary guarantee.

- b. The “fully funded secondary guarantee” at any time is:

i. For a shadow account secondary guarantee, the minimum shadow account fund value necessary to fully fund the secondary guarantee for the policy at that time. For any policy for which the secondary guarantee contractually cannot be fully funded in advance, this shall be the present value of the contractually permitted premium stream that would fully fund the guarantee at the earliest possible date (using the valuation interest rate and mortality standard specified in Section 3.C).

ii. For a cumulative premium secondary guarantee, the amount of cumulative premiums required to have been paid to that time that would result in no future premium requirements to fully fund the guarantee, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee. For any policy for which the secondary guarantee contractually cannot be fully funded in advance, this shall be the present value of the contractually permitted premium stream that would fully fund the guarantee at the earliest possible date (using the valuation interest rate and mortality standard specified in Section 3.C).

- c. The “actual secondary guarantee” at any time is:

i. For a shadow account secondary guarantee, the actual shadow account fund value at that time.

ii. For a cumulative premium secondary guarantee, the actual premiums paid to that point in time, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

- d. The “level secondary guarantee” at any time is:

i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.6.c.i.

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ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.6.c.i, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. ~~Section 3.B.4, Section 3.B.5 and Section 3.B.6 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4, Section 3.B.5 and Section 3.B.6, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.~~

3. ~~Since terminal NPRs are computed as of the end of a policy year and not the reporting date, the terminal NPR as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date. This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in SSAP 51R. Other appropriate methods, including an exact reserve valuation, may also be used.~~

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Moved up [1]: The definition of the NPR in Section 3.B.4, Section 3.B.5 and Section 3.B.6 is intended to result in a terminal NPR under the assumption of an annual mode gross premium. The gross premium referenced should be the gross premium for the policy assuming an annual premium mode.

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VM-20 Section 3.B.6.d.i

As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASG_{x+t} , as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted $FFSG_{x+t}$, as outlined in Section 3.B.1.b.

Dates: Received	Reviewed by Staff	Distributed	Considered
09/23/20	RM		
APF 2020-08			

**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.

Tim Cardinal, FSA, MAAA, CERA. Cardinalis 1 Consulting.
Clarify and introduce a third permissible technique for the calculation of company experience rates.

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:

2020 Edition – Valuation Manual, VM-20 Section 9.C.2.d.vi.

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 Appendix.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

See attached Appendix and Excel file.

Appendix

SECTION:

VM-20 Section 9.C.2.d.vi.

REDLINE:

9.C.2.d.vi. If the company uses the aggregate company experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall use one of the following methods:

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- a. Use techniques to further subdivide the aggregate experience into the various mortality segments (e.g., start with aggregate non-smoker and then use the conservation of total deaths principle, normalization or other approach to divide the aggregate mortality into super preferred, preferred and residual standard non-smoker class assumptions).
- b. Use techniques to adjust the experience of each mortality segment in the group to reflect the aggregate company experience for the group (e.g., by credibility weighting the individual mortality segment experience with the aggregate company experience for the group).

c. Use a two-step sequential method, which

- 1) forms subgroups which are groups of mortality segments and are subsets of the aggregate class of mortality segments being aggregated,
- 2) uses techniques as in (b) to adjust the experience of each subgroup from (1) to reflect the aggregate company experience for the group and conserve deaths, and
- 3) finally, uses techniques as in (a) to further subdivide the subgroups' adjusted experience from (2) into the various mortality segments while conserving each subgroup's deaths determined in step (2)'s conservation of deaths.

For example, if mortality segments vary by sex, risk class, and face bands, then

- 1) segments that differ by face band are aggregated to form subgroups that vary just by sex and risk class,
- 2) the subgroups' mortality experience is credibility weighted with the aggregate company experience for the group and normalized, and
- 3) the subgroups' adjusted mortality experience are then subdivided into the various mortality segments based on credible, external face band relativities and conservation of deaths is applied to each subgroup's normalized deaths determined in (2).

REASONING:

A minor point is clarity. "Either" can mean one or both. The intent is one of a) or b) but not both. The major issue is both a) and b) have weaknesses in contexts with high levels of granularity resulting in a large number of mortality segments such as 120 or 360 segments. For example consider a block with 360 mortality segments determined by 2 sexes × 6 risk classes × 5 face bands × 3 product types × 2 underwriting types (such as full and accelerated). A company may have very high credibility for each of 12 segments as determined by 2 sexes × 6 risk classes but have very low credibility for each of the 360 segments. Both a) and b) could produce company experience rates that negate the very reasons a company uses a high level of granularity. Using b) for example, all segment rates would be equal to the aggregate A/E rates, which is equivalent to no granularity. By applying b) to subgroups and applying a) to divide the subgroups, the proposed technique c) is more robust drawing upon a) and b)'s strengths

while mitigating their weakness. If there is one subgroup which is the aggregate then a) is a special case of c). If each subgroup is a segment then b) is a special case of c). See the attached excel file that adds two examples to the NAIC examples for a) and b). Example 8 is an example of a correct way to apply c) and Example 9 is an incorrect way.

Dates: Received	Reviewed by Staff	Distributed	Considered
Notes: APF 2020-09 v.6 (with editorial changes added at time of adoption) Adopted 11/5/20			

**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

Title of the Issue:

1. Modify Life PBR Exemption to not require annual exemption requests if the company continues to meet the premium thresholds and does not have any ULSG with material SG.
2. Not require VM-20 when all new issues arise due to policyholders exercising guarantees or options (e.g. for conversion) in existing policies valued under VM-A/VM-C.

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:

Valuation Manual Section II, Subsection 1.D

January 1, 2020 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.)

Reduce filing burden for companies and state regulators by making the Life PBR Exemption a one-time filing until conditions for the exemption change. Allow exemption for companies that do not meet the premium thresholds, but are only issuing new policies that would be subject to VM-20 due to policyholders exercising guarantees or options (e.g. for conversion) from existing policies being valued under the pre-PBR framework.

* 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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Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company fails to meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter "SEE EXPLANATION" in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:

- a. The company has less than \$300 million of ordinary life premiums¹, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums¹ of less than \$600 million; or
- b. The only new policies subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies that are being valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:

- a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a "non-material secondary guarantee."

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

¹ Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, "Ordinary Life Insurance" excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed

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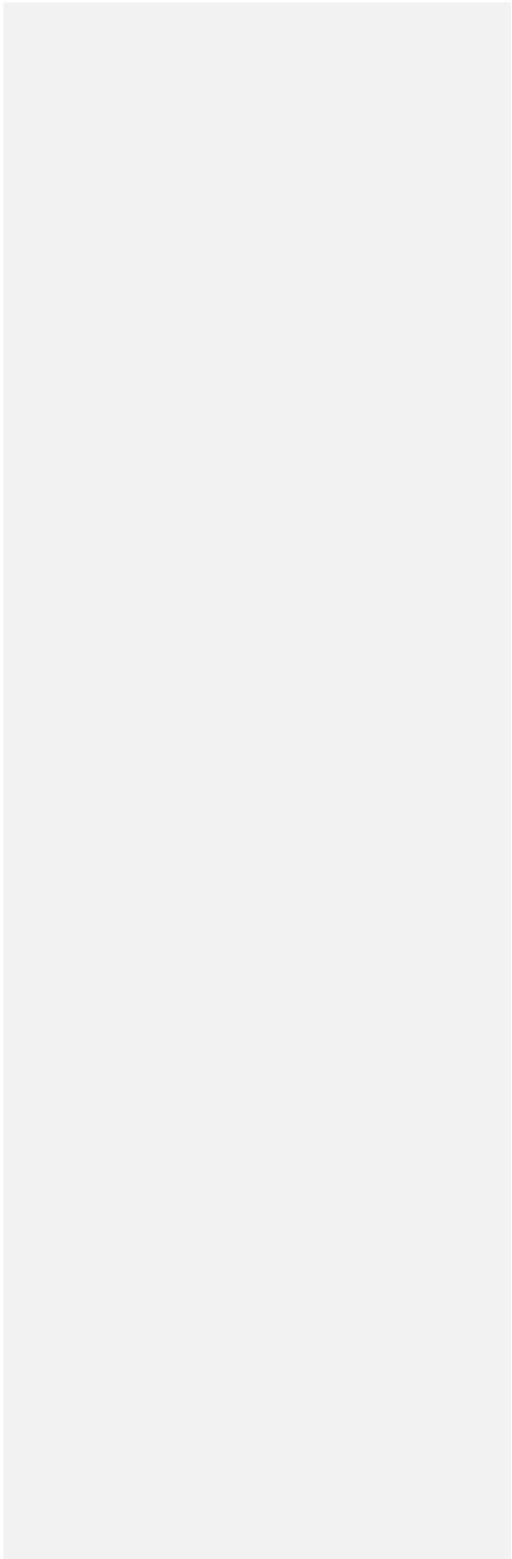
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transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.



**Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 12-day public comment period ending June 7, 2021**

Request for Comment: During the exposure, commenters are specifically asked to address the four versions exposed for the handling of YRT for the 2017-2019 issue years.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.

Dates: Received	Reviewed by Staff	Distributed	Considered
	RM		
APF 2020-10 exposed 5/27/21 with non-substantive revision			

**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.

Pat Allison – NAIC, Scott O’Neal – NAIC, Mary Bahna-Nolan – Pacific Life, and Rachel Hemphill – Texas Department of Insurance; SOA for development of rates and loading.

Reflect a prudent level of mortality improvement beyond the valuation date.

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:

Valuation Manual (January 1, 2021 edition), VM-20 Section 6.A.2.b.v, VM-20 Section 8.C Introductory Paragraph, VM-20 Section 8.C.18 and Guidance Note, VM-20 Section 9.C.2.h, VM-20 Section 9.C.3.g, VM-20 Section 9.C.7.a, VM-20 Section 9.C.7.h (new), VM-31 Section 3.D.8.g (new – for 2017-2019 YRT Version 3 only), VM-31 Section 3.D.3.i, VM-31 Section 3.D.8.g (2017-2019 YRT handling option 3 only, new reporting section), VM-31 Section 3.D.11.c.i

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 Appendix.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement).

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.

For LATF consideration for re-exposure, there are four versions of the handling of the 2017-2019 issue year carveout from the interim YRT solution: 1) the original exposure, removing the carveout with the 1/2cx being made a longer term approach, 2) a modified version that removes the carveout, but makes that removal contingent on the first set of SOA future mortality rates being adopted, in case of delay, 3) a modified version that removes the carveout, but allows for a phase-in of the effect of this change, and 4) a version making the carveout long-term. These versions are presented starting on Page 6 of this document, after the other edits which do not vary based on this options.

Appendix

VM-20 Section 6.A.2.b.v:

- v. Anticipated mortality improvement beyond the projection start date shall be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio. The future mortality improvement factors shall be no greater than the unloaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

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Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, for example, if the company's best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company's option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-20 Section 9.C.2.h:

- h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.

Guidance Note: Future mortality improvement is not applied to the company experience mortality rates, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

VM-20 Section 9.C.3.g:

- g. Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date shall be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, <https://www.soa.org/research/topics/indiv-val-exp-study-list/> (Mortality Improvement Rates for AG-38 for Year-End YYYY).

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Guidance Note: Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.a:

If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, adjusted as necessary pursuant to Section 9.C.7.e and for any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi. Future mortality improvement, pursuant to Section 9.C.7.f, shall be applied to the prudent estimate assumption for mortality.

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Section 9.C.7.b.vi:

Beginning in the first policy duration after policy duration E, the prudent estimate mortality assumptions for each policy in a given mortality segment are determined as a weighted average of the company experience mortality rates with margins and the applicable industry basic table with margins, in which the weights on the company rates grade linearly from 100% down to 0%. This grading must be completed—i.e., must reach 100% of industry table—no later than the beginning of the first policy duration after policy duration Z (the determination of the applicable industry basic table is described in Section 9.C.3). Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e, and 9.C.7.f below, is:

Commented [RH1]: Craig: Section 9.C.7.f needs to be added in Section 9.C.7.b.vi, as follows: “Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e and 9.C.7.f below, is:”

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VM-20 Section 9.C.7.f (new section):

Twenty years of future mortality improvement that the company anticipates beyond the valuation date shall be applied to the prudent estimate assumptions for mortality, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, even zero, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-31 Section 3.D.3.i:

- i. Mortality Improvement – Description of and rationale for the mortality improvement assumptions applied up to the valuation date and the mortality improvement assumptions applied beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

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VM-31 Section 3.D.11.c.i:

- i. If the company believes the method used to determine anticipated experience mortality 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.

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2017-2019 for Long-Term YRT – Version 1:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020: ¶

VM-20 Section 8.C.18 and Guidance Note:

18. ▾

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. 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 actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.¶

2017-2019 for Long-Term YRT – Version 2:

VM-20 Section 8.C, introductory paragraph:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

~~For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.~~

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VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

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. 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 actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.¶

2017-2019 for Long-Term YRT – Version 3:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

~~For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.~~

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020: ¶

~~For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 *Valuation Manual* for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than $(20XX-YYYY)/(20XX-2021)$, where YYYY is the current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.~~

VM-20 Section 8.C.18 and Guidance Note:

18. ~~▼~~

~~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. 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 actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.~~

Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

~~For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 *Valuation Manual* for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than $(20XX-YYYY)/(20XX-2021)$, where YYYY is the~~

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.¶

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current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-31 Section 3.D.8.g (new):

g. Phase-In: If electing a phase-in period as described in VM-20 Section 8.C, documentation of the length of the phase-in approved by the company's domiciliary commissioner, the result of the current and prior methodologies, the weights applied to each result, and confirmation that reinsurance assumptions for the calculation of the prior methodology are discussed in Section 3.D.8.b above.

2017-2019 for Long-Term YRT – Version 4:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

Deleted: ¶

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

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. 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 actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.¶

Dates: Received	Reviewed by Staff	Distributed	Considered
11/30/20			Adopted 2/11/21
APF 2020-11			

**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.

Rachel Hemphill, TDI – Allows exemption of policies from prior issue years when there is a change in the Life PBR Exemption requirements.

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:

Valuation Manual (January 1, 2021 edition), Section II, Subsection 1.D.4, with the addition of the APF 2020-09 revisions to VM Section II, Subsection 1.D.1 – Subsection 1.D.3 (adopted by LATF on Nov. 5, 2020) shown in blue.

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.)

Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting ~~the~~ **at least one of the conditions** in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. **If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, Such a the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met based on premiums from the prior calendar year annual statement and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.**

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company **does not** meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE

Deleted: fails to

EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
 - a. The company has less than \$300 million of ordinary life premiums¹, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums¹ of less than \$600 million; or
 - b. The only new policies ~~that would otherwise be~~ subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.
3. Policies Excluded from the Life PBR Exemption:
 - a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”
4. Each exemption, or lack of an exemption, outlined in D.1 – D.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Deleted: that are being

Valuation Manual Section II, Subsection 1.D - Footnote

¹ Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

Addresses the exemption of policies issued in 2020 and 2021 (such as conversions) that may be exempted under the 2022 Valuation Manual requirements but did not qualify under the 2020 or 2021 Valuation Manual requirements.

Dates: Received	Reviewed by Staff	Distributed	Considered
12/7/20	RM		
Notes: APF 2020-13			

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force Amendment Proposal Form*

- Identify yourself, your affiliation and a very brief description (title) of the issue.

Identification:

Dany Provencher, Appointed Actuary, Industrial Alliance group of companies

Title of the issue:

Asset collar when modeled reserve is negative

- Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

Valuation Manual, Jan.1 2020 Edition
VM-20 Section 7.D.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.)

If for all model segments combined, the aggregate annual statement value of the final starting assets, less the corresponding PIMR balance, is

- (a) ~~less than 98% of the modeled reserve; or~~
 - (i) 98% of the modeled reserve if modeled reserve is positive;
 - (ii) 102% of the modeled reserve if modeled reserve is negative; or
- (b) greater than the largest of:
 - (i) 102% of the modeled reserve;
 - (ii) the NPR for the same set of policies, net of due and deferred premiums thereon;
 - and
 - (iii) zero,

then the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

- State the reason for the proposed amendment? (You may do this through an attachment.)

If modeled reserve is negative, using assets corresponding to 100% of modeled reserve, would not fall within the asset collar.

* 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.

**Life Actuarial (A) Task Force
Amendment Proposal Form 2021-03
Exposed for a 21-day public comment period ending May 3, 2021**

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/3/21.

Dates: Received	Reviewed by Staff	Distributed	Considered
	RM		
Notes: APF 2021-03v2 revised 4/12			

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.

American Academy of Actuaries, Variable Annuity Reserves & Capital Work Group

Update the reference to the required minimum distribution (RMD) age in the VM-21 Standard Projection Amount for the Setting Every Community Up for Retirement Enhancement (SECURE) Act change.

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, 2021, version of the 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.)

In VM-21, Section 6.C.5:

- i. For tax-qualified contracts, add the following to the revised $GAPV^2$ corresponding to an initial withdrawal age of ~~71~~ the federal required minimum distribution (RMD) age.

$$0.50 \times \left\{ \begin{array}{l} 0.95 - \sum_{i=Issue\ Age}^{Initial\ WD\ Age} GAPV^2_{Adjusted,Scaled} \text{ , if contract is a tax - qualified GMWB} \\ 0.85 - \sum_{i=Issue\ Age}^{Initial\ WD\ Age} GAPV^2_{Adjusted,Scaled} \text{ , if contract is a tax - qualified hybrid GMIB} \end{array} \right.$$

- j. Scale the revised $GAPV^2$ values at all future initial withdrawal ages—i.e., all ages greater than ~~71~~ the federal required minimum distribution (RMD) age, as identified in the preceding step—such that the sum of the revised $GAPV^2$ values equals 0.95 for tax-qualified GMWB contracts and 0.85 for tax-qualified hybrid GMIB contracts again.

|

- n. The cohorts and their associated weights as determined in Section 6.C.5.a through Section 6.C.5.k are for a contract with attained age equal to its issue age. Because the discount rate used in this determination is fixed, generally these calculations only need to be performed once for a given set of contracts with a certain issue age, guaranteed benefit product, and tax status.

Guidance Note: Cohorts and their associated weights may need to be revised if prescribed assumptions are updated.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The Standard Projection's withdrawal delay cohort method includes an adjustment at the required minimum distribution (RMD) age. The SECURE Act changed the RMD age from 70.5 to 72. This proposed amendment implements the change by directly referencing the RMD age. The direct reference will reduce Valuation Manual maintenance for any future changes.

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

* 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\

Dates: Received	Reviewed by Staff	Distributed	Considered
3/19/20			
APF 2021-04 rev. 4/8/21			

**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.

Brian Bayerle, ACLI – edits adopted changes to VM-02 for improved clarity and to remove potential circularity.

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:

Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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.)

Subsequent the adopted changes to the federal tax code (IRC S. 7702), this proposed change would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.

Valuation Manual VM-02

Section 3: Interest

- A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Deleted: applicable interest rate prescribed to meet the definition of life insurance

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the *Universal Life Insurance Model Regulation* (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.

Dates: Received	Reviewed by Staff	Distributed	Considered
4/13/21	RM		
Notes: APF 2021-05			

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: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation

Title of the Issue: Clarify the definition of modeled company investment strategy and the comparison to the alternative investment strategy.

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, 2020 NAIC *Valuation Manual*

- VM-01 VM-21 Section 4.D
- VM-20 Section 7.E VM-31 Sections 3.D.6 and 3.F.6

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.)

There is an inconsistency in VM-20/VM-21 and VM-31 regarding the term “model investment strategy”. The term “model investment strategy” is used throughout VM-20 and VM-21 to describe the investment strategy used in the model as a proxy for the company’s actual investment strategy. However, VM-31 uses the term “modeled company investment strategy” in several places rather than “model investment strategy”. “Modeled company investment strategy” is the preferred term, so VM-20 and VM-21 have been modified to use “modeled company investment strategy” so that the terminology in VM-20, VM-21 and VM-31 are consistent.

Also, to address the ambiguity of whether the final investment strategy in the model is the initial investment strategy based on the company’s investment strategy or the alternative investment strategy when the alternative strategy is constraining, the term “modeled company investment strategy” has been added to the definitions in VM-01 (and a parenthetical has been added to VM-31) to clarify that the term refers to the investment strategy in the model prior to comparison to the alternative investment strategy. In addition, VM-21 has been modified to be consistent with the wording in VM-20 to clarify that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.

VM-01 Changes:

VM-01 provides definitions for terms used in the *Valuation Manual*. The definitions in VM-01 do not apply to documents outside the *Valuation Manual* even if referenced or used by the *Valuation Manual*, such as the AP&P Manual. Some terms in the *Valuation Manual* may be defined in specific sections of the *Valuation Manual* instead of being defined in VM-01.

- The term “margin” means an amount included in the assumptions used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the *Valuation Manual*. It is intended to provide for estimation error and adverse deviation.
- The term “modeled company investment strategy” means the investment strategy used in the model that is intended to be a representation of the actual investment strategy of the company. It is before the comparison is made to the alternative investment strategy. It does not refer to the alternative investment strategy when the alternative investment strategy is constraining.
- The term “modeled reserve” means the deterministic reserve on the policies determined under VM-20 Section 2.A.1.a, 2.A.2.a and 2.A.3.b, plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

VM-20 Changes:

Section 7: Cash-Flow Models

E. Reinvestment Assets and Disinvestment

1. At the valuation date and each projection interval as appropriate, model the purchase of general account reinvestment assets with available cash and net asset and liability cash flows in a manner that is representative of and consistent with the company’s investment policy for each model segment, subject to the following requirements:
 - a. The modeled company investment strategy may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.

Deleted: model investment strategy

Guidance Note: A complex model representation may include, for example, illiquid or callable assets whereas a simple model representation may involve mapping of more complex assets to combinations of, for example, public non-callable corporate bonds, U.S. Treasuries and cash.

- b. The final maturities and cash-flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation.
- c. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the then-current U.S. Department of the Treasury (Treasury Department) curve along the relevant scenario and the requirements for gross asset spread assumptions stated below.
- d. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in 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.

- e. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in Section 9.F.8.d for interest rate swap spreads.
- f. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps as defined in Section 9.F.8.
- 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 a clearly defined hedging strategy (in compliance with Section 7.L) are not affected by this requirement.

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the modeled company investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the modeled company investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance.

Deleted: model investment strategy

VM-21 Changes:

Section 4: Determination of the Stochastic Reserve

- D. Projection of Assets
 - 4. General Account Assets
 - a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company’s investment policy, subject to the following requirements:
 - i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a

fixed or floating rate interest basis, shall be determined by the company as part of the model representation;

- ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;
 - iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. 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 for interest rate swap spreads;
 - v. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.
- b. Notwithstanding the above requirements, the stochastic 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 a clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

VM-31 Changes:

Section 3: PBR Actuarial Report Requirements

- D. Life Report – This subsection establishes the Life Report requirements for individual life insurance policies valued under VM-20.
6. Assets – The following information regarding the asset assumptions used by the company in performing a principle-based valuation under VM-20:
- r. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and

Deleted: model investment strategy

Deleted: model investment strategy

Deleted: any non-prescribed asset spreads shall be adjusted as necessary so that the aggregate reserve is not less than that which would be obtained

Deleted: all

Deleted: used in the demonstration of compliance required by VM-31 Section 3.D.6.s

documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

- s. ~~Alternative Investment Strategy~~ – Documentation demonstrating compliance with VM-20 Section 7.E.1.g, showing that the modeled reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

Deleted: Modeled

F. VA Report – This subsection establishes the VA Report requirements for variable annuity contracts valued under VM-21.

6. General Account Assets – The following information regarding the general account asset assumptions used by the company in performing a principle-based valuation under VM-21:

- a. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before the comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

Deleted: asset

Deleted: used in the model

Deleted: model investment strategy

- b. Alternative Investment Strategy – Documentation demonstrating compliance with VM-21 Section 4.D.4.b showing that the stochastic reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

Deleted: model investment strategy does not produce a

Deleted: that is less than the stochastic reserve that would result by assuming an

Deleted: based on the limitations defined in VM-21 Section 4.D.4.b.

Dates: Received	Reviewed by Staff	Distributed	Considered
4/19/21	RM		
Notes: APF 2021-06			

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.

Angela McNabb & Pat Allison – NAIC staff support

Revisions to VM-50 and VM-51 to allow for data experience reporting to be performed by a reinsurer or third-party administrator and a correction to VM-51 Appendix 4.

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 1,2021, version of the Valuation Manual – VM-50 Section 4.B.2; VM-50 Section 4.B.3; VM-51 Section 2.B; VM-51 Appendix 4.

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 redline document.

4. State the reason for the proposed amendment? (You may do this through an attachment.)

This APF is needed for the following reasons:

1. VM-51 Appendix 4 includes a column indicating the position within the data file for each field. This is not valid as the NAIC’s RDC system was designed to accept comma delimited files. This APF will remove that column.
2. The VM-51 Section 2.B states that companies must submit data for all their direct written business prior to reinsurance ceded. The only exception is in the case of assumption reinsurance where policies have been legally novated. The NAIC has received feedback from a number of companies indicating that they have business that is reinsured and fully administered by the reinsurer. Since the ceding companies do not have the data, it represents a hardship for them to submit this business.
3. Currently, VM-51 Appendix 4 only allows one company code. In order to allow a reinsurer or third-party administrator to submit data on behalf of the direct writer, the NAIC must be able to identify both the submitting company and the direct writer of the block of business. This APF adds an additional field to accomplish this. By having the submitting company’s code, any questions the NAIC has regarding the data can be directed to the submitting company without fear of breaching confidentiality.
4. Having separate identifiers for the submitting company and direct writer will allow the NAIC to validate the reconciliations required by VM-50 Section 4.B.3.

Below are examples showing how the reconciliations would work according to the amended language in VM-50 Section 4.B.3.

Example 1: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.c. Company A is a direct writer selected for VM-51 reporting.

- The company has retained and administers 35,000 policies (out of a total of 100,000).
- Company B (a reinsurer not selected to submit their own business) administers 50,000 policies for Company A.

Experience Reporting Requirements

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- Company C (a reinsurer selected to submit their own direct business) administers 15,000 policies for Company A.

RECONCILIATION FOR COMPANY A (Direct Writer)		
	Policy Count	Insurance Amount
Total Business as Reported in Company A's Annual Statement	100,000	2,500,000,000
Business being reported by Company B	(50,000)	(1,250,000,000)
Business being reported by Company C	(15,000)	(50,000,000)
Totals included in Company A's data submissions	35,000	1,200,000,000

Example 2: This example illustrates the scenario described in the redlined language in VM-50 Section 4.B.3.a. Company D is another direct writing company selected for VM-51 reporting. Company B has been asked by Companies A and D to submit data Company B has assumed and administers.

- Company B administers 50,000 policies for Company A.
- Company B administers 100,000 policies for Company D.
- Company B is not required to reconcile to their Annual Statement since they were not selected to submit their direct business.
- In this example, Company B is a reinsurer. However, Company B could also be a third-party administrator that is not an insurance company.

RECONCILIATION FOR COMPANY B		
	Policy Count	Insurance Amount
Business being reported on behalf of Company A	50,000	1,250,000,000
Business being reported on behalf of Company D	100,000	1,500,000,000
Totals included in Company B's data submission	150,000	2,750,000,000

Example 3: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.b. Company C has also been asked by company A to submit data Company C has assumed and administers.

- Company C has 1,500,000 policies reported in their Annual Statement.
- Company C has 250,000 of reinsurance assumed policies which should not be included in their submission. Reinsurance assumed should only be included when the ceding company requests that the reinsurer report it on their behalf.
- Company C has 1,250,000 policies of direct written business that they must report.
- In addition to Company C's direct written business, they will also be reporting 15,000 policies that they administer on behalf of Company A (per Company A's request).

RECONCILIATION FOR COMPANY C		
	Policy Count	Insurance Amount
Total Business as Reported in Company C's Annual Statement	1,500,000	180,000,000,000
Assumed Reinsurance Total	(250,000)	(6,000,000,000)
Subtotal - Direct Written Business for Company C	1,250,000	174,000,000,000
Business being reported on behalf of Company A	15,000	50,000,000
Totals included in Company C's data submissions	1,265,000	174,050,000,000

Dates: Received	Reviewed by Staff	Distributed	Considered
4/19/21	RM		
Notes: APF 2021-06			

VM-50: Experience Reporting Requirements

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Section 1: Overview

A. Purpose of the Experience Reporting Requirements

The purpose of this section is to define the requirements pursuant to Section 13 of Model #820 for the submission and analysis of company data. It includes consideration of the experience reporting process, the roles of the relevant parties, and the intended use of and access to the data, and the process to protect the confidentiality of the data as outlined in Model #820.

B. PBR and the Need for Experience Data

The need for experience data includes but is not limited to:

1. PBR may require development of assumptions and margins based on company experience, industry experience or a blend of the two. The collection of experience data provides a database to establish industry experience tables or factors, such as valuation tables or factors as needed.
2. The development of industry experience tables provides a basis for assumptions when company data is not available or appropriate and provides a comparison basis that allows the state insurance regulator to perform reasonableness checks on the appropriateness of assumptions as documented in the actuarial reports.
3. The collection of experience data may assist state insurance regulators, reviewing actuaries, auditors and other parties with authorized access to the PBR actuarial reports to perform reasonableness checks on the appropriateness of principle-based methods and assumptions, including margins, documented in those reports.
4. The collection of experience data provides an independent check on the accuracy and completeness of company experience studies, thereby encouraging companies to establish a disciplined internal process for producing experience studies. Industry aggregate or sub-industry aggregate experience studies may assist an individual company for use in setting experience-based assumptions. As long as the confidentiality of each company's submitted results is maintained, a company may obtain results of a study on companies' submitted experience for use in formulating experience assumptions.
5. The collection of experience data will provide a basis for establishing and updating the assumptions and margins prescribed by regulators in the *Valuation Manual*.
6. The reliability of assumptions based on company experience is founded on reliable historical data from comparable characteristics of insurance policies including, but not limited to, underwriting standards and insurance policy benefits and provisions. As with

all forms of experience data analysis, larger and more consistent statistical samples have a greater probability of producing reliable analyses of historic experience than smaller or inconsistent samples. To improve statistical credibility, it is necessary that experience data from multiple companies be combined and aggregated.

7. The collection of experience data allows state insurance regulators to identify outliers and monitor changes in company experience factors versus a common benchmark to provide a basis for exploring issues related to those differences.
8. PBR is an emerging practice and will evolve over time. Research studies other than those contemplated at inception may be useful to improvement of the PBR process, including increasing the accuracy or efficiency of models. Because the collection of experience data will facilitate these improvements, research studies of various types should be encouraged.
9. The collection of experience data is not intended as a substitute for a robust review of companies' methodologies or assumptions, including dialogue with companies' actuaries.

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

1. Model #820 provides the legal authority for the *Valuation Manual* to prescribe experience reporting requirements with respect to companies and lines of business within the scope of the model.
2. The statutes and regulations requiring data submissions generally apply to all companies licensed to sell life insurance, A&H insurance and deposit-type contracts. These companies must submit experience data as prescribed by the *Valuation Manual*.
3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

1. For the purposes of implementing the experience reporting required by state laws based on Section 13 of Model #820, an Experience Reporting Agent will be used for the purpose of collecting, pooling and aggregating data submitted by companies as prescribed by lines of business included in VM-51.
2. The NAIC is designated as Experience Reporting Agent for the Statistical Plan for Mortality beginning Jan. 1, 2020, and NAIC expertise in collecting and sorting data from multiple sources into a cohesive database in a secure and efficient manner, but the designation of the NAIC as Experience Reporting Agent does not preclude state insurance regulators from independently engaging other entities for similar data required under this *Valuation Manual* or other data purposes.

Section 3: Experience Reporting Requirements

A. Statistical Plans

1. Consistent with state laws based on Section 13 of Model #820, the Experience Reporting Agent shall collect experience data based on statistical plans defined in the *Valuation Manual*.
2. Statistical plans are detailed instructions that define the type of experience data being collected (e.g., mortality; elective policyholder behavior, such as surrenders, lapses,

premium payment patterns, etc.; and company expense data, such as commissions, policy expenses, overhead expenses etc.). The state insurance regulators serving on the Life Actuarial (A) Task Force and Health Actuarial (B) Task Force, or any successor body, will be responsible for prescribing the requirements for any statistical plan by applicable line of business. For each type of experience data being collected, the statistical plan will define the data elements and format of each data element, as well as the frequency of the collection of experience data. The statistical plan will define the process and the due dates for submitting the experience data. The statistical plan will define criteria that will determine which companies must submit the experience data. The statistical plan will also define the scope of business that is to be included in the experience data collection, such as lines of business, product types, types of underwriting, etc. Statistical plans are defined in VM-51 of the *Valuation Manual*. Statistical plans will be added to VM-51 of the *Valuation Manual* when they are ready to be implemented. Additional data elements and formats to be collected will be added as necessary, in subsequent revisions to the *Valuation Manual*.

3. Data must conform to common data definitions. Standard definitions provide for stable and reliable databases and are the basis of meaningful aggregated insurance data. This will be accomplished through a uniform set of suggested minimum experience reporting requirements for all companies.

B. Role and Responsibilities of the Experience Reporting Agent

1. Based on requirements of VM-51, the Experience Reporting Agent may design its data collection procedures to ensure it is able to meet these regulatory requirements. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.
2. The Experience Reporting Agent will aggregate the experience of companies using a common set of classifications and definitions to develop industry experience tables.
3. The Experience Reporting Agent will seek to enter into agreements with a group of state insurance departments for the collection of information under statistical plans included in VM-51. The number of states that contract with the Experience Reporting Agent will be based on achieving a target level of industry experience prescribed by VM-51 for each line of business in preparing an industry experience table.
 - a. The agreement between the state insurance department(s) and the Experience Reporting Agent will be consistent with any data collection and confidentiality requirements included within Model #820 and the *Valuation Manual*. Those state insurance departments seeking to contract with the Experience Reporting Agent will inform the Experience Reporting Agent of any other state law requirements, including laws related to the procurement of services that will need to be considered as part of the contracting process.
 - b. Use of the Experience Reporting Agent by the contracting state insurance departments does not preclude those state insurance departments or any other state insurance departments from contracting independently with another Experience Reporting Agent for similar data required under this *Valuation Manual* or other data purposes.
4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will be responsible for the content and maintenance of the experience reporting requirements. The Life

Actuarial (A) Task Force or Health Actuarial (B) Task Force or a working group will monitor the data definitions, quality standards, appendices and reports described in the experience reporting requirements to assure that they take advantage of changes in technology and provide for new regulatory and company needs.

5. To ensure that the experience reporting requirements will continue to be useful, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will seek to review each statistical plan on a periodic basis at least once every five years. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force should have regular dialogue, feedback and discussion of this topic. In seeking feedback and engaging in discussions, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force shall include a broad range of data users, including state insurance regulators, consumer representatives, members of professional actuarial organizations, large and small companies, and insurance trade organizations.
6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company's request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term "good cause" shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

The Experience Reporting Agent may ask for other organizations to play a role for one or more of the following items, including the execution of agreements and incorporation of confidentiality requirements where appropriate:

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;
2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;
3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;

4. Create initial experience tables and any revised tables;
5. Provide feedback in the development and evaluation of requests for proposal for services related to the reporting of experience requirement;
6. Create statutory valuation tables as appropriate and necessary;
7. Determine and produce additional industry experience tables or reports that might be suggested by the data collected;
8. Work with the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force, in accordance with the *Valuation Manual* governance process, in developing new reporting formats and modifying current experience reporting formats;
9. Support a close working relationship among all parties having an interest in the success of the experience reporting requirement.

Section 4: Data Quality and Ownership

A. General Requirements

1. The quality, accuracy and consistency of submitted data is key to developing industry experience tables that are statistically credible and represent the underlying emerging experience. Statistical procedures cannot easily detect certain types of errors in reporting of data. For example, if an underwriter fails to evaluate the proper risk classification for an insured, then the “statistical system” has little chance of detecting such an error unless the risk classification is somehow implausible.
2. To ensure data quality, coding a policy, loss, transaction or other body of data as anything other than what it is known as is prohibited. This does not preclude a company from coding a transaction with incomplete detail and reporting such transactions to the Experience Reporting Agent, but there can be nothing that is known to be inaccurate or deceptive in the reporting. An audit of a company’s data submitted to the Experience Reporting Agent under a statistical plan in VM-51 can include comparison of submitted data to other company files.
3. When the Experience Reporting Agent determines that the cause of an edit exception could produce systematic errors, the company must correct the error and respond in a timely fashion, with priority given to errors that have the largest likelihood to affect a significant amount of data. When an error is found that has affected data reported to the Experience Reporting Agent, the company shall report the nature of the error and the nature of its likely impact to the Experience Reporting Agent. Retrospective correction of data subject to systematic errors shall be done when the error affects a significant amount of data that is still being used for regulatory purposes and it is reasonably practical to make the correction through the application of a computer program or a procedure applied to the entire data set without the need to manually examine more than a small number of individual records.

B. Specific Requirements

1. Once the data file is submitted by the company, the Experience Reporting Agent will perform a validity check of the data elements within each data record in the data file for proper syntax and verify that required data elements are populated. The Experience Reporting Agent will notify the company of all syntax errors and any missing data elements

- that are required. Companies are required to respond to the Experience Reporting Agent by submitting a corrected data file. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.
2. Each submission of data filed by ~~an insurance~~ a company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.
 3. Each company submitting experience data ~~and each company on whose behalf data is being submitted~~ as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. ~~The reconciliation must include policy count and insurance amount.~~
 - a. ~~If a third-party administrator that is not an insurance company or an insurance company not required to submit their direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.~~
 - b. ~~If the third-party administrator is an insurance company that is required to submit their direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.~~
 - c. ~~The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or third-party administrator must include lines indicating the amount of business that is being reported by the reinsurer or third-party administrator. The NAIC will use this information to confirm that all in-scope business is reported and there is no double counting of policies.~~
 4. Validity checks are designed to identify:
 - a. Improper syntax or incomplete coding (e.g., a numeric field that is not numeric, missing elements of a date field);
 - b. Data elements containing codes that are not contained within the set of possible valid codes;
 - c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code;
 - d. Required data elements that are not populated.
 5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.

6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.
7. The Experience Reporting Agent will undertake reasonability checks that include the comparison of aggregate and company experience for underwriting class and type of coverage data elements for the current reporting period to company and aggregate experience from prior periods for the purpose of identifying potential coding or reporting errors. When reporting instructions are changed, newly reported data elements shall be examined to see that they correlate reasonably with data elements reported under the old instructions.
8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
 - a. An unusually large percentage of company data reported under a single or very limited number of categories;
 - b. Unusual or unlikely reporting patterns in a company’s data;
 - c. Claim amounts that appear unusually high or low for the corresponding exposures;
 - d. Reported claims without corresponding policy values and exposures;
 - e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
 - f. Unusual shifts in the distribution of business from one reporting period to the next.
9. If a company’s unusual pattern under Section 4.B.8.a, Section 4.B.8.b or Section 4.B.8.c is verified as accurate (that is, the reason for the apparent anomaly is an unusual mix of business), then it is not necessary that a similar pattern for the same company be reconfirmed year after year.
10. The Experience Reporting Agent will keep track of the results of the validity and reasonability checks and may adjust thresholds in successive reporting years to maintain a reasonable balance between the magnitude of errors being found and the cost to companies.
11. Results that may indicate a likelihood of critical indications, as defined below, will be reported to the company with an explanation of the unusual findings and their possible significance. When the possible or probable errors appear to be of a significant nature, the Experience Reporting Agent will indicate to the company that this is a “critical indication.” “Critical indications” are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used in reports to the state insurance regulator and included in industry databases. It is intended that Experience Reporting Agents will have reasonable flexibility to implement this under the direction of the state insurance regulators. Also, under the direction of the state insurance regulators, the Experience Reporting Agent may grade the severity of indications, or it may simply

identify certain indications as critical. While companies are expected to undertake a reasonable examination of all indications provided to them, they are not required to respond to every indication except for those labeled by the Experience Reporting Agent as “critical.”

12. The Experience Reporting Agent will use its discretion regarding the omission of data from reports owing to the failure of an insurer company to respond adequately to unusual reasonability indications. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.
13. Companies shall acknowledge and respond to reasonability queries from the Experience Reporting Agent. This shall include specific responses to all critical indications provided by the Experience Reporting Agent. Other indications shall be studied for apparent errors, as well as for indications of systematic errors. Corrections for critical indications shall be provided to the Experience Reporting Agent or, when a correction is not feasible, the extent and nature of the error shall be reported to the Experience Reporting Agent.

C. Ownership of Data

1. Experience data submitted by companies to the Experience Reporting Agent will be considered the property of the companies submitting such data, but the recognition of such ownership will not affect the ability of state insurance regulators or the NAIC to use such information as authorized by state laws based on Model #820 or the *Valuation Manual*, or, in case of state insurance regulators, for solvency oversight, financial examinations and financial analysis.
2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the *Valuation Manual*. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

1. Using the data collected under statistical plans, as defined in the *Valuation Manual*, the Experience Reporting Agent produces aggregate databases as defined by this *Valuation Manual*. The Experience Reporting Agent, and/or other persons assisting the Experience Reporting Agent, will utilize those databases to produce industry experience tables and reports as defined in the *Valuation Manual*. In order to ensure continued relevance of reports, each defined data collection and resulting report structure shall be reviewed for usefulness at least once every five years since initial adoption or prior review.
2. Data compilations are evaluated according to four distinct, and often competing, standards: quality, completeness, timeliness and cost. In general, quality is a primary goal in developing any statistical data report. The priorities of the other three standards vary according to the purpose of the report.
3. The Experience Reporting Agent may modify or enlarge the requirements of the *Valuation Manual*, through recommendation to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force and in accordance with the *Valuation Manual* governance process for information to accommodate changing needs and environments. However, in most cases,

changes to existing data reporting systems will be feasible only to provide information on future transactions. Requirements to submit new information may require that companies change their systems. Also, the Experience Reporting Agent may need several years before it can generate meaningful data meeting the new requirements with matching claims and insured amounts. The exact time frames for implementing new data requirements and producing reports will vary depending on the type of reports.

B. Design of Reports Linked to Purpose

Fundamental to the design of each report is an evaluation of its purpose and use. The Life Actuarial (A) Task Force and Health Actuarial (B) Task Force shall specify model reports responding to general regulatory needs. These model reports will serve the basic informational needs of state insurance regulators. To address a particular issue or problem, a state insurance regulator may have to request to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force that additional reports be developed.

C. Basic Report Designs

1. The Life Actuarial (A) Task Force or Health Actuarial (A) Task Force will designate basic types of reports to meet differing needs and time frames. Each statistical plan defined in VM-51 of the *Valuation Manual* will provide a detailed description of the reports, the frequency and time frame for the reports. Statistical compilations are anticipated to be the primary reports.
2. Statistical compilations are aggregate reports that generally match appropriate exposure amounts and transaction event amounts to evaluate the recent experience for a line of business. For example, a statistical compilation of mortality experience would match insurance face amounts exposed to death with actual death claims paid. Here the exposure amount is the total insurance face amount exposed to death, and the transaction event amounts would be the death claims paid. As another example, a statistical compilation of surrender experience would match total cash surrender amounts exposed to surrender with actual surrender amounts paid. Here the exposure amount is the total cash surrender amounts that could be surrendered, and the transaction event amounts would be the total surrender amounts actually paid. Statistical compilations can be performed for the industry or for the state of domicile.
3. In addition to statistical compilations, state insurance regulators can specify additional reports based on elements in the statistical plans in VM-51. State insurance regulators can also use statistical compilations and additional reports to evaluate non-formulaic assumptions.
4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will specify the reports to be provided to the professional actuarial associations to fulfill their roles as specified in Section 3.C of this VM-50. In general, the reports are expected to include statistical compilation at the industry level.
5. State insurance regulators can use the reports to review long-term trends. Aggregate experience results may indicate areas warranting additional investigation.

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.

2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

The Experience Reporting Agent will periodically provide the following reports to state insurance departments:

1. A list of companies whose data is included in the compilation.
2. A list of companies whose data was excluded from the compilation because it fell outside of the tolerances set for missing or invalid data, or for any other reason.

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

1. The confidentiality of the experience data, experience materials and related information collected pursuant to the *Valuation Manual* is governed by state laws based on Section 14.A.(5) of Model #820. The following information is considered “confidential information” by state laws based on Section 14A(5) of the Model #820:

Any documents, materials, data and other information submitted by a company under Section 13 of [the Standard Valuation Law] (collectively, “experience data”) and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any “experience data,” the “experience materials”) and any other documents, materials, data and 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 connection with such experience materials.

2. Nothing in the experience reporting requirements or elsewhere within the *Valuation Manual* is intended to, or should be construed to, amend or supersede any applicable statutory requirements, or otherwise require any disclosure of confidential data or materials that may violate any applicable federal or state laws, rules, regulations, privileges or court orders applicable to such data or materials.

B. Treatment of Confidential Information

1. Confidential information may be shared only with those individuals and entities specified in state laws based on Section 14B(3) of Model #820. Any agreement between a state insurance department and the Experience Reporting Agent will address the extent to which the Experience Reporting Agent is authorized to share confidential information consistent with state law.
2. The Experience Reporting Agent may be required to use confidential information in order to prepare compilations of aggregated experience data that do not permit identification of individual company experience or personally identifiable information. These reports of aggregated information, including those reports referenced in Section 5 of VM-50, are not considered confidential information, and the Experience Reporting Agent may make publicly available such reports. Reports using aggregate experience data will have

sufficient diversification of data contributors to avoid identification of individual companies.

3. Consistent with state laws based on Section 14B(3) of the Model #820 and any agreements between a state insurance department and the Experience Reporting Agent, access to the confidential information will be limited to:
 - a. State, federal or international regulatory agencies;
 - b. The company with respect to confidential information it has submitted, and any reports prepared by the Experience Reporting Agent based on such confidential information;
 - c. The NAIC, and its affiliates and subsidiaries;
 - d. Auditor(s) of the Experience Reporting Agent for purposes of the experience reporting function outlined in this VM-50; and
 - e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.

VM-51: Experience Reporting Formats

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Section 1: Introduction

- A. The experience reporting requirements are defined in Section 3 of VM-50. The experience reporting requirements state that the Experience Reporting Agent will collect experience data based on statistical plans that are defined in VM-51 of the *Valuation Manual*. Statistical plans are to be added to VM-51 of the *Valuation Manual* when they are ready to be implemented.

- B. Each statistical plan shall contain the following information:
 - 1. The type of experience data to be collected (e.g., mortality experience; policy behavior experience, such as surrenders, lapses, conversions, premium payment patterns, etc.; and company expense experience, such as commission expense, policy issue and maintenance expense, company overhead expenses etc.);
 - 2. The scope of business to be included in the experience data to be collected (e.g., line(s) of business, such as individual or group, life, annuity or health; product type(s), such as term, whole life, universal life, indexed life, variable life, fixed annuity, indexed annuity, variable annuity, LTC or disability income; and type of underwriting, such as medically underwritten, simplified issue (SI), GI, accelerated, etc.);
 - 3. The criteria for determining which companies or legal entities must submit the experience data to be collected;
 - 4. The process for submitting the experience data to be collected, which will include the frequency of the data collection, the due dates for data collection and how the data is to be submitted to the Experience Reporting Agent;
 - 5. The individual data elements and format for each data element that will be contained in each experience data record, along with detailed instructions defining each data element or how to code each data element. Additional information may be required, such as questionnaires and plan code forms that will assist in defining the individual data elements that may be unique to each company or legal entity submitting such experience data elements;
 - 6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

- A. Type of Experience Collected Under This Statistical Plan

The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S. ~~and~~ All values should be prior to any reinsurance ceded **except for the situation defined in VM-51 Section 2.B.2. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double counting of experience submitted by an issuer and by its reinsurers; however,** Assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, preneed, home service, credit life, and corporate-owned life insurance (COLI)/bank-owned life insurance (BOLI)/charity-owned life insurance (CHOLI).
2. ~~In the event a reinsurer or third-party administrator is responsible for administering a block of business, the reinsurer or third-party administrator may submit that block of business on behalf of the direct writer. In this case the reinsurer or third-party administrator must be identified in Appendix 4 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 4 Item 2 - NAIC Company Code of Direct Writer.~~
 - a. ~~As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or third-party administrators must include lines indicating the amount of business that is being reported by the reinsurers and/or third-party administrators. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or third-party administrators to ensure that all business is included and there is no double counting of policies.~~
 - b. ~~If an insurance company is required to submit their direct written business and they also have reinsurance assumed business, they should only submit the assumed business if asked to do so by the ceding company since some ceding companies may not have been selected for data submission.~~
3. ~~The direct writing company is ultimately responsible for all the data submitted for their company.~~

C. Criteria to Determine Companies That Are Required to Submit Experience Data

Companies with less than \$50 million of direct individual life premium shall be exempted from reporting experience data required under this statistical plan. This threshold for exemption shall be measured based on aggregate premium volume of all affiliated companies and shall be reviewed annually and be subject to change by the Experience Reporting Agent. At its option, a group of nonexempt affiliated companies may exclude from these requirements affiliated companies with less than \$10 million direct individual life premium provided that the affiliated group remains nonexempt.

Additional exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator, based on achieving a target level of approximately 85% of industry experience for the type of experience data being collected under this statistical plan.

D. Process for Submitting Experience Data Under This Statistical Plan

Data for this statistical plan for mortality shall be submitted on an annual basis. Each company required to submit this data shall submit the data using the Regulatory Data Collection (RDC) online software submission application developed by the Experience Reporting Agent. For each data file submitted by a company, the Experience Reporting Agent will perform reasonability and completeness checks, as defined in Section 4 of VM-50, on the data. The Experience Reporting Agent will notify the company within 30 days following the data submission of any possible errors that need to be corrected. The Experience Reporting Agent will compile and send a report listing potential errors that need correction to the company.

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2016, which is the observation calendar year.

Given an observation calendar year of 20XX, the calendar year method requires reporting of experience data as follows:

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

E. Experience Data Elements and Formats Required by This Statistical Plan

Companies subject to reporting pursuant to the criteria stated in Section 2.C are required to complete the data forms in Appendix 1, Appendix 2 and Appendix 3 as appropriate, and also complete the Experience Data Elements and Formats as defined in Appendix 4.

The data should include policies issued as standard, substandard (optional) or sold within a preferred class structure. Preferred class structure means that, depending on the underwriting results, a policy could be issued in classes ranging from a best preferred class to a residual standard class. Policies issued as part of a preferred class structure are not to be classified as substandard.

Policies issued as conversions from term or group contracts should be included. For these converted policies, the issue date should be the issue date of the converted policy, and the underwriting field will identify them as issues resulting from conversion.

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.

Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by June 30 of the year after the observation year.

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

Each company is to submit data for in-force and terminated life insurance policies that are within the scope defined in Section 2.B except:

- i. For policies issued before Jan. 1, 1990, companies may certify that submitting data presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.
- ii. For policies issued on or after Jan. 1, 1990, companies must:
 - a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and
 - b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

1. Using the data collected under this statistical plan, the Experience Reporting Agent will produce an experience data report that aggregates the experience data of all companies whose data have passed all of the validity and reasonableness checks outlined in Section 4 of VM-50 and has been determined by the Experience Reporting Agent to be acceptable to be used in the development of industry mortality experience.
2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company's identity, which will be used to develop industry mortality experience and valuation mortality tables.
3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company's experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance

regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.

Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. **Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.**

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

Company	NAIC Company Code
Name	Date

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

- Issue Date Range Date through Date
- Issue Age Range Date through Date
- Face Amount Range Date through Date
- Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- Issue Date Range Date through Date
- Issue Age Range Date through Date
- Face Amount Range Date through Date
- Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

- a) Issue Date Range Date through Date
- b) Issue Age Range Date through Date
- c) Face Amount Range Date through Date
- d) Plan Types (use three-digit codes from item 19, Plan)

Appendix 2: Mortality Claims Questionnaire**MORTALITY CLAIMS QUESTIONNAIRE**

The purpose of this mortality claims questionnaire is for a company to respond to the questions whether or not it is submitting death claim data as specified. If the company is not submitting death claim data as specified, provide the additional detail requested.

Fill out this questionnaire for your individual life business and submit in addition to policy-level information.

Company	NAIC Company Code
Name	Date

MORTALITY CLAIMS

1. If the data is provided using a reporting run-out that is other than six months, what run-out period was used? mm/dd/yyyy
2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
 - a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR
 Other (describe):
 If not as specified, indicate time period for which this occurred _____ - _____
 - b. Gross basis (before reinsurance) as specified OR Other (describe):
 If not as specified, indicate time period for which this occurred: _____ - _____
 Is this the same basis used for face amounts included in the study data? Yes No
3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
 - a) Termination reported date
 If not reported date, indicate Reported date Other (describe):
 basis for dates provided
 - b) Actual termination date for death claims: Date of death Other (describe):
 If not date of death, indicate
 basis for dates provided
4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six month run out are -to be included.

Are such pending claims included in the study data? Yes No

If no indicate time period for which this occurred: _____

5. The face amounts and death claim amounts are to be included without capping by amount. Are the face amounts and death claims/exposures included without capping by amount?

Yes No

If No, describe how face amounts and death claims are capped and at what amount the capping is being done.

6. For death claims on policies issued before 1990:

Are death claims matched up to a corresponding in-force policy? Yes No

If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.

Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: _____ Title: _____
 Company: _____ NAIC Company Code: _____ Date: _____
 Phone Number: _____ Email: _____

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

Plan Code For Product I	Plan Code for Product II	Plan Code for Product III
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Enter specific plan names for each product.

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A. General Product Information

	Product I	Product II	Product III
1. In what year was each product introduced?			
2. Briefly describe the product.	_____ _____	_____ _____	_____ _____
3. Enter three-digit plan code in the range 300 to 999.			

B. For the products listed, please fit each product into one of the categories below.

Categories for Product I		Categories for Product II		Categories for Product III	
1	Traditional Whole Life Plans	1	Traditional Whole Life Plans	1	Traditional Whole Life Plans
2	Term Insurance Plans	2	Term Insurance Plans	2	Term Insurance Plans
3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)	3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)	3	Universal Life Plans (excl. Variable and excl. Secondary Guarantees)
4	Universal Life Plans with Secondary Guarantees (excl. Variable)	4	Universal Life Plans with Secondary Guarantees (excl. Variable)	4	Universal Life Plans with Secondary Guarantees (excl. Variable)
5	Variable Life Plans (without Secondary Guarantees)	5	Variable Life Plans (without Secondary Guarantees)	5	Variable Life Plans (without Secondary Guarantees)
6	Variable Life Plans with Secondary Guarantees	6	Variable Life Plans with Secondary Guarantees	6	Variable Life Plans with Secondary Guarantees
7	Nonforfeiture	7	Nonforfeiture	7	Nonforfeiture
8	Other	8	Other	8	Other

Appendix 4: Mortality Data Elements and Format

ITEM	COLUMN	LENGTH	DATA ELEMENT	DESCRIPTION
1		9	Submitting Company ID	<p>ID number representing the company submitting this file.</p> <p>If the company has an NAIC Company Code, then that code must be used.</p> <p>If the company does not have an NAIC Company Code, the company's Federal Employer Identification Number (FEIN) must be used.</p> <p>If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</p>
2	1-5	5	NAIC Company Code of the Direct Writer of Business	<p>You The NAIC Company Code of the company that wrote the business being reported.</p> <p>In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer.</p> <p>If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</p>
3	6-9	4	Observation Year	Enter Calendar Year of Observation
4	10-29	20	Policy Number	Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.
5	30-32	3	Segment Number	<p>If only one policy segment exists, enter segment number '1.' For a single life policy, the base policy is to be put in the record with segment number '1.' Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.</p> <p>For joint life policies, the base policy of the first life is to be put in a record with segment number '1,' and the base policy of the second life is to be put in a separate record with segment number '2.' Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers.</p> <p>Policy segments with the same policy number are to be submitted for:</p> <ol style="list-style-type: none"> Single life policies; Joint life policies; Term/paid up riders; or Additional amounts of insurance including purchase through dividend options.
6	33-34	2	State of Issue	Use standard, two-letter state abbreviation codes (e.g., NY for New York)

7	35	1	Gender	0 = Unknown or unable to subdivide 1 = Male 2 = Female 3 = Unisex – Unknown or unable to identify 4 = Unisex – Male 5 = Unisex – Female
8	36-43	8	Date of Birth	Enter the numeric date of birth in YYYYMMDD format
9	44	1	Age Basis	0 = Age Nearest Birthday 1 = Age Last Birthday 2 = Age Next birthday Drafting Note: Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.
10	45-47	3	Issue Age	Enter the insurance Issue Age
11	48-55	8	Issue Date	Enter the numeric calendar year in YYYYMMDD format.
ITEM	COLUMN	LENGTH	DATA ELEMENT	DESCRIPTION
12	56	1	Smoker Status (at issue)	Smoker status should be submitted where reliable. 0 = Unknown 1 = No tobacco usage 2 = Nonsmoker 3 = Cigarette smoker 4 = Tobacco user
13	57	1	Preferred Class Structure Indicator	0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown. 1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment. Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.
14	58	1	Number of Classes in Nonsmoker Preferred Class Structure	If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.

15	59	1	Nonsmoker Preferred Class	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank.</p> <p>For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes:</p> <p>1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8</p> <p>Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</p>
16	60	1	Number of Classes in Smoker Preferred Class Structure	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.</p> <p>For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</p>
ITEM	COLUMN	LENGTH	DATA ELEMENT	DESCRIPTION
17	61	1	Smoker Preferred Class	<p>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank.</p> <p>For smoker policy segments that could have been issued as one of multiple preferred and standard classes:</p> <p>1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8</p> <p>Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</p>

18	62-63	2	Type of Underwriting Requirements	<p>If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI.</p> <p>01 = Underwritten, but unknown whether fluid was collected 02 = Underwritten with no fluid collection 03 = Underwritten with fluid collected 06 = Term Conversion 07 = Group Conversion 09 = Not Underwritten 99 = For issues where underwriting requirement unknown or unable to subdivide</p>
19	64	1	Substandard Indicator	<p>0 = Policy segment is not substandard 1 = Policy segment is substandard 2 = Policy segment is uninsurable</p> <p>Note:</p> <ul style="list-style-type: none"> a. All policy segments that are substandard need to be identified as substandard or uninsurable. b. Submission of substandard policies is optional. c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard.
ITEM	COLUMN	LENGTH	DATA ELEMENT	DESCRIPTION
20	65-67	3	Plan	<p>Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:</p> <p>000 = If unable to distinguish among plan types listed below 100 = Joint life plan unable to distinguish among joint life plan types listed below</p> <p>Permanent Plans:</p> <p>010 = Traditional fixed premium fixed benefit permanent plan 011 = Permanent life (traditional) with term 012 = Single premium whole life 013 = Econolife (permanent life with lower premiums in the early durations) 014 = Excess interest whole life 015 = First to die whole life plan (submit separate records for each life) 016 = Second to die whole life plan (submit separate records for each life) 017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life)</p>

				<p>018 = Permanent products with non-level death benefits</p> <p>019 = Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)</p> <p>Term Insurance Plans:</p> <p>020 = Term (traditional level benefit and attained age premium)</p> <p>021 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)</p> <p>211 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)</p> <p>212 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)</p> <p>213 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)</p> <p>214 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)</p> <p>215 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)</p> <p>022 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)</p> <p>221 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)</p> <p>222 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)</p> <p>223 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)</p> <p>224 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)</p> <p>023 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)</p> <p>231 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)</p> <p>232 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)</p> <p>233 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)</p> <p>024 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)</p>
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				<p>241 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</p> <p>242 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 year)</p> <p>025 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</p> <p>251 = Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 year)</p> <p>026 = Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</p> <p>027 = Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</p> <p>271 = Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</p> <p>028 = Term (decreasing benefit)</p> <p>040 = Select ultimate term (premium depends on issue age and duration)</p> <p>041 = Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</p> <p>042 = Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</p> <p>043 = Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</p> <p>044 = Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</p> <p>045 = Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</p> <p>046 = Economatic term</p> <p>059 = Term plan, unable to classify</p> <p>101 = First to die term plan (submit separate records for each life)</p> <p>102 = Second to die term plan (submit separate records for each life)</p> <p>103 = Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</p> <p>Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:</p> <p>061 = Single premium universal life</p> <p>062 = Universal life (decreasing risk amount)</p> <p>063 = Universal life (level risk amount)</p> <p>064 = Universal life – unknown whether code 062 or 063</p> <p>065 = First to die universal life plan (submit separate records for each life)</p> <p>066 = Second to die universal life plan (submit separate records for each life)</p>
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				<p>067 = Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</p> <p>068 = Indexed universal life</p> <p>Universal Life Plans (Other than Variable) with Secondary Guarantees:</p> <p>071 = Single premium universal life with secondary guarantees</p> <p>072 = Universal life with secondary guarantees (decreasing risk amount)</p> <p>073 = Universal life with secondary guarantees (level risk amount)</p> <p>074 = Universal life with secondary guarantees – unknown whether code 072 or 073</p> <p>075 = First to die universal life plan with secondary guarantees (submit separate records for each life)</p> <p>076 = Second to die universal life plan with secondary guarantees (submit separate records for each life)</p> <p>077 = Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)</p> <p>078 = Indexed universal life with secondary guarantees</p> <p>Variable Life Plans issued without a Secondary Guarantee:</p> <p>080 = Variable life</p> <p>081 = Variable universal life (decreasing risk amount)</p> <p>082 = Variable universal life (level risk amount)</p> <p>083 = Variable universal life – unknown whether code 081 or 082</p> <p>084 = First to die variable universal life plan (submit separate records for each life)</p> <p>085 = Second to die variable universal life plan (submit separate records for each life)</p> <p>086 = Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)</p> <p>Variable Life Plans with Secondary Guarantees:</p> <p>090 = Variable life with secondary guarantees</p> <p>091 = Variable universal life with secondary guarantees (decreasing risk amount)</p> <p>092 = Variable universal life with secondary guarantees (level risk amount)</p> <p>093 = Variable universal life with secondary guarantees –unknown whether code 091 or 092</p> <p>094 = First to die variable universal life plan with secondary guarantees (submit separate records for each life)</p> <p>095 = Second to die variable universal life plan with secondary guarantees (submit separate records for each life)</p>
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				<p>096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)</p> <p>Nonforfeiture: 098 = Extended term 099 = Reduced paid-up 198 = Extended term for joint life (submit separate records for each life) 199 = Reduced paid-up for joint life (submit separate records for each life)</p>
21	68	1	In-force Indicator	<p>0 = If the policy segment was not in force at the end of the calendar year of observation 1 = If the policy segment was in force at the end of the calendar year of observation</p>
22	69-80	12	Face Amount of Insurance at Issue	<p>Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. If the policy was issued during the observation year, the Face Amount of Insurance at the Beginning of the Observation Year should be blank.</p>
23	81-92	12	Face Amount of Insurance at the Beginning of the Observation Year	<p>Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.</p>
24	93-104	12	Face Amount of Insurance at the End of the Observation Year	<p>Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors.</p> <p>If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.</p>
25	105-116	12	Death Claim Amount	<p>If In-force Indicator is 1, leave blank.</p> <p>Death claim amount rounded to the nearest dollar.</p> <p>If In-force Indicator is 0 and Cause of Termination is 04, then enter the face amount.</p> <p>If In-force Indicator is 0 and Cause of Termination is not 04, then leave blank.</p> <p>If the policy provides payment of cash value in addition to face amount, report face amount, and do not include cash value.</p>

26	117-124	8	Termination Reported Date	If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.
27	125-132	8	Actual Termination Date	If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred. If termination is due to death (Cause of Termination is 04), enter actual date of death. If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid to.
28	133-134	2	Cause of Termination	If Inforce Indicator is 1, leave blank. 00 = Termination type unknown or unable to subdivide 01 = Reduced paid-up 02 = Extended term 03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13 04 = Death 07 = 1035 exchange 09 = Term conversion – unknown whether attained age or original age 10 = Attained age term conversion 11 = Original age term conversion 12 = Coverage expired or contract reached end of the mortality table 13 = Surrendered for full cash value 14 = Lapse (other than to Reduced Paid Up or Extended Term) 15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision

29	135-144	10	Annualized Premium at Issue	For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium set at issue. Except for level term segments specified above, leave blank for non-base segments. For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue. Round to the nearest dollar. If unknown, leave blank.
30	145-154	10	Annualized Premium at the Beginning of Observation Year	For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year.

				<p>Except for level term segments specified above, leave blank for non-base segments.</p> <p>For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium for the policy year that includes the beginning of the observation year.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
31	155-164	10	Annualized Premium at the End of Observation, if available. Otherwise Annualized Premium as of Year/Actual Termination Date	<p>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the Inforce Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).</p> <p>Except for level term segments specified above, leave blank for non-base segments.</p> <p>For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator =1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26).</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
32	165-166	2	Premium Mode	<p>01 = Annual 02 = Semiannual 03 = Quarterly 04 = Monthly Bill Sent 05 = Monthly Automatic Payment 06 = Semimonthly 07 = Biweekly 08 = Weekly 09 = Single Premium 10 = Other / Unknown</p>
33	167-176	10	Cumulative Premium Collected as of the Beginning of Observation Year	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p>

				<p>1) For non-base segments, leave blank.</p> <p>2) For base segments, enter the cumulative premium collected since issue, as of the beginning of the observation year. Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank. If unknown, leave blank.</p>
34	177-186	10	<p>Cumulative Premium Collected as of the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date</p>	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>1) For non-base segments, leave blank.</p> <p>2) For base segments inforce at the end of the observation year, enter the cumulative premium collected as of the end of the observation year.</p> <p>3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, as of the Actual Termination Date (Item 26).</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
35	187-188	2	<p>ULSG/VLSG Premium Type</p>	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>00 = Unknown 01 = Single premium 02 = ULSG/VLSG Whole life level premium 03 = Lower premium (term like) 04 = Other</p>
36	189-190	2	<p>Type of Secondary Guarantee</p>	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>00 = Unknown 01 = Cumulative Premium without Interest (Single Tier) 02 = Cumulative Premium without Interest (Multiple Tier) 03 = Cumulative Premium without Interest (Other) 04 = Cumulative Premium with Interest (Single Tier) 05 = Cumulative Premium with Interest (Multiple Tier) 06 = Cumulative Premium with Interest (Other) 11 = Shadow Account (Single Tier)</p>

				<p>12 = Shadow Account (Multiple Tier) 13 = Shadow Account (Other) 21 = Both Cumulative Premium without Interest and Shadow Account 22 = Both Cumulative Premium with Interest and Shadow Account 23= Other, not involving either Cumulative Premium or Shadow Account</p>
37	191-200	10	Cumulative Minimum Premium as of the Beginning of Observation Year	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <p>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</p> <ol style="list-style-type: none"> 1) Leave non-base segments, blank. 2) For base segments: Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year. <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
38	201-210	10	Cumulative Minimum Premium as of the End of Observation Year/ Actual Termination Date	<p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:</p> <p>If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:</p> <ol style="list-style-type: none"> 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year. 3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26) <p>Round to the nearest dollar.</p>

				If unknown, leave blank.
39	211-220	10	Shadow Account Amount at the Beginning of Observation Year	<p>If not ULSG, or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22: 1) Leave non-base segments blank. 2) For base segments: Enter total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero or negative.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
40	221-230	10	Shadow Account Amount at the End of Observation Year/ Actual Termination Date	<p>If not ULSG, or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22: 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative. 3) For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative.</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
41	231-240	10	Account Value at the Beginning of Observation Year	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy</p>

				<p>Account Value can be positive, zero or negative.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank.</p> <p>If unknown, leave blank.</p>
42	241-250	10	Account Value at the End of Observation Year/Actual Termination Date	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <ol style="list-style-type: none"> 1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative. 2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 26). The policy Account Value can be positive, zero or negative. <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
43	251-260	10	Amount of Surrender Charge at the Beginning of Observation Year	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan, enter the dollar Amount of the Surrender Charge as of the Beginning of the Observation Year.</p> <p>Round to the nearest dollar.</p> <p>For policies issued in the observation year, leave blank. If unknown, leave blank.</p>
44	261-270	10	Amount of Surrender Charge at the End of Observation Year/Actual Termination Date	<p>For non-base segments, leave blank.</p> <p>If not ULSG or VLSG, leave blank.</p> <p>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</p> <ol style="list-style-type: none"> 1) If policy is in force at the end of observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year. 2) If policy terminated during the observation year, enter the dollar amount of the Surrender Charge

				<p>as of the Actual Termination Date (Item 26).</p> <p>Round to the nearest dollar.</p> <p>If unknown, leave blank.</p>
45	271-272	2	Operative Secondary Guarantee at the Beginning of Observation Year	<p>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year.</p> <p>If Item 35, Type of Secondary Guarantee is blank, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 00 through 23:</p> <p>1) For non-base segments, leave blank.</p> <p>2) For base segments:</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p>
46	273-274	2	Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date	<p>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date.</p> <p>If Item 35, Type of Secondary Guarantee is blank, leave blank.</p> <p>If Item 35, Type of Secondary Guarantee is 00 through 23:</p> <p>1) For non-base segments, leave blank.</p> <p>2) For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year:</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p> <p>3) For base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26):</p> <p>00 = If unknown whether the secondary guarantee is in effect</p> <p>01 = If secondary guarantee is not in effect</p> <p>02 = If secondary guarantee is in effect</p> <p>03 = If all secondary guarantees have expired</p>
47	275-276	2	State of Domicile	<p>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner's domicile.</p> <p>If unknown or outside of the U.S., leave blank.</p>

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Dates: Received	Reviewed by Staff	Distributed	Considered
4/30/2021	RM		
Notes: APF 2021-07			

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: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation of GA

Title of the Issue: Clarify ULSG NPR calculation requirements

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, 2021 NAIC *Valuation Manual*, but incorporating APF 2020-03
 Section 2.A.3 Section 3.B.1, 2, 5 and 6 Section 6.B.5.b
 Section 3.A Section 3.C.2 and 3

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.

As a general overview, Section 3.B.5 stayed in 3.B.5 but was renumbered, but Section 3.B.6 was moved to 3.B.5.b and c.

Below is a detailed summary of the items that were moved to a new section (and/or renumbered) but were not redlined. In some cases, the wording was redlined after it was moved (if the wording changed).

Prior version	New version
3.B.5 last half of first sentence	3.B.5.a
3.B.5 2nd and 3rd sentence	3.B.5.d
3.B.5.a thru g	renumbered as 3.B.5.d.i thru vii
3.B.6.a	3.B.5.b
3.B.6.b	3.B.5.c
3.B.6.c	3.B.5.c.i (with sub-bullets renumbered)
3.B.6.d	3.B.5.c.ii (with sub-bullets renumbered)
3.B.6.e	3.B.5.c.iii (with sub-bullets renumbered)

4. State the reason for the proposed amendment? (You may do this through an attachment.)

The NPR calculation requirements for ULSG products are currently contained in Section 3.B.5 and 3.B.6 of the Valuation Manual. The current wording takes the reader back and forth between Section 3.B.5 and 3.B.6 when trying to follow the reserve calculation for ULSG products, which can be confusing. And the current wording also has led some people to incorrectly interpret Section 3.B.5 to be applicable to UL products without a SG.

The APF combines the current 3.B.5 and 3.B.6. sections into a single section labeled 3.B.5 and clarifies how to determine the NPR when the policy duration at the valuation date is either prior to, or after the SG has expired. Importantly, no change has been made to the current requirements, only the formatting of the requirements to make them easier to follow. Note that the new wording has flipped the order of the old 3.B.5 and 3.B.6 when combining them in the new 3.B.5, but this movement is not shown as a tracked change (since no changes were made to the existing reserve calculation requirements in the two sections).

Section 3.A has also been revised to eliminate the confusion that can arise on whether the NPR for products in the All Other VM-20 Reserving Category is still a VM-20 reserve. The NPR requirement for products in the All Other VM-20 Reserving Category has been moved to Section 3.B.6.

Impacted references have been updated.

ATTACHMENT

Section 2: Minimum Reserve

- A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.
1. Term Reserving Category —
 2. ULSG Reserving Category —
- c. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.
3. All Other VM-20 Reserving Category— All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3.c unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.

Commented [MR1]: CA suggestion #1

Deleted: (Life Insurance Policies Subject to Section 3.A.2)

Section 3: Net Premium Reserve

- A. Applicability
1. The NPR for each policy must be determined on a seriatim basis pursuant to Section 3.
 2. When valuing term riders pursuant to Paragraph E in “Riders and Supplemental Benefits Requirements” in Section II, the reserve requirements for term policies are applicable.
- B. NPR Calculation
1. For the purposes of Section 3, the following terms apply:
 - b. The “level secondary guarantee” at any time is:
 - i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.5.c.i.1.
 - ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.5.c.i.1, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.
 2. Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.
 4. For all policies and riders within the Term Reserving Category, other than those addressed in Section 3.B.8 below, the NPR on any valuation date shall be equal to the actuarial present value of future

Deleted: term policy and for each ULSG

Deleted: <#>Except for policies subject to Section 3.A.1, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.¶

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benefits less the actuarial present value of future annual valuation net premiums as follows:

5. For all policies and riders within the ULSG Reserving Category, the NPR shall be determined as follows:

a. If the policy duration on the valuation date is Prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section 3.B.5.c and the reserve amount determined in Section 3.B.5.d, subject to the floors specified in Section 3.D.2.

b. If the policy duration on the valuation date is after the expiration of all secondary guarantee periods, the NPR shall be the reserve amount determined according to Section 3.B.5.d only, subject to the floors specified in 3.D.2.

c. A reserve amount for the policy shall be calculated assuming the secondary guarantee is in effect as described below. If the policy has multiple secondary guarantees, the NPR shall be calculated as below for the secondary guarantee that provides the greatest NPR as of the valuation date. For the purposes of this subsection, let n be the longest number of years the policy can remain in force under the provisions of the secondary guarantee. However, if a shorter period produces a materially greater NPR, then n shall be that shorter number of years.

i. As of the policy issue date:

1. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as v years in this subsection, that would keep the policy in force to the end of year n, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall v be greater than n for purposes of the NPR calculated in this subsection.

2. Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.

3. Using the level gross premium from Section 3.B.5.c.i.1 above, determine the value of the expense allowance components for the policy at issue as x_1 , y_{2-5} and z_1 defined below.

x_1 = a first-year expense equal to the level gross premium at issue

y_{2-5} = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year

z_1 = a first-year expense of \$2.50 per \$1,000 of insurance issued

The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. E_{x+t} , the expense allowance balance as of the end of the policy year t, shall be computed as follows:

$$E_{x+t} = VNPR \cdot \ddot{a}_{x+t:v-t} \left[\frac{x_1 + z_1}{\ddot{a}_{x:v}} + y_{2-5} \cdot C_{x+t} \right] \quad \text{for } t < v$$

$$= 0 \quad \text{for } t \geq v$$

Where:

$t = 1, 2, \dots$ (number of completed years since issue)

Commented [MR2]: Section 3.B.5.a was moved from what was previously part of the first sentence of Section 3.B.5

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Commented [MR3]: Section 3.B.5.b was moved from what was previously Section 3.B.6.a

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Commented [MR4]: Section 3.B.5.c was moved from what was previously Section 3.B.6.b

Deleted: The NPR shall be calculated as in Section 3.B.6.c through Section 3.B.6.e below, and the resulting NPR shall be used in the comparison with the NPR calculated in accordance with Section 3.B.5.

Commented [MR5]: Section 3.B.5.c.i was moved from what was previously part of the first sentence of Section 3.B.6.c and the sub-bullets were renumbered

Commented [MR6]: CA suggestion #5

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$$VNPR = \text{Valuation Net Premium Ratio from 3.B.5.c.i.2 above}$$

$$C_{x+t} = 0 \quad \text{when } t = 1$$

$$= \sum_{w=1}^{t-1} (1/\ddot{a}_{x+w:\overline{v-w}|}) \quad \text{when } 2 \leq t \leq 5$$

$$= C_{x+5} \quad \text{when } t > 5$$

ii. After the policy issue date, on each future valuation date, the NPR shall be determined as follows:

1. As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASG_{x+t} , as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted $FFSG_{x+t}$, as outlined in Section 3.B.1.b.
2. Divide ASG_{x+t} by $FFSG_{x+t}$, with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee, which is used to establish reserves. Assumptions within the numerator and denominator of the ratio, therefore, must be consistent in order to appropriately reflect the level of prefunding. As used here, "assumptions" include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.
3. Compute the net single premium (NSP_{x+t}) on the valuation date for the coverage provided by the secondary guarantee for the period of time ending at attained age $x+n$, using the interest, lapse and mortality assumptions prescribed in Section 3.C below. The net single premium (NSP) shall include consideration for death benefits only.
4. The NPR for an insured age x at issue at time t shall be according to the formula below:

$$\text{Min} \left[\frac{ASG_{x+t}}{FFSG_{x+t}}, 1 \right] \cdot NSP_{x+t} - E_{x+t}$$

Guidance Note: For a non-integer value of t , E_{x+t} is obtained by taking the present value at duration t of E_{x+T} , where T is the next higher integer; i.e., entails discounting by valuation interest, mortality, and lapse for the fractional year between the valuation date and next anniversary ($T - t$).

- iii. Actuarial present values referenced in this Section 3.B.5.c are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C below.
- d. A reserve amount for the policy shall be calculated assuming the secondary guarantee is not in effect. The reserve amount shall be determined by the policy features and guarantees of the policy without considering any secondary guarantee provisions as follows:
 - i. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as "s" in this subsection, that would keep the policy in force for the entire period coverage is to be provided based on the policy guarantees of mortality, interest and expenses.
 - ii. Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present

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Commented [MR10]: Section 3.B.5.c.ii was moved from what was previously part of the first sentence of Section 3.B.6.d and the sub-bullets were renumbered

Commented [MR11]: Section 3.B.5.c.iii was moved from what was previously part of the first sentence of Section 3.B.6.e

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Commented [MR12]: Section 3.B.5.d was moved from what was previously part of the second and third sentences of Section 3.B.5

Deleted: Once all secondary guarantee periods have expired, the NPR shall, subject to the floors specified in Section 3.D.2, be the reserve calculated in Section 3.B.5.a through Section 3.B.5.g below. ...

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Commented [MR13]: Section 3.B.5.d.i through 3.B.5.d.vii were previously Section 3.B.5.a through 3.B.5.g

value of future valuation net premiums shall equal the actuarial present value of future benefits.

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- iii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as x_t , y_{2-5} and z_t defined below.

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x_t = a first-year expense equal to the level gross premium at issue

y_{2-5} = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year

z_t = a first-year expense of \$2.50 per \$1,000 of insurance issued

The expense allowance shall be amortized over the period during which premiums are permitted to be paid. E_{x+t} , the expense allowance balance, as of the end of policy year t , shall be calculated as follows:

$$E_{x+t} = VNPR \cdot \ddot{a}_{x+t:\overline{s-t}|} [(x_1 + z_1) / \ddot{a}_{x:s} + y_{2-5} \cdot C_{x+t}] \quad \text{for } t < s$$

$$= 0 \quad \text{for } t \geq s$$

Where:

$t = 1, 2, \dots$ (number of completed years since issue)

$VNPR =$ Valuation Net Premium Ratio from 3.B.5.d.ii above

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$$C_{x+t} = 0 \quad \text{when } t = 1$$

$$= \sum_{w=1}^{t-1} (1 / \ddot{a}_{x+w:\overline{s-w}|}) \quad \text{when } 2 \leq t \leq 5$$

$$= C_{x+5} \quad \text{when } t > 5$$

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- iv. For a policy issued at age x , at any duration t , the net premium reserve shall equal:

$m_{x+t} \cdot r_{x+t}$ Where:

- m_{x+t} = the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy, E_{x+t} ,

Deleted: <#>Determine the annual valuation net premiums as that uniform percentage (the valuation net premium ratio) of the respective gross premiums, such that at issue the actuarial present value of future valuation net premiums shall equal the actuarial present value of future benefits...¶

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Guidance Note: For a non-integer value of t , E_{x+t} is obtained by taking the present value at duration t of E_{x+T} , where T is the next higher integer; i.e., entails discounting by valuation interest and survivorship for the fractional year between the valuation date and the next anniversary ($T - t$).

- Let:

e_{x+t} = max (the actual policy fund value on the valuation date, 0)

f_{x+t} = the policy fund value on the valuation date is that amount which, together with the payment of the future level gross premiums determined in Section 3.B.5.d.i above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.

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Then set r_{x+t} equal to:

$$1, \text{ if } f_{x+t} \leq 0$$

$\min([e_{x+t}/f_{x+t}], 1)$, otherwise

- v. The future benefits used in determining the value of m_{x+t} shall be based on the greater of e_{x+t} and f_{x+t} together with the future payment of the level gross premiums determined in Section 3.B.5.d.i above, and assuming the policy guarantees of mortality, interest and expenses.
 - vi. The values of \ddot{a} are determined using the NPR interest, mortality and lapse assumptions applicable on the valuation date.
 - vii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C.
6. For all policies and riders within the **All Other VM-20 Reserving Category**, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.
7. The actuarial present value of future benefits equals the present value of future benefits including, but not limited to, death, endowment (including endowments intermediate to the term of coverage) and cash surrender benefits. Future benefits are before reinsurance and before netting the repayment of any policy loans.
8. For life insurance coverage that the company has assumed on a YRT basis, the reinsurer's net premium reserve shall be one half year's cost of insurance for the reinsured net amount at risk.

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Deleted: as follows. Prior to the point when all secondary guarantee periods have expired, the NPR shall, subject to the floors specified in Section 3.D.2, be the greater of the reserve amount determined according to Section 3.B.5, assuming the policy has no secondary guarantees, and the reserve amount for the policy determined according to the methodology and requirements in Section 3.B.6.b through Section 3.B.6.e below

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C. Net Premium Reserve Assumptions

2. Interest Rates

a. For NPR amounts calculated according to Section 3.B.5.d:

b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.c:

Commented [MR18]: CA Suggestion #2

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3. Lapse Rates

a. For NPR amounts calculated according to Section 3.B.5.d, the lapse rates used shall be 0% per year during the premium paying period and 0% per year thereafter.

Commented [MR19]: CA Suggestion #3

c. For NPR amounts calculated according to Section 3.B.5.c, the lapse rate, L_{x+t} , for an insured age x at issue for all durations subsequent to the valuation date shall be determined as follows:

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i. Determine the ratio R_{x+t} where:

$$R_{x+t} = [FFSG_{x+t} - ASG_{x+t}] / [FFSG_{x+t} - LSG_{x+t}] \text{ but not } > 1 \text{ and not } < 0$$

Where:

$FFSG_{x+t}$ = the fully funded secondary guarantee on the valuation date for the insured age x at issue

ASG_{x+t} = the actual secondary guarantee on the valuation date for the insured age x at issue

LSG_{x+t} = the level secondary guarantee on the valuation date for the insured age x at issue

Guidance Note: The $FFSG_{x+t}$, ASG_{x+t} , and LSG_{x+t} are based on the secondary guarantee values as of the valuation date and will remain constant throughout the cash flow projection. This will result in a constant lapse assumption, calculated as of the valuation date, that does not vary by duration throughout the cash flow projection for the NPR calculation.

- ii. As of the valuation date, which is t years after issue, the annual lapse rate for the policy shall be assumed to be level for all future years and denoted as L_{x+t} , which shall be set equal to:

$$L_{x+t} = R_{x+t} \cdot 0.01 + (1 - R_{x+t}) \cdot 0.005 \cdot r_{x+t}$$

Where r_{x+t} is the ratio determined in Section 3.B.5.d.iv.2.

Guidance Note: By similar logic, it follows (from ASG_{x+t} being 0 when $t=0$) that the level annual lapse rate to be used in the calculations in Section 3.B.5.c.i.2 and 3.B.5.c.i.3 is 1%. On the other hand, when performing the calculations in Section 3.B.5.c.ii.3, L_{x+t} , though level, is not generally equal to what it was for the same policy on the previous valuation date.

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Section 6: Stochastic and Deterministic Exclusion Tests

B. Deterministic Exclusion Test (DET)

- 5. For purposes of determining the valuation net premiums used in the demonstration in Section 6.B.2:
 - a. If pursuant to Section 2, the NPR for the group of policies is the minimum reserve required under VM-A and VM-C, then the valuation net premiums are determined according to those minimum reserve requirements.
 - b. If the NPR is determined according to Section 3.B.4 or Section 3.B.5, then the lapse rates assumed for all durations shall for the purposes of the DET be set to 0%;

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Dates: Received	Reviewed by Staff	Distributed	Considered
5/18/21	JF		
Notes: APF 2021-09			

**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:

1. Address determination of materiality. VM-21 often refers to materiality but is missing a discussion on how materiality is determined.
2. Address use of approximations and simplifications in VM-21.

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.E (new), VM-21 Section 3.H (new), VM-31 Section 3.E.1, VM-31 Section 3.F.2.e

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.)

1. VM-21 often refers to materiality but is missing a discussion on how materiality is determined (a materiality standard), as VM-20 has in VM-20 Section 2.H. Moreover, the current language of Materiality in the VA Summary in VM-31 Section 3.E.1 (2021 edition) is based on the Life PBR Summary in VM-31 (2019 edition). The language of Materiality in the VA Summary in Section 3.E.1 of VM-31 should be updated, consistent with adding a new section to VM-21 to address materiality.

For reference, here are the relevant VM-20 passages:

VM-20 Section 2.H

The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

VM-31 Section 3.C.1

Life Summary – The PBR Actuarial Report shall contain a Life Summary of the critical elements of all sub-reports of the Life Report as detailed in Section 3.D. In particular, this Life Summary shall include:

1. *VM-20 Materiality – The standard established by the company pursuant to VM-20 Section 2.H.*
2. While it is common for companies to use a significant number of approximations, simplifications, and modeling efficiency techniques for their VM-21 valuation, VM-21 is missing an explicit allowance of approximations, simplifications, or modeling efficiency techniques. To understand the impact of the large number of approximations, simplifications, and modeling efficiency techniques, they should be covered in one location in the PBR reporting for VA, in contrast to the current reporting where they are scattered throughout the PBR Report. VM-20 Section 2.G does not allow simplifications to bias the reserve downward. This addresses the concern that a large number of immaterial simplifications could add up to a material understatement. VM-21 needs an assurance that simplifications do not compound one another to become material even more than VM-20, due to the very larger number of simplifications commonly used.

VM-21 Section 1.E (new)

Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve or TAR. This standard shall be applied when identifying material risks.

VM-21 Section 3.H (new)

H. A company may use simplifications, approximations and modeling efficiency techniques to calculate the stochastic reserve and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate TAR by a material amount, and the expected value of TAR calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of TAR calculated that does not use them.

Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.H. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used. Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.H without needing a demonstration. However,

rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of TAR.

2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting TAR. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.H.
3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understate TAR by a material amount and the expected value of TAR would not be less than the expected value of TAR that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the TAR estimate rather than a brute force demonstration.
4. Justify the use of randomly sampling withdrawal ages for each contract instead of following the exact prescribed WDCM method by demonstrating that the random sampling method is materially equivalent to the exact prescribed approach, and the simplification does not materially reduce the Additional Standard Projection Amount and the final reported TAR. In particular, the company should demonstrate that the statistical variability of the results based on the random sampling approach is immaterial by testing different random sets, e.g., if randomly selecting a withdrawal age for each contract, the probability distribution of the withdrawal age should be stable and not vary significantly when using different random number sets.

VM-31 Section 3.E.1

VA Summary - The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:

1. Materiality - The Standard established by the company pursuant to VM-21 Section 1.E.

VM-31 Section 3.F.2.e

e. Approximations, Simplifications, and Modeling Efficiency Techniques - A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.

Deleted: A description of the rationale for determining whether a decision, information, assumption, risk or other element of a principle-based valuation under VM-21 has a material impact on the modeled reserve. Such rationale could include criteria such as a percentage of reserves, a percentage of surplus, and/or a specific monetary value, as appropriate.

Deleted: Approximations and Simplifications - Description of any approximations and simplifications used in cash flow projection calculations and not described in a different section of this report, including documentation that these did not materially reduce the resulting reserve.

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.

Angela McNabb & Pat Allison – NAIC staff support

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 1,2021, version of the Valuation Manual – VM-51 Appendix 4

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.)

ITEM	L	DATA ELEMENT	DESCRIPTION
11	1	Smoker Status (at issue)	Smoker status should be submitted where reliable. 0 = Unknown 1 = No tobacco usage 2 = Nonsmoker 3 = Cigarette smoker 4 = Tobacco user

4. State the reason for the proposed amendment? (You may do this through an attachment.)

In the event that additional underwriting is done after issue, it is possible that the preferred class would be inconsistent with the smoker status at issue. By removing the “at issue” specification, the smoker status would then be the current smoker status.

* 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:

Dates: Received	Reviewed by Staff	Distributed	Considered
6/3/2021	RM		
Notes: APF 2021-10			

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