2024 Fall National Meeting
Denver, Colorado

JOINT MEETING OF THE EXECUTIVE (EX) COMMITTEE
AND INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
Sunday, November 17, 2024
10:00 – 11:30 a.m.

Meeting Summary Report

The Executive (EX) Committee met in joint session with the Internal Administration (EX1) Subcommittee Nov. 17, 2024. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee:

1. Adopted their Oct. 31 and Summer National Meeting minutes, which included the following action:
   A. Approved the release of the proposed 2025 NAIC budget for public comment prior to its consideration by the full Membership during the joint meeting of the Executive (EX) Committee and Plenary on Dec. 18.
   B. Received an update on the property/casualty (P/C) market intelligence (PCMI) data call.

2. Adopted the Executive (EX) Committee's Summer National Meeting minutes.

3. Adopted the report of the Audit Committee, including its Nov. 13 minutes. During this meeting, the Committee took the following action:
   A. Received the Sept. 30 financial update.
   B. Received an update on the 2024 year-end financial audit.
   C. Received an update on the upcoming Service Organization Control (SOC) 1 and SOC 2 reviews.
   D. Heard an update on the Enterprise Resource Planning (ERP) project.
   E. Reviewed the status of Zone financials.

4. Adopted the report of the Internal Administration (EX1) Subcommittee, including its Aug. 26 minutes. During this meeting, the Subcommittee took the following action:
   A. Received the June 30 Long-Term Investment Portfolio report.
   B. Received the June 30 Defined Benefit Portfolio report.
   C. Received a status update on the termination of the Defined Benefit Pension Plan.

5. Adopted a fiscal for model office testing related to the Generator of Economic Scenarios (GOES).

6. Approved the public release of a request for proposal (RFP) related to the due diligence framework for credit rating agencies.

7. Heard a technology and cybersecurity report.

8. Heard the Chief Executive Officer (CEO) report.

Virtual Meetings

EXECUTIVE (EX) COMMITTEE
December 10, 2024 / October 31, 2024

Summary Report

The Executive (EX) Committee met Dec. 10 and Oct. 31, 2024, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings.

1. During its Dec. 10 meeting, the Committee:
   A. Held a public hearing in open session to receive comments from interested parties.
   B. Adopted the NAIC 2025 proposed budget.

2. During its Oct. 31 meeting, the Committee:
   A. Approved the release of the NAIC 2025 proposed budget, including eight fiscals, for public review and comment.

Draft: 12/12/24

REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force met Nov. 19 and took the following action: 1) adopted its Summer National Meeting minutes; 2) received an update on deliverables from the *NAIC National Climate Resilience Strategy for Insurance* (Climate Resilience Strategy); 3) heard a presentation from United Policyholders (UP) and state insurance regulators on the lessons learned from recent wildfire disasters; 4) heard an update from British Columbia Financial Services Authority (BCFSA) on Canadian flood insurance; 5) heard an update from NAIC staff on federal activities; and 6) heard an update from the Center for Insurance Policy and Research (CIPR) on the NAIC Climate Scenario Resource Center.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met Nov. 17 and took the following action: 1) adopted its Summer National Meeting minutes; 2) received a status report from its workstreams and adopted the Life Workstream's endorsement supporting state legislation requiring a financial literacy course as a prerequisite to high school graduation; and 3) received an update on the Member Diversity Leadership Forum. Discussions at the beginning of 2025 will focus on transitioning the work of the Special Committee to the Standing Committees.

- **Health Workstream**—As reported during the Special (EX) Committee's Nov. 17 meeting, since the Summer National Meeting, the Health Workstream met Oct. 24 and Sept. 9. During its Sept. 9 meeting, the Workstream heard from the Pennsylvania Insurance Department (PID) about its work related to the collection of race and ethnicity data in insurance applications. The Workstream also heard from Independence Blue Cross (IBX) on how the collection of relevant demographic data helps it identify health equity issues and then intervene and monitor progress to address identified problems. The Workstream also heard about the Blue Cross Blue Shield Association's (BCBSA's) National Health Equity Strategy. This strategy aims to address health disparities and build a more equitable healthcare system. The Data Equity Coalition, a partnership between the BCBSA, National Minority Quality Forum (NMQF), and 17 other organizations, focuses on setting standards for collecting accurate and representative data on race, ethnicity, language, sexual orientation, and gender identification, with the goal of improving health outcomes by optimizing the collection of relevant demographic data and addressing barriers to providing personal information. The Workstream continued its demographic data collection discussions during its Oct. 24 meeting. During this meeting, the Workstream heard from AHIP on the challenges with demographic data collection, such as inaccurate and incomplete data, lack of interoperability, and a non-patient-centric demographic data collection process. AHIP also discussed its Demographic Data Element Modernization Initiative, which is aimed at addressing some of these issues by modernizing and enhancing national demographic data content and exchange standards so that they are culturally sensitive, sufficiently granular, and allow for alignment across stakeholders. The Workstream also heard from NCQA about its approach to building a foundation of equity data for action, including using its Health Equity Accreditation program and embedding equity in various programs to advance this goal. The Workstream plans to meet in regulator-to-regulator session after the Fall National Meeting to consider its work to date and potential year-end deliverables. The Workstream also plans to continue its work on its collaborative space on NAIC Connect, which the Workstream intends to be a platform where Workstream members can

share with other NAIC members the information it has captured during its meetings and serve as a platform for discussions and conversations about health equity and other related topics, including adding blog posts from various stakeholders on issues and topics relevant to its work.

- **Life Workstream**—As the Life Workstream reported to the Special (EX) Committee on Race and Insurance on Nov. 17, it plans to continue to focus on "marketing, distribution, and access to life insurance products in minority communities," including focusing on criminal history. Throughout 2024, the Workstream heard a number of presentations exploring the impact of criminal history on an applicant's ability to access life insurance. To learn more, the Life Workstream circulated a draft survey asking about insurers' use of criminal history in life insurance underwriting for a public comment period that ended Sept. 5. Based on the comments received, a revised chair draft survey was distributed and discussed during a public Webex call on Oct. 17. Work continues to finalize the survey questions and develop a process for issuing the survey.

- **Property/Casualty (P/C) Workstream**—The P/C Workstream met Nov. 16 to hear updates on the District of Columbia Department of Insurance, Securities and Banking (DISB) initiative to evaluate unintentional bias in private passenger automobile (PPA) insurance; California's low-cost auto insurance program; Casualty Actuarial Society (CAS) papers related to race and insurance; and Verisk's work related to the testing of models for bias. The Workstream also discussed the possibility of how the NAIC Property and Casualty Market Intelligence (PCMI) Data Call results could be leveraged.

Draft: 12/12/24

Model Law Development Report

Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). The Accident and Sickness Insurance Minimum Standards (B) Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019. Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. During the last few months of 2022, the Subgroup's discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for short-term, limited-duration (STLD) plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans.

The Subgroup resumed its meetings in February 2023 and plans to continue meeting regularly to continue its discussions. It plans to work on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24, 2023, comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup's review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup is completing work on Section 9—Required Disclosure Provisions. It recently completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171. The Subgroup resumed its meetings in January to discuss the comments received. The Subgroup completed its review of those comments following the Spring National Meeting and distributed a draft reflecting all its discussions for final comment. The Subgroup received additional comments on the draft and began discussion of those comments in June. The Subgroup completed its discussion of the additional comments following the Summer National Meeting and adopted the revisions to Model #171 on Oct. 17. The Regulatory Framework (B) Task Force adopted the revisions to Model #171 on Nov. 4. The Health Insurance and Managed Care (B) Committee adopted the revisions to Model #171 on Nov. 19. The Executive (EX) Committee and Plenary will consider adoption of the proposed revisions to Model #171 during its joint meeting on Dec. 18.

Amendments to the *Public Adjuster Licensing Model Act* (#228)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #228 during the 2024 Spring National Meeting. The Model Law Review Request provided guidance that Model #228 should be amended to strengthen regulatory standards governing the conduct of public adjusters for the following four issues: 1) individuals acting as unlicensed public adjusters; 2) contractors who are also acting as public adjusters on the same claim; 3) inappropriate assignment of benefit rights; and 4) excessive fees charged by public adjusters.

The Public Adjuster Licensing (D) Working Group met July 17, June 18, and April 5. During its April 5 meeting, the Working Group discussed proposed modifications to Sections 3 and 14 of the model, which address public adjuster fees. During its June 18 meeting, the Working Group discussed proposed amendments to Sections 15, 16, and 19 of the model to strengthen regulatory standards regarding individuals acting as unlicensed public adjusters; contractors who are also acting as public adjusters on the same claim; and inappropriate assignment of benefit rights. During its July 17 meeting, the Working Group adopted proposed amendments. One significant revision that industry continues to oppose is an amendment to Section 14 of the model, which provides that a public adjuster shall not charge more than 10% for any catastrophic claim settlement and no more than 15% for any insurance claim settlement.

The Producer Licensing (D) Task Force received comments on the model during its Aug. 13 meeting. The Task Force reviewed these comments during its Oct. 31 call. The Task Force adopted the revised model act on Nov. 17. The Market Regulation and Consumer Affairs (D) Committee adopted the revised model on Nov. 19.

Amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672) —During the 2022 Summer National Meeting, the Executive (EX) Committee approved a Request for NAIC Model Law Development for a new model that would replace existing models in order to enhance consumer protections and corresponding obligations of entities licensed by insurance departments to reflect the extensive innovations that have been made in communications and technology. The Privacy Protections (H) Working Group approved this request on Aug. 2, 2022. However, after working on a draft of a new privacy model, the Working Group determined that the better path forward would be to amend the existing NAIC privacy model, Model #672.

Since then, the Working Group has gone through a leadership transition and exposed a chair draft amending Model #672. The Privacy Protections (H) Drafting Group met Sept. 30, 2024, in open session to hear comments on Section 5—Third-Party Service Provider Arrangements of the chair draft. The Drafting Group met again Oct. 31 to continue its discussion on Section 5. On Nov. 4, the Working Group met in regulator-to-regulator session to discuss next steps. Most recently, the Working Group requested comments on Article III of the chair draft. During the 2024 Fall National Meeting, the Working Group and the Innovation, Cybersecurity, and Technology (H) Committee approved a request for an extension of time to continue drafting amendments to Model #672 until Dec. 31, 2025.

Executive Summary
NAIC 2025 Budget

The NAIC's mission is to empower its members—insurance regulators—in their efforts to protect consumers and maintain fair, competitive insurance markets. In line with this mission, the services and products provided by the NAIC are extensive and multifaceted, catering to members, the public, and insurers alike. Every function and operation within the NAIC is guided by two primary objectives: 1) to support state-based regulation, ensuring local oversight remains robust and responsive to the unique needs of each jurisdiction and 2) to assist regulators in navigating the complexities of an evolving insurance landscape.

NAIC's Focus: Members and Mission

Members are state insurance regulators from diverse backgrounds—but are united in their shared commitment to set standards and ensure fair, competitive, and healthy insurance markets to protect consumers. The singular mission of the NAIC is to support its members in these noble causes.

By staying true to these guiding principles, the NAIC not only fortifies the foundation of state-based regulation but also champions innovation and adaptability. Looking toward the future, the NAIC remains steadfast in its commitment to fostering a regulatory environment that balances consumer protection with market growth, embraces technological advancements, and promotes collaboration among all stakeholders.

Through its members, the NAIC stands as a beacon of leadership and stability, ensuring that the values of transparency, fairness, and consumer advocacy continue to shape the insurance industry for generations to come. To support these values, the NAIC offers a wide range of services, including consumer education, data collection and analysis, technology support, financial analysis and reporting, licensing, and testing. Additionally, the NAIC, through its committees, task forces, and working groups, develops model laws and regulations to help standardize insurance practices across member jurisdictions, ensuring a consistent and effective regulatory framework.

The NAIC's latest strategic plan, *State Connected,* was designed to prepare both staff and system infrastructure for the next ten-plus years of member and regulatory support. With 32 significant goals spread across six strategic focus areas, NAIC membership has laid a formidable path, effectively advancing insurance regulation while increasing automation and efficiency in the insurance market—a notable win that extends beyond regulators. By enhancing technology platforms, insurers will benefit from improved data accuracy and quicker processing times, all of which will help lead to a faster speed to market.

State Connected guides decisions on budget, personnel, and resources. Consequently, the 2025 budget was crafted with great care, considered the impact and resource needs for all requests and changes, and remained aligned with the strategic plan's goals. Beyond strategic objectives, the 2025 budget continues NAIC's commitment to supporting a variety of programs, products, and services in the financial solvency and market regulatory arenas. The

NAIC offers a wide range of systems, services, data, accreditation reviews, and many other essential services to assist insurance regulators in achieving their fundamental regulatory goals in a timely and cost-effective manner. Through this approach, the NAIC stands by to maintain the U.S. as one of the strongest and most resilient insurance markets in the world.

Support of the Membership

The NAIC is dedicated to assisting insurance regulators in serving the public interest, promoting a competitive marketplace, and ensuring the fair and equitable treatment of insurance customers. The focus is on maintaining the reliability, solvency, and financial stability of insurers while supporting and enhancing insurance regulation. By leveraging NAIC technology solutions, regulatory tools, and staff resources, members can achieve these objectives with significant cost savings. Membership in the NAIC offers a range of additional benefits and services, often at no charge. In addition to the numerous solvency tools and system access, members receive jurisdiction funding, training, analytical data, regulatory tools, and subject matter experts, all of which provide value that far exceeds the cost of membership. Many of NAIC's systems would be prohibitively expensive for jurisdictions to implement independently. Without the NAIC's collective support and economies of scale, the cost of regulating insurers would rise significantly, leading to higher expenses for insurers, and therefore consumers. Maintaining the NAIC's funding mechanisms benefits all parties involved by keeping regulatory costs manageable.

By the Numbers

NAIC products and services.

- **System for Electronic Rates & Forms Filing (SERFF)** 517,571 transactions processed in 2023.
- **Online Premium Tax for Insurance (OPT*ins*)** 191,719 transactions processed in 2023.
- **State Based Systems (SBS)** Back-office services, with varying functionality, currently provided to 36 jurisdictions.
- **Professional Designation Program** 2,254 designations awarded since the program's inception in 2006 through year-end 2023.
- **Center for Insurance Policy and Research (CIPR)** Nearly 150 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency.
- In 2023, the NAIC processed nearly **$6.2 Billion** in payments on behalf of the members, which represents a significant efficiency for both regulators and insurers.

A Focus on Consumers

The NAIC employs a multi-channel approach to help consumers make informed decisions and effectively utilize their insurance benefits. The website offers a wealth of information, including insurance advice articles, interactive learning modules, and the widely-used Life Insurance Policy Locator. The NAIC also runs various communication campaigns, provides the NAIC Home Inventory mobile app, and engages in media initiatives. Additionally, in the event of an unforeseen disaster, NAIC offers regulatory support to provide local regulators with additional tools and resources to assist the public in their time of need.

Valuable Products and Services

The NAIC seeks to support its mission through a wide variety of products and services offered to regulators, the insurance industry, and insurance consumers. For regulators and those in industry, the NAIC offers web-based systems that automate, standardize, and streamline regulatory processes by transmitting data and facilitating regulatory transactions. For consumers, the NAIC offers a wide range of informational products to help consumers make informed decisions.

The NAIC remains committed to maintaining and enhancing its infrastructure by staying abreast of emerging technologies. This commitment ensures that regulators are equipped with the necessary tools to protect consumers and promote a fair, competitive, and healthy insurance market. Accordingly, the 2025 budget includes eight fiscal impact statements (fiscals), five of which are focused on technology. These fiscals either continue ongoing modernization efforts, initiate new projects to upgrade critical regulatory support and communication systems, or provide additional resources to improve the speed of system enhancements. The remaining three fiscals will sponsor a significant study on long-term care insurance, provide the infrastructure needed for financial modeling of various types of securities held by insurers, and adds staffing in areas with critical needs.

Building the Budget

The NAIC is committed to transparency in both its budgeting process and overall operations. Each May, department managers evaluate the current year's revenues and expenses to forecast a year-end financial outlook. They then develop budget proposals for the upcoming year, including fiscals for new or significant projects, aligning requests with operational goals and member-driven initiatives. Managers focus on articulating the differences between the current year's budget and projected outcomes, as well as anticipated needs for the following year. This comprehensive process involves reviewing all projects, products, programs, services, committee directives, and technology initiatives in relation to the NAIC's mission, its strategic plan, and member directives. Following this, the NAIC's Chief Executive Officer and senior management conduct a detailed review of each department's budget to make necessary adjustments, ensuring alignment with the association's strategic and financial goals, before consolidating all requests into a single, unified budget.

Following the extensive development and internal review process, the budget is presented to the NAIC Officers, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee, and the full NAIC membership to ensure alignment before being released for public review and comment. To ensure transparency, a public hearing is conducted to gather comments before the NAIC Executive (EX) Committee and Plenary give final consideration and adopt the budget and proposals.

Expected Results for 2024

Based on actual operating results through June 30, 2024, the NAIC projects an operating loss of $3.8 million compared to a budgeted negative operating margin of $5.6 million, an improvement of $1.8 million. Investment income is projected to be a gain of $15.1 million, resulting in a net asset increase of $11.3 million, resulting in $205.2 million in projected net assets at year-end. While investment income is projected at $11.8 million over budget at year-end, it is important to note that $7.8 million is based on market valuations. Markets remain volatile and increasing uncertainty may impact future financial performance.

2025 Budget

The 2025 NAIC total operating budget reflects revenues of $163.7 million and expenses of $173.6 million, which represent a 6.3% and 8.8% increase, respectively, from the 2024 budget, resulting in $9.9 million in projected expenses over revenues. Viewed in relation to the 2024 projected totals, the 2025 budget represents an operating revenue increase of 4.5% and operating expense increase of 8.2%. Additional information about the 2025 budget is included in the detailed footnotes of the budget.

A fiscal is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of $100,000 or more either in the current budget or within the following few years' budgets, or which require more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact; and an assessment of the risks. The total financial impact of the eight fiscals included in the 2025 budget is $4.5 million in expenses and $5.9 million in capital spending. Additional information about each initiative is included in the various fiscal sections of the budget.

The 2025 budget also includes $3.3 million in investment income from the NAIC's long-term investment portfolio and cash equivalent investments. Investment income is composed of interest and dividends earned, reduced by investment management fees. Investment gains and losses are volatile and therefore are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2025 budget has a reduction in net assets of $6.7 million, with projected net assets of $198.5 million at the end of 2025.

Ensuring Financial Stability

The NAIC maintains an operating reserve designed to ensure organizational financial stability in the event of emerging business risks and uncertainties as well as to provide a means to absorb new priority initiatives pursued by NAIC membership. The association's reserve status is a paramount consideration in the budgeting process, as is the strong and prudent financial management of the NAIC's assets.

In 2022, following an extensive review of current and future risks and an evaluation of comparable organizations by an independent financial advisory firm, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved the establishment of a new methodology for determining NAIC's

2025 Fiscal Impact Statements

SERFF Modernization – 2025 Transition Stages
Continues funding of a multi-year initiative to improve the SERFF platform. In 2025, life and property/casualty users will move into the platform. This request includes the addition of two headcount.
- Expense of $716K for headcount, travel, and amortization.
- Capital of $5.9M for professional and other services.

VISION Support Team
Includes the addition of five technical staff to support the NAIC's Capital Markets and Investment Analysis Office's immediate and long-term development needs.
- Expense of $428K for staffing.

Enterprise Data Asset Management – Phase IV
Continues to build upon previous phases which delivered a cloud-based enterprise data platform populated with financial and regulatory data and includes the addition of one headcount for development and ongoing system maintenance.
- Expense of $719K for staffing and consulting.

Monitoring Collateralized Loan Obligations (CLOs)
Responds to a Valuation of Securities (E) Task Force initiative to maintain credit assessments for various insurer-owned securities, specifically CLOs. This fiscal includes the addition of one headcount for analytical support.
- Expense of $561K for staffing, consulting, and software.

Long-Term Care Insurance Experience Study
Sponsors an upcoming study with the Society of Actuaries. NAIC members will receive training as well as the study results for assisting with the expenses of this study.
- Expense of $100K for sponsorship.

Financial Data Repository (FDR) – Modernization Proof-of-Concept
Requests funding for a proof-of-concept (PoC) to explore a third-party solution to house and manage FDR's technical infrastructure. This will demonstrate the vendor's capabilities and potential benefits from utilizing their technology which will modernize the FDR platform.
- Expense of $450K for the PoC.

Member Customer Relationship Management
Provides funding for a customer relationship management system to improve member engagement and service quality.
- Expense of $454K for staffing, consulting, and software.

Operational Staffing
Requests the addition of eight headcount in operational and regulatory support areas.
- Expense of $1.1M for staffing, travel, and equipment.

operating reserves. The new methodology reviews three areas: working capital needed to maintain day-to-day operations over three months; an assessment of the funds needed to mitigate potential risks if certain events were to occur; and funding necessary for strategic initiatives planned in the upcoming three years.

Operating Reserve Target

The reserve makes assets available to allow an organization to take mission-related risks and to absorb or respond to changes in its environment or circumstances.

Based on the evaluation of these three areas, the current operating reserve target of $170.4 million was approved. This reserve reflects support of its business operations as well as the ongoing investments required to enhance and modernize many of the association's information technology and technical infrastructure applications. Details of these investments can be seen throughout the 2025 budget.

Preparing for the Unknown

The budget and operating reserve includes all activities anticipated to occur in 2025. However, situations or additional strategic or emerging projects may arise that require additional funding. In such an event, a funding request will be prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration and direction. Supplemental funding can also come from the Regulatory Modernization and Initiatives Fund, which is an extra layer of protection established in 2005 to manage requests that arise following the adoption and implementation of an annual budget. This fund is based on 1.5% of the NAIC's projected net assets as of December 31, 2025, or $3.0 million.

Contact Information

The NAIC appreciates the opportunity to present this budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming year. A summary of the key components of the 2025 budget is included in the budget overview.

Please contact Jim Woody, Chief Financial Officer, at jwoody@naic.org, or Carol Thompson, Senior Controller, at cthompson@naic.org, should you have any questions or need additional information.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2025 BUDGET
REVENUE AND EXPENSE BY LINE

Description	Reference	2023 Actual	2024 6/30/2024 Actual	2024 12/31/2024 Projected	2024 Budget	2024 Projected Variance	**2025 Budget**	2025 Increase (Decrease) from 2024 Budget	%	2025 Increase (Decrease) from 2024 Projected	%
Member Assessments	R1	$2,125,696	$1,064,803	$2,131,204	$2,131,205	($1)	**$2,420,261**	$289,056	13.6%	$289,057	13.6%
Database Fees	R2	40,955,141	43,655,514	43,656,336	42,308,824	1,347,512	**48,301,095**	5,992,271	14.2%	4,644,759	10.6%
Publications and Insurance Data Products	R3	18,397,511	11,589,231	18,316,224	18,262,175	54,049	**17,548,935**	(713,240)	-3.9%	(767,289)	-4.2%
Valuation Services	R4	33,620,467	11,239,765	32,581,050	33,105,400	(524,350)	**33,937,575**	832,175	2.5%	1,356,525	4.2%
Transaction Filing Fees	R5	21,924,289	12,057,114	22,388,949	23,209,726	(820,777)	**23,278,074**	68,348	0.3%	889,125	4.0%
National and Major Meetings	R6	2,605,556	924,027	2,964,234	2,977,913	(13,679)	**2,973,225**	(4,688)	-0.2%	8,991	0.3%
Education and Training	R7	398,826	149,000	368,621	368,319	302	**350,290**	(18,029)	-4.9%	(18,331)	-5.0%
License Fees and Administrative Services	R8	30,677,213	16,685,958	33,703,090	31,352,387	2,350,703	**34,637,821**	3,285,434	10.5%	934,731	2.8%
Other	R9	77,920	317,631	473,163	256,843	216,320	**254,016**	(2,827)	-1.1%	(219,147)	-46.3%
Total Operating Revenues		150,782,619	97,683,043	156,582,871	153,972,792	2,610,079	**163,701,292**	9,728,500	6.3%	7,118,421	4.5%
Salaries	E1	65,894,244	35,003,146	72,838,514	72,350,639	487,875	**78,187,077**	5,836,438	8.1%	5,348,563	7.3%
Temporary Personnel	E2	870,817	349,825	741,896	801,552	(59,656)	**491,094**	(310,458)	-38.7%	(250,802)	-33.8%
Payroll Taxes	E3	5,062,210	2,920,896	5,539,646	5,580,512	(40,866)	**6,185,220**	604,708	10.8%	645,574	11.7%
Employee Benefits	E4	12,378,750	6,920,719	14,651,225	13,767,525	883,700	**15,158,263**	1,390,738	10.1%	507,038	3.5%
Employee Development	E5	646,511	338,094	862,073	963,501	(101,428)	**853,713**	(109,788)	-11.4%	(8,360)	-1.0%
Professional Services	E6	16,477,353	6,645,487	20,053,326	18,999,561	1,053,765	**21,805,006**	2,805,445	14.8%	1,751,680	8.7%
Computer Services	E7	8,499,674	4,235,050	8,676,036	8,926,699	(250,663)	**8,822,896**	(103,803)	-1.2%	146,860	1.7%
Travel	E8	5,570,248	2,556,273	5,823,536	6,256,314	(432,778)	**6,544,523**	288,209	4.6%	720,987	12.4%
Occupancy and Rental	E9	4,845,683	2,296,232	4,546,183	4,725,987	(179,804)	**4,713,456**	(12,531)	-0.3%	167,273	3.7%
Software License Fees	E10	$8,342,811	4,993,242	10,035,274	10,414,055	(378,781)	**11,954,688**	1,540,633	14.8%	1,919,414	19.1%
Depreciation and Amortization	E11	3,618,383	1,585,417	4,286,091	5,617,094	(1,331,003)	**6,841,100**	1,224,006	21.8%	2,555,009	59.6%
Operational	E12	2,082,259	1,180,840	1,982,282	1,797,706	184,576	**1,918,766**	121,060	6.7%	(63,516)	-3.2%
Library Reference Materials	E13	388,412	197,921	387,120	390,291	(3,171)	**419,982**	29,691	7.6%	32,862	8.5%
National and Major Meetings	E14	6,259,434	2,848,218	5,857,805	5,113,270	744,535	**5,614,179**	500,909	9.8%	(243,626)	-4.2%
Education and Training	E15	183,361	13,688	189,682	220,039	(30,357)	**259,816**	39,777	18.1%	70,134	37.0%
Grant and Zone	E16	2,118,802	847,542	2,596,964	2,445,000	151,964	**2,525,000**	80,000	3.3%	(71,964)	-2.8%
Other	E17	1,285,134	1,018,284	1,362,937	1,301,572	61,365	**1,620,171**	318,599	24.5%	257,234	18.9%
Total Operating Expenses		144,524,086	73,950,874	160,430,590	159,671,317	759,273	**173,914,950**	14,243,633	8.9%	13,484,360	8.4%
Revenues Over/(Under) Expenses before Investment Income		6,258,533	23,732,169	(3,847,719)	(5,698,525)	1,850,806	**(10,213,658)**	(4,515,133)		(6,365,939)	
Investment Income	II1	17,100,356	7,346,185	15,108,985	3,294,000	11,814,985	**3,276,000**	(18,000)		(11,832,985)	
Revenues Over/(Under) Expenses		$23,358,889	$31,078,354	$11,261,266	($2,404,525)	$13,665,791	**($6,937,658)**	($4,533,133)		($18,198,924)	

A detailed analysis of each line item is included in the Revenue Detail, Expense Detail, and Investment Income Detail sections.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2025 BUDGET WITH FISCAL IMPACT STATEMENTS
FISCAL IMPACT STATEMENTS

Fiscal Number	Description	2025 Budget: Capital Expenditures	2025 Budget: Revenues	2025 Budget: Expenses	**Net Impact 2025 Budget**
	Total Revenues Over/(Under) Expenses Before Fiscals and Investment Income	$6,607,712	$163,686,292	$169,430,423	**($5,744,131)**
1	SERFF Modernization - 2025 Transition Stages	5,874,563	15,000	715,983	**(700,983)**
2	VISION Support Team			428,004	**(428,004)**
3	Enterprise Data Asset Management - Phase IV			718,990	**(718,990)**
4	Monitoring Collateralized Loan Obligations (CLOs)			560,883	**(560,883)**
5	Long-Term Care Insurance Experience Study			100,000	**(100,000)**
6	Financial Data Repository (FDR) - Modernization Proof-of-Concept			450,000	**(450,000)**
7	Member Customer Relationship Management			453,651	**(453,651)**
8	Operational Staffing			1,057,016	**(1,057,016)**
	Total Fiscal Revenues Over/(Under) Expenses	5,874,563	15,000	4,484,527	**(4,469,527)**
	Investment Income		3,276,000		**3,276,000**
	Total Revenues Over/(Under) Expenses After Fiscals and Investment Income	$12,482,275	$166,977,292	$173,914,950	**($6,937,658)**

Date: December 6, 2024

To: All NAIC Members and Interested Parties

From: Jon Godfread, North Dakota Insurance Commissioner and NAIC-President Elect
Gary Anderson, NAIC Chief Executive Officer
Andy Beal, NAIC Chief Operating Officer and Chief Legal Officer
Jim Woody, NAIC Chief Financial Officer

Re: Summary of Comments on the Proposed 2025 NAIC Budget

In response to the Executive (EX) Committee's and Internal Administration (EX1) Subcommittee's request for comment on the NAIC's proposed 2025 budget, the NAIC received one comment letter on the proposed budget after it was released for public comment on October 31, 2024, from the National Association of Mutual Insurance Companies (NAMIC) (Attachment One). This memorandum summarizes the submitted comments and includes NAIC's responses.

A public hearing will be held on December 10th at 12:00 p.m. CT to discuss these comments. Participation instructions for the public hearing can be accessed at https://content.naic.org/about_budget.htm.

Opening Remarks

The NAIC appreciates NAMIC's continued support for the state-based system of insurance regulation and its recognition of the financial and operational challenges faced by both regulators and insurers. As NAMIC noted, the evolving landscape of risks—such as extreme weather events, inflation, litigation pressures, and challenges within reinsurance markets—requires an even closer partnership between regulators, the industry, and the NAIC. We value NAMIC's acknowledgment of NAIC's ongoing efforts to ensure state insurance departments have access to the necessary tools, resources, and support to navigate these challenges.

Additionally, we appreciate NAMIC's recognition of the transparency provided in the proposed budget, particularly the eight fiscal impact statements. NAMIC's acknowledgment of the balance between technology-focused initiatives and operational enhancements reflects NAIC's commitment to modernizing tools and capabilities in a financially prudent manner that supports our members while avoiding regulatory redundancies. NAMIC continues to commend the NAIC and its members for their steadfast commitment to the multi-year strategic plan 'State Connected.' The NAIC also appreciates NAMIC's recognition that the tools and projects outlined in the 2025 budget—specifically those supported by fiscal impact statements—further enhances effective insurance regulation. NAMIC has provided comments on various fiscal impact statements as follows:

1. System for Electronic Rates and Forms Filing (SERFF) Modernization – 2025 Transition Stages

NAMIC expressed strong support for NAIC's continued investment in the SERFF modernization project, emphasizing that SERFF remains crucial to insurers' daily operations, particularly in rate and form filings. They acknowledged the ongoing multi-year initiative, noting the 2025 allocation of over $6 million for the project, which includes additional staff and consulting. NAMIC highlighted the importance of improving filing efficacy and speed-to-market, underscoring that these are key objectives of the modernization effort, which would greatly benefit their members. In line with their previous comments, NAMIC stressed the need for continuous stakeholder engagement and suggested that NAIC staff participate in future NAMIC Compliance Council meetings to provide updates. NAMIC also recommended outreach to other industry organizations, such as the Association of Insurance Compliance Professionals, to solicit valuable feedback from SERFF users.

NAIC Response: The NAIC appreciates NAMIC's ongoing support for the SERFF modernization initiative. We agree that SERFF is an essential tool for both regulators and insurers, and we are committed to improving its efficiency, filing accuracy, and speed-to-market. These upgrades will help streamline rate and form filings, enhancing efficiencies for all stakeholders in the regulatory process.

We highly value NAMIC's emphasis on continuous engagement with stakeholders and recognize the importance of maintaining open lines of communication throughout the development process. To facilitate this, the NAIC SERFF development team will continue to host sessions at all NAIC National Meetings, where both regulators and industry participants can provide feedback. Additionally, we will conduct another, dedicated SERFF workshop in Kansas City in 2025, specifically for industry participants and we welcome input as well as attendance from NAMIC members and all others in industry who wish to attend either in person or virtually at other SERFF specific sessions. NAIC staff will also reach out to NAMIC, ensuring they can share upcoming development sessions with their members. Our steering committee and project focus groups remain active, ensuring that feedback from end-users continues to inform the project at each stage of its development.

The NAIC remains committed to working closely with regulators and the industry to ensure that the final product meets the needs of all users and contributes to a more efficient regulatory environment. We look forward to continued collaboration in refining and enhancing the SERFF platform. Interested parties are encouraged to review updates or participate in a focus group by visiting https://www.serff.com/serff_modernization.htm.

2. VISION Support Team and Monitoring of Collateralized Loan Obligations (CLOs)

NAMIC acknowledged the appropriateness of adding staff to the Capital Markets and Investment Analysis Office (collectively referred to as the IAO) and a position dedicated to analytical support of CLOs, as directed by the Valuation of Securities (E) Task Force (VOSTF). They emphasized the valuable role the IAO plays in the regulatory system but suggested further clarification on both short-term and long-term personnel and office needs.

NAIC Response: The NAIC values NAMIC's recognition of the critical role played by the IAO in supporting insurance regulators and the broader regulatory system. The ability to provide independent, expert analysis on increasingly complex investment instruments is fundamental to regulator's understanding of investment risk as well as maintaining the solvency and financial stability of insurers.

The decision to add a dedicated analyst for CLOs reflects NAIC's proactive approach responding to the needs of the VOSTF, addressing emerging risks, and ensuring that regulators have the necessary resources

to effectively assess evolving financial market challenges. The personnel additions, beyond the CLO analyst, will strengthen the IAO's capabilities by improving the velocity of system enhancements as requested by regulators and the VOSTF. These new positions will include two software engineers, a software quality engineer, a software quality analyst and a business analyst, all focused on system design and enhancement.

It is important to note that these positions will initially focus on addressing the backlog of work identified in the 2024 *IT VISION System Enhancements* fiscal impact statement and other long-overdue enhancements. This backlog represents approximately 3-5 years of work, and these new personnel are vital for addressing these needs while ensuring that the IAO can continue to meet the long-term objectives identified by the VOSTF and NAIC members.

In response to longer term needs, we would like to highlight that the NAIC's Financial Condition (E) Committee initiated a *Framework for Regulation of Insurer Investments – A Holistic Review* initiative. This initiative includes several critical objectives but, in short, will result in the development of a mechanism to reduce "blind" reliance on credit rating provider (CRP) ratings, while maintaining their use under a robust due diligence framework. The outcome of this long-term project could fundamentally reshape how the IAO operates by aligning its focus more sharply on administering and maintaining this holistic due diligence framework. These enhancements will ensure that the SVO remains equipped to meet evolving regulatory needs while continuing to prioritize accuracy, efficiency, and regulator responsiveness.

Interested parties or firms wishing to review the RFP are encouraged to visit https://content.naic.org/fiscals-requests-proposal.

3. Enterprise Data Management – Phase IV

Consistent with previously offered comments on this initiative, NAMIC acknowledges the importance of the NAIC's ongoing efforts to enhance its data environment, particularly given the growing volume of data sets collected, analyzed, and stored. NAMIC supports the initiative as a beneficial use of funds, emphasizing the value of avoiding duplicative data gathering efforts and improving regulator access to relevant data, tools, and training.

NAMIC highlights the importance of transparency and education across the NAIC enterprise, expressing encouragement about the newly announced Data Call Study Group under the Innovation, Cybersecurity and Technology (H) Committee. However, NAMIC reiterates its caution against the NAIC performing functions that should remain exclusively within the purview of regulators. They emphasize the need for public accountability and collaborative discussions regarding the purpose, process, and protections related to data gathering and sharing.

NAMIC also reflects on lessons learned from the 2024 Property and Casualty Insurance Market Intelligence (PCMI) data call, underscoring the importance of ensuring that future data calls are conducted with the right legal authorities and protections in place. They encourage a careful approach to ensure meaningful and efficient data collection, while reducing unnecessary or less valuable efforts.

NAIC Response: The NAIC appreciates NAMIC's observations and continued support for its efforts to enhance the data environment, particularly acknowledgment of the value in improved access to relevant data, tools, and training. These initiatives are designed to better equip regulators with efficient, streamlined tools, reducing duplication of efforts and enabling deeper insights into regulated entities. By consolidating datasets and databases into a unified platform, the NAIC aims to provide regulators with a

more comprehensive view of the industry while making data analysis more accessible through customizable tools that do not require specialized programming expertise.

NAMIC's emphasis on avoiding duplicative data collection efforts is well-taken. Our members and the NAIC remain committed to reducing burdens on regulators and the industry by centralizing efforts where possible. Without the NAIC's facilitative role, individual jurisdictions would face significant financial burdens in developing and executing their own data calls, increasing costs and administrative tasks for insurers and regulators alike. As always, the NAIC operates under the guidance of its members and remains steadfast in its role as a facilitator rather than a regulator. The centralized infrastructure provided by the NAIC enables efforts that would otherwise be uneconomical or operationally inefficient for individual jurisdictions. Nonetheless, we remain committed to acting solely under the direction of our members.

Regarding the newly established Data Call Study Group, the NAIC shares NAMIC's enthusiasm for fostering collaboration and transparency in the data collection process. This group will serve as a forum for regulators, industry stakeholders, and other interested parties to evaluate and refine data collection methodologies, ensuring that the questions posed and the data gathered are aligned with the intended regulatory outcomes and legal frameworks.

The NAIC also acknowledges NAMIC's observations about lessons learned from the 2024 PCMI data call. These experiences underscore the importance of open dialogue and careful planning to ensure data requests are both meaningful and appropriately structured. We value NAMIC's commitment to productive collaboration and transparency in data efforts, and the NAIC will continue to prioritize these principles to strengthen confidence in the data collection process across its enterprise.

4. Financial Data Repository (FDR) – Modernization Proof of Concept

NAMIC recognizes the potential benefits of exploring third-party solutions to manage FDR's technical infrastructure, particularly if such an approach offers long-term cost savings through modernization and outsourcing. However, NAMIC stresses the importance of the NAIC being mindful of its relationships with third-party vendors, especially in relation to sensitive financial data, given the increased focus by regulators on third-party vendors within the insurance industry. NAMIC continues to support the enhancement of information technology security across the NAIC, emphasizing that, as custodians of sensitive information, the NAIC must prioritize data protection in all technological investments and governance decisions, just as regulators require of the entities they oversee.

NAIC Response: The NAIC echoes NAMIC's comments regarding the exploration of third-party solutions to house and manage FDR's technical infrastructure. The NAIC recognizes the potential for long-term cost savings and efficiency improvements through modernization and outsourcing and is committed to carefully evaluating such solutions where appropriate. The NAIC is mindful of the importance of maintaining robust relationships with third-party vendors, especially when it comes to handling sensitive financial information and will continue to prioritize data security and transparency in its dealings with all external partners.

As stewards of critical insurer and policyholder data, the NAIC remains unwavering in its commitment to safeguarding sensitive information. As part of the ongoing modernization efforts, we ensure that all technology-related investments are made with stringent security measures in place, aligning with the same standards of protection that regulators expect from the entities they oversee. The NAIC will continue

to prioritize data security in all future initiatives, while also balancing the need for cost-effective, innovative solutions to meet the demands of a rapidly evolving regulatory landscape.

5. Member Customer Relationship Management (CRM)

NAMIC supports the NAIC's pursuit of an enterprise-wide CRM system to address challenges with managing member and stakeholder information across various siloed databases. This improvement will reduce manual tasks, enhance accuracy, and streamline record-keeping, ultimately enabling more efficient and transparent communication with regulators and stakeholders.

NAIC Response: The NAIC appreciates NAMIC's support for the initiative to implement an enterprise-wide member-based CRM system. This initiative will improve efficiency, and accuracy, and will enhance communication with regulators and stakeholders. We believe this system will significantly advance internal operations, ensuring better coordination and transparency across the organization.

6. Operational Staffing

NAMIC appreciates the detailed descriptions of the eight additional operational staff positions outlined in the final fiscal. While recognizing the need for adequate staffing to provide efficient assistance to regulators, NAMIC encourages the NAIC to maintain a balance that ensures resources are effectively utilized without duplication of effort or encroaching on the regulatory responsibilities of state insurance departments.

NAIC Response: The NAIC is committed to carefully balancing staffing needs with the critical role it plays in supporting insurance regulators across 56 jurisdictions. NAIC's support is broad and includes maintaining several vital regulatory infrastructures such as the Financial Data Repository, SERFF, and a host of other items, all of which are indispensable tools for state regulators.

In addition to these technical systems, the NAIC supports various other initiatives, including financial and investment analysis, committee support, regulatory training, hosts national meetings, and funds numerous activities that provide ongoing assistance to regulators. The NAIC's efforts directly support thousands of insurance regulators nationwide, contributing to consumer protection and the stability of the insurance market.

That said, the NAIC continually ensures the effectiveness of these broad operations and is equally committed to reviewing and refining our processes to maintain efficiency. This ongoing evaluation helps us ensure that we deliver the best possible support to state regulators while maintaining a streamlined and effective operational framework.

Concluding Comments

The NAIC values the engagement and inquiries shared by NAMIC. Transparency and collaboration are deeply embedded in the NAIC's processes, strategic plan, and culture, serving as cornerstones of its success for over 150 years. The NAIC takes a comprehensive approach to developing its annual budget, drawing on input from NAIC staff, officers, the Executive Committee, and all its members.

As part of its commitment to transparency, the NAIC publishes a proposed budget for public review and welcomes feedback from interested parties. This feedback is thoughtfully considered and addressed through written responses and in an open Public Hearing. This inclusive process ensures that the NAIC effectively supports insurance regulators in their mission to protect policyholders and maintain the financial stability of the insurance industry. The NAIC strives to do so in a fiscally responsible manner that

minimizes impacts on the industry wherever possible and remains dedicated to identifying opportunities to reduce costs, enhance operational efficiency, and deliver exceptional support to its members, regulators, stakeholders, and insurance consumers.

Attachment 1

NAMIC®
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

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November 25, 2024

Jim Woody
Chief Financial Officer
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

VIA Email Transmission: jwoody@naic.org

RE: NAMIC Comments – NAIC Proposed 2025 Budget

Dear Mr. Woody:

The following comments are submitted on behalf of the National Association of Mutual Insurance Companies[1] regarding the NAIC's proposed 2025 budget.

NAMIC and its members have long been staunch supporters of the state-based regulatory system; as such, we are very mindful of the financial challenges facing state insurance departments. As insurers continue to confront a new era of risk characterized by increased extreme weather events, inflationary pressures, litigation abuse, and novel challenges in reinsurance markets, it is imperative that regulators and a right-sized NAIC remain attentive to the need for streamlined and efficient regulatory tools, standards, and guidance. We understand that the NAIC also faces budgetary challenges related to the increased cost of labor, travel, and most products and services needed to run a successful organization that accomplishes much in defense of state-based regulation. As always, we offer these comments in the spirit of collaboration and a commitment to work together on behalf of our member carriers and your member regulators.

Continued Implementation of "State Connected"

We appreciate the continued financial commitment to the multi-year "State Connected" strategic plan to better connect and empower individual NAIC members and their staffs – the plan builds out several

[1] NAMIC membership includes nearly 1,500 member companies. The association supports regional and local mutual insurance companies on main streets across America and many of the country's largest national insurers, including 7 of the top 10 auto insurers in the country. NAMIC member companies write $357 billion in annual premiums. Our members account for 69 percent of homeowners, 56 percent of automobile, and 31 percent of the business insurance markets. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

programs and services NAMIC has applauded in previous years and continues to support.[2] Efforts to make state regulators better at maintaining the reliability, solvency, and financial stability of their markets are important, and the NAIC creates economies of scale that facilitate many processes for state regulators. At the same time, we urge caution and a reminder that it is state regulators, not the NAIC, that are responsible for the actual regulation of licensed entities in their states.

We commend the NAIC for its transparency where the budget is concerned, and for highlighting the eight major fiscal impact statements in the proposed 2025 budget – five of which are technology based and three focused on compilation of information, enhancing analytical capabilities, and operational capabilities. We note that five of the eight fiscal impact statements involve addition of headcount, bringing the proposed NAIC total headcount to 559 – more than all but four NAIC member state Departments of Insurance. While this growth may be appropriate as the NAIC is asked to do more by its members, taking on an even more prominent role in compiling and analyzing data increases the risk of blurring the line between standard-setting and regulatory activity. With that in mind, we provide additional comments regarding some of the specific fiscals:

SERFF Modernization – 2025 Transition Stages

The NAIC 2025 budget includes more than $6 million toward the multi-year initiative to improve the SERFF platform, including two additional staff and $5.9 million in capital consulting and software. While everything the NAIC does affects carriers in some fashion, it is safe to say that SERFF is among the most crucial for day-to-day operations; it is in the filing of rates and forms that the rubber meets the road for much of insurance regulation. The ongoing modernization project seeking to improve rate and form filing efficacy and speed-to-market will be a welcome upgrade for NAMIC member staff involved in the filing process. As you continue to allocate funds, resources, personnel, and time to these upgrades, we encourage continuous engagement and outreach to appropriate stakeholders who are deeply affected by any changes. Consistent with our offer from last year, we would welcome attendance, participation, and updates by appropriate NAIC staff at a future meeting of the NAMIC Compliance Council and encourage you to reach out proactively to industry organizations like the Association of Insurance Compliance Professionals, where you are likely to get the most productive feedback from SERFF users.

VISION Support Team and Monitoring of Collateralized Loan Obligations (CLOs)

Adding staff to the Capital Markets and Investment Analysis Office, as well as a staffer dedicated to analytical support of CLOs at the specific initiative from the Valuation of Securities (E) Task Force appear appropriate in light of the stated long-term development needs for the office, which plays a valuable role in the insurance regulatory system. There may be value in the NAIC more publicly highlighting the specific roles contemplated for better understanding of the fiscal and personnel needs, as well as outlining additional anticipated growth of the office and roles in future years.

[2] https://content.naic.org/about/state-connected

Enterprise Data Management – Phase IV

The NAIC's continued efforts to update its data environment is important, particularly as more data sets are collected, analyzed, and housed by the NAIC. At the outset of this effort several years ago, NAMIC noted that the NAIC supporting its members with improved access to relevant data, tools, and training was a worthwhile use of funds. We agree that there is value in avoiding duplicative data gathering efforts, and we encourage additional education for regulators, their staff, and interested parties (as appropriate) to inform data collection efforts across the entire NAIC enterprise – we are encouraged by the newly announced Data Call Study Group that will report to the (H) Committee.

NAMIC continues to caution against the NAIC performing functions only appropriate for regulators; even with legal memoranda of understanding with states in place, the NAIC remains a private entity and should not become a clearinghouse for sensitive and proprietary supervisory information about regulated entities.

Public accounting and collaborative opportunities for open discussion of what, when, how, and why data is being gathered by the NAIC, as well as if and how it is being shared with outside parties would bolster confidence in both the process and the value of data gathering exercises, while potentially also identifying those collections that are less valuable and any that might be discontinued. The 2024 experience with the PCMI data call has provided many valuable lessons and opportunities for learning that we hope the industry and regulators can use to ensure that in the future, the right questions are asked the right way with the right legal authorities cited and protections in place to produce the most meaningful responses and useful results for all parties involved.

Financial Data Repository (FDR) – Modernization Proof of Concept

Exploring a third-party solution to house and manage FDR's technical infrastructure may be appropriate, particularly if there are long term cost savings to be had from modernizing and outsourcing the platform. We note that at a time when regulators and the NAIC are showing increasing interest in the scope and use of third-party vendors by regulated insurers through the Third-Party Data and Models (H) Task Force, it is only fair that the NAIC be especially mindful of its own relationships with third-parties and vendors, particularly where financial information is concerned.

As we have stated in previous years, we enthusiastically support enhancements of information technology security across the NAIC – as we see technology evolve, we are reminded that regulators and the NAIC are entrusted with the safekeeping of extremely sensitive and valuable insurer and policyholder information. To the extent that the NAIC is investing in technology related projects, we encourage the NAIC to prioritize information security and data protection in all budgetary and governance considerations, just as regulators continuously require regulated entities to do.

Member Customer Relationship Management (CRM)

The fact that currently member and stakeholder information is stored across the NAIC in manually maintained spreadsheets, documents, and various siloed databases is good reason to pursue an enterprise-wide CRM that could reduce manual tasks, reduce errors, and improve both record-keeping services and opportunities for consistent, strategic, and transparent communication with regulators and stakeholders. We expect this to be a valuable improvement for NAIC operations.

Operational Staffing

We appreciate the detailed descriptions of the eight additional operational staff positions in the final fiscal. As always, we encourage the NAIC to strive for the right balance of having enough staff and resources to provide efficient assistance to regulators without being wasteful or intruding into the regulation of insurance. Of particular interest to NAMIC is the proposed addition of a Senior Property and Casualty Manager to assist with numerous initiatives of the Property and Casualty Insurance (C) Committee to support the property and casualty market intelligence data call (PCMI Data Call) and other NAIC strategic priorities including support for the Climate and Resiliency (EX) Task Force. We look forward to working closely with this individual once they join the NAIC staff.

General / Closing Comments

The role of the insurance industry and our partnerships with state regulators have never been more important to consumers all around the country than they are now. Just as NAMIC members continue to carefully assess every expenditure, investment, and strategic decision, the NAIC's growth and expansion should remain proportionate to expected needs and tempered by continuous review. Insurance regulators and the NAIC are uniquely positioned to solve for inefficiencies and remove redundancies that result in excessive costs to all insurance stakeholders.

NAMIC appreciates the opportunity to provide input on the NAIC 2025 annual budget. We believe the NAIC continues to responsibly manage the growing finances of the organization and is investing in projects that will benefit the states' insurance markets and consumers alike. Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies, and their policyholders.

Sincerely,

Tony Cotto
Public Policy Counsel

Draft: 12/4/24
Pending Adoption by the Executive (EX) Committee and Plenary, Dec. 18, 2024

2025 Proposed Charges

EXECUTIVE (EX) COMMITTEE

The mission of the Executive (EX) Committee is to manage the affairs of the NAIC in a manner consistent with its Articles of Incorporation and its Bylaws.

Ongoing Support of NAIC Programs, Products or Services

1. The **Executive (EX) Committee** will:
   A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2025 Commissioners' Conference.
   B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2025 as necessary.
   C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
   D. Consider requests from NAIC members for friend-of-the-court briefs.
   E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
   F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
   G. Conduct strategic planning on an ongoing basis.
   H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
   I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
   J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
   K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
   L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Climate and Resiliency (EX) Task Force, Nov. 6, 2024

2025 Proposed Charges

CLIMATE AND RESILIENCY (EX) TASK FORCE

The mission of the Climate and Resiliency (EX) Task Force is to serve as the coordinating NAIC body for discussion and engagement on climate-related risk and resiliency issues, including dialogue among state insurance regulators, industry, and other stakeholders.

1. The **Climate and Resiliency (EX) Task Force** will:

    A. Consider how state insurance departments that opt into the insurer's climate risk disclosure reporting requirement review the information received.
    B. Evaluate financial regulatory approaches to climate risk and resiliency in coordination with other relevant committees, task forces, and working groups, such as the International Insurance Relations (G) Committee, the Property and Casualty Insurance (C) Committee, the Financial Condition (E) Committee, and the Financial Stability (E) Task Force, including:
        i. Evaluation of the use of modeling by carriers and their reinsurers concerning climate risk.
        ii. Evaluation of how rating agencies incorporate climate risk into their analysis and governance.
        iii. Evaluation of the potential solvency impact of insurers' exposures, including both underwriting and investments, to climate-related risks.
        iv. Evaluation and development of climate risk-related disclosure, stress testing, and scenario modeling.
    C. Consider innovative insurer solutions to climate risk and resiliency, including:
        i. Evaluation of how to apply technology and innovation to the mitigation of storm, wildfire, other climate risks, and earthquake.
        ii. Evaluation of insurance product innovation directed at reducing, managing, and mitigating climate risk, as well as closing protection gaps.
    D. Identify adaptation, resilience, and mitigation issues and solutions related to the insurance industry.
    E. Consider pre-disaster mitigation and resiliency and the role of state insurance regulators in resiliency.
    F. Engage with the Center for Insurance Policy and Research (CIPR) Catastrophe Modeling Center of Excellence (COE) regarding climate-related risk and mitigation research and analysis.

NAIC Support Staff: Aaron Brandenburg/Libby Crews

Draft 11/6/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Government Relations (EX) Leadership Council, Nov. 6, 2024

2025 Proposed Charges

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council coordinates the NAIC's ongoing work with the federal government and state government officials on legislative and regulatory policy. The Leadership Council, in conjunction with the NAIC's other standing committees, is responsible for quickly responding to federal legislative and regulatory developments that affect insurance regulation.

The mission of the Government Relations (EX) Leadership Council is to develop, coordinate, and implement the NAIC's legislative, regulatory, and outreach initiatives. The Leadership Council will devise strategies for NAIC action and promote the participation of all NAIC members in the NAIC's government relations initiatives.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Government Relations (EX) Leadership Council** will:
   A. Monitor, analyze, and respond to federal legislative and regulatory actions and other issues of importance to the NAIC membership.
   B. Work with other standing committees, task forces, and working groups to help develop and communicate the NAIC's policy views to federal and state officials on pending legislation and regulatory issues by involvement of NAIC members through testimony, correspondence, and other approaches.
   C. Develop a strategy and program for directly engaging NAIC members with the U.S. Congress and federal agencies to advocate for NAIC objectives and the benefits and efficiencies of state-based insurance regulation.
   D. Secure broader participation from NAIC membership on all government affairs advocacy initiatives.
   E. Report to the Executive (EX) Committee on all activities and matters relating to the annual charges of the Leadership Council.

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb/Shana Oppenheim

Draft: 8/26/24
Adopted by Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Internal Administration (EX1) Subcommittee, Aug. 26, 2024

2025 Proposed Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

The mission of the Internal Administration (EX1) Subcommittee is to monitor the operations of the NAIC, including: 1) preparing a budget for Executive (EX) Committee review; 2) providing direction on personnel issues; 3) approving emergency expenditures; 4) evaluating the chief executive officer (CEO); and 5) assisting the CEO in resolving competing demands for NAIC staff resources.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Internal Administration (EX1) Subcommittee** will:
   A. Review and approve all expenditures of funds not included in the annual budget by considering any fiscal impact statements of unbudgeted resource requests and reporting its actions to the Executive (EX) Committee.
   B. Annually work with the CEO and other senior management to review the business operations plan, which will incorporate the Executive (EX) Committee's strategic management initiatives and report its actions to the Committee.
   C. Oversee a review of any management areas of the NAIC that should be designated for formal operational reviews by working with the CEO.
   D. Oversee the development, revision, and delivery of all NAIC education programs, or the addition of new programs, by coordinating with other committees, as appropriate, and providing direction to the CEO.
   E. Receive a report at each national meeting from the Audit Committee, which will be chaired by the secretary-treasurer. The Audit Committee will meet with NAIC management at or before each national meeting, or more frequently as necessary, to review the NAIC financial statements and hear reports from NAIC management on emerging financial issues for the NAIC, and it will report such information to the Subcommittee. The Audit Committee shall also carry out the following activities pursuant to its charter:
      i. Engage the NAIC's independent accountants with respect to the annual audit. This will include the appointment of an independent audit firm, a review of the results of the annual audit, and discussions with the independent auditors and NAIC management to ensure all audit comments or suggestions are addressed in a timely manner.
      ii. Engage the NAIC's service advisory firm. This will include the selection of an independent firm to provide Statement on Standards for Attestation Engagements (SSAE) services to the NAIC.
   F. Serve as the primary liaison between NAIC membership and the NAIC investment advisor, or appoint a subcommittee to act in that capacity, including receiving reports on the performance of the NAIC's investment portfolio and, from time to time, meeting directly with investment firm representatives to hear periodic reports and recommendations.
   G. Review and revise, as necessary and appropriate, the criteria and categories for registrants at national meetings.
   H. Conduct evaluations of the CEO and make appropriate recommendations to the Executive (EX) Committee. Consult with the CEO on the compensation of senior management.

NAIC Support Staff: Andrew J. Beal/Kay Noonan/Jim Woody

Draft: 10/11/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Life Insurance and Annuities (A) Committee, Oct. 21, 2024

2025 Proposed Charges

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

The mission of the Life Insurance and Annuities (A) Committee is to: 1) consider issues relating to life insurance and annuities; and 2) review new life insurance products.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Insurance and Annuities (A) Committee** will:
   A. Monitor the activities of the Life Actuarial (A) Task Force.

2. The **Annuity Suitability (A) Working Group** will:
   A. Consider how to promote greater uniformity in the adoption of the *Suitability in Annuity Transactions Model Regulation* (#275) across NAIC member jurisdictions.

NAIC Support Staff: Jennifer R. Cook/Jolie H. Matthews

Draft: 9/23/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Life Insurance and Annuities (A) Committee, Oct. 21, 2024
Adopted by the Life Actuarial (A) Task Force, Oct. 9, 2024

2025 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

The mission of the Life Actuarial (A) Task Force is to identify, investigate, and develop solutions to actuarial problems in the life insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Life Actuarial (A) Task Force** will:
   A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      i. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements for life insurance and annuities, as appropriate.
      ii. Provide recommendations for guidance and requirements for accelerated underwriting (AU) and other emerging underwriting practices, as needed.
      iii. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      iv. Provide recommendations and changes to other reserve and nonforfeiture requirements to address issues as appropriate and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      v. Work with the selected vendor to develop and implement the new generator of economic scenarios (GOES) for use in regulatory reserve and capital calculations.
      vi. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark these with PBR requirements.
      vii. Coordinate with the Reinsurance (E) Task Force on actuarial items related to reinsurance.

2. The **Experience Reporting (A) Subgroup** will:
   A. Continue the development of the experience reporting requirements within the *Valuation Manual*. Provide input on the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

LIFE ACTUARIAL (A) TASK FORCE (*Continued*)

3. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material GOES updates, either driven by periodic model maintenance or changes to the economic environment, and provide recommendations.
   C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant GOES updates, and maintain a public timeline for GOES updates.
   D. Support the implementation of the GOES for use in statutory reserve and capital calculations.
   E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

4. The **Life and Annuity Illustration (A) Subgroup** will:
   A. Consider changes to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020* (AG 49-A), as needed. Provide recommendations for the consideration of changes to the *Life Insurance Illustrations Model Regulation* (#582) to the Task Force, as needed.
   B. Consider any guidance, actions, or recommendations that may be necessary to regulate annuity illustration practices.

5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate.

6. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the variable annuities (VA) reserve framework and RBC calculation, and determine if revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of VA capital and reserve requirements and reporting.

7. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Recommend requirements for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Task Force, as appropriate. Continue working with the Academy on a PBR methodology for non-variable annuities.

NAIC Support Staff: Scott O'Neal/Jennifer Frasier

Draft: 11/8/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024

2025 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

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

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

Draft: 9/30/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024
Adopted by the Health Actuarial (B) Task Force, Oct. 1, 2024

2025 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

The mission of the Health Actuarial (B) Task Force is to identify, investigate, and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
   F. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

2. The **Long-Term Care Actuarial (B) Working Group**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      ii. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      iii. Develop LTCI experience reporting requirements in VM-50 and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
      iv. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

NAIC Support Staff: Eric King

Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024
Adopted by the Regulatory Framework (B) Task Force, Nov. 4, 2024

2025 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group, and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2025.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage and short-term, limited-duration (STLD) coverage.

2. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), and modify it, as necessary, to reflect developments related to ERISA. Report annually.

REGULATORY FRAMEWORK (B) TASK FORCE *(Continued)*

3. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the MHPAEA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

4. The **Pharmaceutical Benefit Management Regulatory Issues (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
   C. As the subject matter experts (SMEs) and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related regulated entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group.
   D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
   E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   F. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding PBMs.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

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Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 19, 2024
Adopted by the Senior Issues (B) Task Force, Oct. 21, 2024

2025 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to: 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Senior Issues (B) Task Force** will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist states, as necessary, with regulatory issues. Maintain dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress, as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Work with federal agencies, as appropriate.

SENIOR ISSUES (B) TASK FORCE *(Continued)*

G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.

NAIC Support Staff: David Torian

Draft: 11/19/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024

2025 Proposed Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

The mission of the Property and Casualty Insurance (C) Committee is to: 1) monitor and respond to problems associated with the products, delivery, and cost in the property/casualty (P/C) insurance market and the surplus lines market as they operate with respect to individual persons and businesses; 2) monitor and respond to problems associated with financial reporting matters for P/C insurers that are of interest to regulatory actuaries and analysts; and 3) monitor and respond to problems associated with the financial aspects of the surplus lines market.

Ongoing Support of NAIC Programs, Products or Services

1. The **Property and Casualty Insurance (C) Committee** will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor the activities of the Surplus Lines (C) Task Force.
   D. Monitor the activities of the Title Insurance (C) Task Force.
   E. Monitor the activities of the Workers' Compensation (C) Task Force.
   F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the *Quarterly Listing of Alien Insurers*. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   G. Monitor and review developments in case law related to risk retention groups (RRGs). If warranted, make appropriate recommendations to the Risk Retention Group (E) Task Force for changes to the *Risk Retention and Purchasing Group Handbook.*
   H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
      i. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
      ii. Review law changes and court decisions, and, if warranted, make appropriate changes to the *Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators.*
      iii. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.
   I. Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   J. Provide a forum for discussing issues related to parametric insurance, and consider the development of a white paper or regulatory guidance.
   K. Study and report on the availability and affordability of liability and property coverage for non-profit organizations.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (*Continued*)

L. Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues. Provide analysis of property insurance markets to states.
M. Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.

2. The **Cannabis Insurance (C) Working Group** will:
   A. Assess and periodically report on the status of federal legislation and regulation involving cannabis, especially as it pertains to protecting financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Support insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers, and reinsurers supporting the market, to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Stay abreast of new products and innovative ideas that may shape insurance in this space. Provide insurance resources to insurance regulators and stakeholders, as needed.
   D. Explore potential sources of constraint to coverage limits and availability of cannabis insurance products within the admitted and non-admitted market. Explore the effect of the use of cannabis and related products on P/C insurance lines of business.

3. The **Catastrophe Insurance (C) Working Group** will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils, including mitigation efforts being used in states and investigating loss trends in homeowners markets, with the goal to provide rate stability in the marketplace and protect consumers.
   C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war, and natural disasters.
   E. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC's Catastrophe Resource Center for state insurance regulators to better prepare for disasters.
   F. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market and discuss.
   G. Collaborate with other Task Forces and Working Groups regarding discussion of comparable topics, monitor catastrophe-related data calls, and keep informed about projects addressing the special needs of catastrophe data.
   H. Study, in coordination with other NAIC task forces and working groups, earthquake, severe convective storms, and wildfire matters of concern to state insurance regulators.
   I. Work with the Catastrophe Modeling Center of Excellence (COE) in order to be aware of what states are doing related to mitigation.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (*Continued*)

4. The **NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group** will:
   A. Assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization, and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.
   B. Liaise with insurers and FEMA to provide timely information to necessary parties following a catastrophic loss.
   C. Discuss ways in which states in the same FEMA region can collaborate and share information with other states in their FEMA region.

5. The **Terrorism Insurance Implementation (C) Working Group** will:
   A. Coordinate the NAIC's efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury's (Treasury Department's) Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.

6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
   A. Facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.
   B. Assist other groups with drafting language included within consumer-facing documents.
   C. Develop voluntary regulatory guidance for disclosures for premium increases related to P/C insurance products.
   D. Update and develop web page and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*, as needed.
   E. Study and evaluate ways to engage department of insurance (DOI) communication with more diverse populations, such as rural communities.

NAIC Support Staff: Aaron Brandenburg

Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024
Adopted by the Casualty Actuarial and Statistical (C) Task Force, Oct. 7, 2024

2025 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry.

The Task Force's goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensuring P/C insurance rates are not excessive, inadequate or unfairly discriminatory; and ensuring that appropriate data regarding P/C insurance markets are available.

1. The **Casualty Actuarial and Statistical (C) Task Force** will:
   A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces, and/or working groups. Propose changes to the appropriate work products, with the most common work products noted below, and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities regarding casualty actuarial issues, including the development of financial services regulations and statistical reporting, including disaster.
      i. Property and Casualty Insurance (C) Committee: Ratemaking, reserving, or data issues.
      ii. Blanks (E) Working Group: Property/casualty (P/C) annual financial statement, including Schedule P; P/C quarterly financial statement; and P/C quarterly and annual financial statement instructions, including the Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
      iii. Capital Adequacy (E) Task Force: P/C risk-based capital (RBC) report.
      iv. Statutory Accounting Principles (E) Working Group: *Accounting Practices and Procedures Manual* (AP&P Manual), and review and provide comments on statutory accounting issues being considered under *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts*.
      v. Speed to Market (D) Working Group: P/C actuarial sections of the *Product Filing Review Handbook*.
   B. Monitor national casualty actuarial developments, and consider regulatory implications.
      i. Casualty Actuarial Society (CAS): Statements of Principles and Syllabus of Basic Education.
      ii. American Academy of Actuaries (Academy): Standards of Practices, Council on Professionalism, and Casualty Practice Council.
      iii. Society of Actuaries (SOA): Anticipated changes to education pathways.
      iv. Federal legislation.
   C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-to-regulator meetings.
   D. Conduct the following predictive analytics work:
      i. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
      ii. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee and the Life Actuarial (A) Task Force on the tracking of new uses of artificial intelligence (AI), auditing algorithms, product development, and other emerging regulatory issues. Discuss regulatory oversight of AI and machine learning (ML) in insurers' ratemaking, reserving, and other activities.
      iii. With the NAIC Rate Model team's assistance, discuss guidance for the regulatory review of models used in rate filings.
   E. Research cyber liability insurance, and discuss regulatory data needs.

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE (*Continued*)

2. The **Actuarial Opinion (C) Working Group** will:
   A. Propose revisions to the following as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
      i. *Financial Analysis Handbook.*
      ii. *Financial Condition Examiners Handbook.*
      iii. *Annual Statement Instructions—Property/Casualty.*
      iv. Regulatory guidance to appointed actuaries and companies.
      v. Other financial blanks and instructions, as needed.
   B. Assess the need for changes to the Property and Casualty Statement of Actuarial Opinion instructions upon release of the SOA's proposed changes to its education pathways.

3. The **Statistical Data (C) Working Group** will:
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators* to improve data quality and reporting standards.
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically, evaluate the demand and utility versus the costs of production of each product.
      i. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance* (Homeowners Report).
      ii. *Auto Insurance Database Report* (Auto Report).
      iii. *Competition Database Report* (Competition Report).
      iv. *Report on Profitability by Line by State Report* (Profitability Report).
   C. Enhance the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Report and Homeowners Report.

NAIC Support Staff: Kris DeFrain/Roberto Perez/Libby Crews

Draft: 11/19/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024
Adopted by the Surplus Lines (C) Task Force, Aug. 13, 2024

2025 Proposed Charges

SURPLUS LINES (C) TASK FORCE

The mission of the Surplus Lines (C) Task Force is to monitor the surplus lines market and regulation, including the activity and financial condition of U.S. and non-U.S. surplus lines insurers participating in the U.S. market by providing a forum for discussion of issues and to develop or amend relevant NAIC model laws, regulations and/or guidelines.

1. The **Surplus Lines (C) Task Force** will:

    A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
    B. Review and analyze industry data on U.S. domestic and non-U.S. surplus lines insurers participating in the U.S. market.
    C. Monitor federal legislation related to the surplus lines market, and ensure all interested parties remain apprised.
    D. Develop or amend relevant NAIC model laws, regulations, and/or guidelines.
    E. Oversee the activities of the Surplus Lines (C) Working Group.

2. The **Surplus Lines (C) Working Group** will:

    A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings and in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
    B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC *Quarterly Listing of Alien Insurers*.
    C. Review and consider appropriate decisions regarding applications for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
    D. Analyze renewal applications of alien surplus lines insurers on the NAIC Quarterly Listing of Alien Insurers and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.
    E. Provide a forum for surplus lines-related discussion among jurisdictions.

NAIC Support Staff: Andy Daleo

Draft: 10/5/24
Adopted by the Executive (EX) Committee and Plenary, XX. --, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024
Adopted by the Title Insurance (C) Task Force, Oct. 4, 2024

2025 Proposed Charges

TITLE INSURANCE (C) TASK FORCE

The mission of the Title Insurance (C) Task Force is to study issues related to title insurers and title insurance producers.

1. The **Title Insurance (C) Task Force** will:
   A. Discuss and/or monitor issues and developments affecting the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
   B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces, and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies.
   C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information, education, and disclosure for mortgage lending, closing, and settlement services about the role of title insurance in the real estate transaction process.
   D. Update the *Survey of State Laws Regarding Title Data and Title Matters report* and the *Title Insurance Consumer Shopping Tool Template* as needed.
   E. Stay abreast of consumer issues and complaints submitted to states regarding title insurance. Consider regulatory best practices or standards related to consumer protection.
   F. Evaluate alternative title products and provide guidance to state insurance regulators as needed.

NAIC Support Staff: Anne Obersteadt/Aaron Brandenburg

Draft: 10/24/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 19, 2024
Adopted by the Workers' Compensation (C) Task Force Oct. 23, 2024

2025 Proposed Charges

WORKERS' COMPENSATION (C) TASK FORCE

The mission of the Workers' Compensation (C) Task Force is to study the nature and effectiveness of state approaches to workers' compensation and related issues, including, but not limited to: assigned risk plans; safety in the workplace; treatment of investment income in rating; occupational disease; cost containment; and the relevance of adopted NAIC model laws, regulations and/or guidelines pertaining to workers' compensation.

Ongoing Support of NAIC Programs, Products, or Services:

1. The **Workers' Compensation (C) Task Force** will:
   A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.
   B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.
   C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
   D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
   E. Discuss issues affecting workers' compensation.

2. The **NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group** will:
   A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges based on the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

Draft: 11/4/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 19, 2024

2025 Proposed Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

The mission of the Market Regulation and Consumer Affairs (D) Committee is to monitor all aspects of the market regulatory process for continuous improvement. This includes market analysis, regulatory interventions with companies, and multi-jurisdictional collaboration. The Committee will also review and make recommendations regarding the underwriting and market practices of insurers and producers, as those practices affect insurance consumers, including the availability and affordability of insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities, and provide appropriate recommendations for enhancement, as necessary.
   C. Oversee the activities of the Antifraud (D) Task Force.
   D. Oversee the activities of the Producer Licensing (D) Task Force.
   E. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   F. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   G. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   H. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).

2. The **Advisory Organization (D) Working Group** will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive and efficient. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

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

3. The **Market Actions (D) Working Group** will:
   A. Facilitate interstate communication, and coordinate collaborative state regulatory actions.
   B. Facilitate interstate communication, and coordinate collaborative state regulatory activities involving nontraditional market actions through the Coordinated Market Investigation Subgroup.

4. The **Market Analysis Procedures (D) Working Group** will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
   B. In accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.
   C. Discuss other market data collection issues, and make recommendations, as necessary.
   D. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).
   E. Create and monitor the effectiveness and usefulness of public MCAS ratios.

5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
   A. Review the MCAS data elements and the "Data Call and Definitions" for those lines of business that have been in effect for more than three years and update them, as necessary.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
   A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
   B. Monitor the adoption and revision of NAIC models, and develop market conduct examination standards to correspond with adopted NAIC models.
   C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook.*
   D. Discuss the development of uniform market conduct procedural guidance (e.g., a library, repository, or shared collaborative space with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook.*
   E. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI). (*New Product*)

7. The **Market Information Systems (D) Working Group** will:
   A. Analyze the data in the NAIC Market Information Systems (MIS). In accordance with the first recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, recommend methods to ensure better data quality.
   B. In conjunction with the Market Analysis Procedures (D) Working Group and in accordance with the second recommendation of the adopted *Review of Artificial Intelligence Techniques in Market Analysis*, assess currently available market analysis data to identify needed improvements in the effectiveness of the data for market analysis and the predictive abilities of the market scoring systems utilizing the data.

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

C. Provide guidance on the appropriate use of the MIS and the data entered in them.
   i. Complaints Database System (CDS).
   ii. Electronic Forums.
   iii. Market Actions Tracking System (MATS).
   iv. Market Analysis Profile.
   v. Market Analysis Prioritization Tool (MAPT).
   vi. Market Analysis Review System (MARS).
   vii. Market Conduct Annual Statement (MCAS).
   viii. Regulatory Information Retrieval System (RIRS).
   ix. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).

D. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure efficient use of available NAIC staffing and resources.

8. The **Market Regulation Certification (D) Working Group** will:
   A. Implement the *Voluntary Market Regulation Certification Program* by: i) provisionally certifying each jurisdiction that submits a self-certification report; ii) assessing the submission and monitoring the progress of each provisionally certified jurisdiction towards compliance to each certification standard; and iii) providing peer review and guidance for any participating jurisdiction that requests guidance.
   B. Develop a mechanism for enabling participating jurisdictions to apply for full certification. This will include: i) forming an NAIC review team and ii) developing methods for assessing and auditing full-certification requests.
   C. Review feedback from jurisdictions concerning any issues or recommended changes to the *Voluntary Market Regulation Certification Program* requirements and the *Market Regulation Certification Program Self-Assessment Guidelines* and *Checklist Tool.*
   D. Consider new standards to be incorporated into the *Voluntary Market Regulation Certification Program.*

9. The **Speed to Market (D) Working Group** will:
   A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented to the Working Group by the Product Steering Committee (PSC). Review periodic reports from the PSC, as needed.
   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
   C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed-to-market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
      i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
      ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed-to-market modernization efforts, as measured by nationwide and individual state speed-to-market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
      iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.

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

iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.

D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Receive periodic reports from NAIC staff, as needed.

E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):

i. Provide support to the Compact as the speed-to-market vehicle for asset-based insurance products, encouraging state participation in, and the industry's usage of, the Compact.

ii. Receive periodic reports from the Compact, as needed.

NAIC Support Staff: Tim Mullen/Randy Helder

Draft: 10/30/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 19, 2024
Adopted by the Antifraud (D) Task Force, Oct. 31, 2024

2025 Proposed Charge

ANTIFRAUD (D) TASK FORCE

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring, and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintaining and improving electronic databases regarding fraudulent insurance activities; 2) disseminating the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) providing a liaison function between state insurance regulators, law enforcement—i.e., federal, state, local, and international—and other specific antifraud organizations. The Task Force will also serve as a liaison with the NAIC Information Technology Group (ITG) and other NAIC committees, task forces, and/or working groups to develop technological solutions for data collection and information sharing. The Task Force will monitor all aspects of antifraud activities by its working groups on the following charges.

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
   A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
   B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
   C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
   D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
   E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
   F. Coordinate activities and information from national antifraud organizations, and provide information to state insurance fraud bureaus.
   G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
   H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
   I. Evaluate and recommend methods to track national fraud trends.
   J. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2025 Fall National Meeting.

ANTIFRAUD (D) TASK FORCE (*Continued*)

2. The **Antifraud Technology (D) Working Group** will:
   A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by the 2025 Fall National Meeting.
   B. Evaluate sources of antifraud data, and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2025 Fall National Meeting.

3. The **Improper Marketing of Health Insurance (D) Working Group** will:
   A. Coordinate with state insurance regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.
   B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

NAIC Support Staff: Greg Welker/Lois E. Alexander

Draft: 10/31/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 19, 2024
Adopted by the Producer Licensing (D) Task Force, Oct. 31, 2024

2025 Proposed Charges

PRODUCER LICENSING (D) TASK FORCE

The mission of the Producer Licensing (D) Task Force is to 1) develop and implement uniform license applications, standards, interpretations, and treatment of producer and adjuster licensees and licensing terminology; 2) monitor and respond to developments related to licensing reciprocity; 3) coordinate with industry and consumer groups regarding priorities for licensing reforms; and 4) provide direction based on NAIC membership initiatives to the National Insurance Producer Registry (NIPR) Board of Directors regarding the development and implementation of uniform producer licensing initiatives, with a primary emphasis on encouraging the use of electronic technology.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Producer Licensing (D) Task Force** will:
   A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
   B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
   C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
   D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
   E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
   F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
   G. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
   H. Discuss how criminal convictions may affect producer licensing applicants, review, and amend the NAIC *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* as needed to create a more simplified and consistent approach in how states review 1033 waiver requests.

PRODUCER LICENSING (D) TASK FORCE (*Continued)*

2. The **Adjuster Licensing (D) Working Group** will:
   A. Monitor state implementation of adjuster licensing and reciprocity; update the NAIC adjuster licensing standards, as necessary.

3. The **Producer Licensing Uniformity (D) Working Group** will:
   A. Work closely with state producer licensing directors and exam vendors to ensure that 1) the states achieve full compliance with the standards in order to achieve greater uniformity and 2) the exams test the qualifications for an entry-level position as a producer.
   B. Provide oversight and ongoing updates to the *State Licensing Handbook*, as needed.
   C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
   D. Review and update the NAIC's uniform producer licensing applications and uniform appointment form, as needed. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.

4. The **Uniform Education (D) Working Group** will:
   A. Update the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses, as needed. Provide any recommended updates to the Producer Licensing (D) Task Force by the Fall National Meeting.
   B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards, as necessary.

NAIC Support Staff: Tim Mullen/Greg Welker

Draft: 10/24/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024

2025 Proposed Charges

FINANCIAL CONDITION (E) COMMITTEE

The mission of the Financial Condition (E) Committee is to be the central forum and coordinator of solvency-related considerations of the NAIC relating to accounting practices and procedures; blanks; valuation of securities; financial analysis and solvency; multistate examinations and examiner and analysis training; and issues concerning insurer insolvencies and insolvency guarantees. In addition, the Committee interacts with the technical task forces.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Financial Condition (E) Committee** will:
   A. Monitor all changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Oversee the implementation of the NAIC "Framework for Regulation of Insurer Investments – A Holistic Review," ensuring that updates or reviews of the Risk-Based Capital (RBC) framework align with the Framework's principles and take into consideration insurers evolving role of the insurance sector in financing the economy and reducing the protection gap.
   D. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   E. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues that industry subsequently escalates to the Committee.

2. The **Financial Analysis (E) Working Group** will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
   C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

3. The **Group Capital Calculation (E) Working Group** will:
   A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
   B. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

4. The **Group Solvency Issues (E) Working Group** will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
   B. Critically review and provide input and drafting on IAIS material dealing with group supervision issues and identify best practices in group supervision emerging from the IAIS Supervisory Forum.
   C. Continually review and monitor the effectiveness of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), and consider revisions, as necessary, to maintain effective oversight of insurance groups.

5. The **Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the ORSA implementation.
   B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* (ORSA Guidance Manual); consider revisions as necessary.

6. The **Mutual Recognition of Jurisdictions (E) Working Group** will:
   A. Oversee the process for evaluating jurisdictions, and maintain a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the NAIC GCC.
   B. Maintain the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions* in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.

7. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
   A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

FINANCIAL CONDITION (E) COMMITTEE *(Continued)*

8. The **National Treatment and Coordination (E) Working Group** will:
   A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
   E. Make necessary enhancements to promote electronic submission of all company licensing applications.

9. The **Restructuring Mechanisms (E) Working Group** will:
   A. Evaluate and prepare a white paper that:
      i. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
      ii. Summarizes the existing state restructuring statutes.
      iii. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
      iv. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
      v. Identifies and addresses the legal issues associated with restructuring using a protected cell.
   B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.
   C. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.
   D. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.
   E. Review the various restructuring mechanisms, and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.

10. The **Risk-Focused Surveillance (E) Working Group** will:
    A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
    B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
    C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
    D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

FINANCIAL CONDITION (E) COMMITTEE (Continued)

11. The **Valuation Analysis (E) Working Group** will:
    A. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding principle-based reserves (PBR) and asset adequacy analysis, including actuarial guidelines or other requirements.
    B. Develop and implement a plan to coordinate PBR reviews/examinations.
    C. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), and coordinate with states as appropriate.
    D. Review, on a targeted basis, long-term care (LTC) reserve adequacy filings for *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), and coordinate with states as appropriate.
    E. Provide a confidential forum to address questions/issues regarding PBR and asset adequacy analysis, as well as related reinsurance risk transfer issues, and make referrals, as appropriate, to other NAIC regulator groups.
    F. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual* or related actuarial guidelines.
    G. Assist NAIC resources in the use of models and other analytical tools to support the review of PBR/asset adequacy analysis.
    H. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
    I. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson

Draft: 8/14/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Accounting Practices and Procedures (E) Task Force, Aug. 14, 2024

2025 Proposed Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

The mission of the Accounting Practices and Procedures (E) Task Force is to identify, investigate, and develop solutions to accounting problems with the ultimate goal of guiding insurers in properly accounting for various aspects of their operations; modify the *Accounting Practices and Procedures Manual* (AP&P Manual) to reflect changes necessitated by Task Force action; and study innovative insurer accounting practices that affect the ability of state insurance regulators to determine the true financial condition of insurers.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
   A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.

2. The **Blanks (E) Working Group** will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      i. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in the reporting of financial information by insurers.
      ii. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      iii. Conform the various NAIC blanks and instructions to adopted NAIC policies.
      iv. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these task forces.
   F. Coordinate with the applicable task forces and working groups as needed to avoid duplication of reporting within the annual and quarterly statement blanks.
   G. Consider proposals presented that would address duplication in reporting; eliminate data elements, financial schedules, and disclosures that are no longer needed; and coordinate with other NAIC task forces and working groups if applicable to ensure revised reporting still meets the needs of regulators.
   H. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
   I. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE *(Continued)*

3. The **Statutory Accounting Principles (E) Working Group** will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new U.S. generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed U.S. GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
   D. Obtain, analyze, and review information on permitted practices, prescribed practices, or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

Draft: 9/26/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Capital Adequacy (E) Task Force, Sept. 26, 2024

2025 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

The mission of the Capital Adequacy (E) Task Force is to evaluate and recommend appropriate refinements to capital requirements for all types of insurers.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Capital Adequacy (E) Task Force** will:
   A. Evaluate emerging "risk" issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data, and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.

2. The **Health Risk-Based Capital (E) Working Group**, **Life Risk-Based Capital (E) Working Group**, and **Property and Casualty Risk-Based Capital (E) Working Group will:**
   A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than May 15 of the reporting year, and any proposal that affects the RBC factors and/or instructions must be adopted no later than June 30 of the reporting year. Adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by June 30 and result in an amended change may be considered and adopted by July 30, where the Capital Adequacy (E) Task Force votes to pursue by two-thirds consent of members.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual* (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC's RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results, and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the Summer National Meeting and Fall National Meeting.

CAPITAL ADEQUACY (E) TASK FORCE *(Continued)*

3. The **Longevity Risk (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by new longevity factors.

4. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve the accuracy and clarity of variable annuity (VA) capital and reserve requirements.

5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the RBC results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

6. The **Risk-Based Capital Investment Risk and Evaluation (E) Working Group** will:
   A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
      i. Identifying and acknowledging uses that extend beyond the purpose of the *Risk-Based Capital (RBC) for Insurers Model Act* (#312).
      ii. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action levels.
      iii. Documenting the modifications made over time to the formulas, including, but not limited to, an analysis of the costs in study and development, implementation (internal and external), assimilation, verification, analysis, and review of the desired change to the RBC formulas and facilitating the appropriate allocation of resources.

7. The **Generator of Economic Scenarios (GOES) (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor that the economic scenario governance framework is being appropriately followed by all relevant stakeholders involved in scenario delivery.
   B. Review material economic scenario generator updates, either driven by periodic model maintenance or changes to the economic environment and provide recommendations.
   C. Regularly review key economic conditions and metrics to evaluate the need for off-cycle or significant economic scenario generator updates and maintain a public timeline for economic scenario generator updates.
   D. Support the implementation of an economic scenario generator for use in statutory reserve and capital calculations.
   E. Develop and maintain acceptance criteria that reflect history as well as plausibly more extreme scenarios.

NAIC Support Staff: Eva Yeung

Draft: 9/25/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Examination Oversight (E) Task Force, Sept. 25, 2024

2025 Proposed Charges

EXAMINATION OVERSIGHT (E) TASK FORCE

The mission of the Examination Oversight (E) Task Force is to monitor, develop, and implement tools for the risk-focused surveillance process. For financial examinations and analysis, this includes maintenance of the *Financial Condition Examiners Handbook* and the *Financial Analysis Handbook* to provide guidance to examiners and analysts using a risk-focused approach to solvency regulation and to encourage effective communication and coordination between examiners, analysts, and other regulators. In addition, the mission of the Task Force is to monitor and refine regulatory tools of the risk-focused surveillance process, including Financial Analysis Solvency Tools (FAST), such as company profiles and the FAST ratio scoring system; oversee financial examiner and analyst use of electronic software tools; monitor the progress of coordination efforts among the states in conducting examinations and the sharing of information necessary to solvency monitoring; establish procedures for the flow of information between the states about troubled companies; maintain an effective approach to the review of information technology (IT) general controls; and monitor the timeliness of financial examinations.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Examination Oversight (E) Task Force will:**
   A. Accomplish its mission using the following groups:
      i. Electronic Workpaper (E) Working Group.
      ii. Financial Analysis Solvency Tools (E) Working Group.
      iii. Financial Examiners Coordination (E) Working Group.
      iv. Financial Examiners Handbook (E) Technical Group.
      v. Information Technology (IT) Examination (E) Working Group.

2. The **Electronic Workpaper (E) Working Group** will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight in the transition of electronic workpaper work to the TeamMate+ application.
   C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.

3. The **Financial Analysis Solvency Tools (E) Working Group** will:
   A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks based on input from other regulators and the work or referrals from other NAIC committees, task forces, and working groups to develop, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools that were developed to assist in conducting risk-focused analysis and the monitoring of the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.

EXAMINATION OVERSIGHT (E) TASK FORCE (C*ontinued*)

4. The **Financial Examiners Coordination (E) Working Group** will:
   A. Develop enhancements that encourage the coordination of examination activities for holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam-coordinating states on the most appropriate regulatory strategies, methods, and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Exam Electronic Tracking System (FEETS).

5. The **Financial Examiners Handbook (E) Technical Group** will:
   A. Continually review the *Financial Condition Examiners Handbook*, and revise when appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance, and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance to provide effective solvency monitoring.
   D. Coordinate with the Information Technology (IT) Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.

6. The **Information Technology (IT) Examination (E) Working Group** will:
   A. Continually review, develop, and revise the guidance in the *Financial Condition Examiners Handbook* and other related tools, as needed, to address IT risks.
   B. Coordinate with the Cybersecurity (H) Working Group to monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the *Financial Condition Examiners Handbook* or other tools, if necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning

Draft: 11/19/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Financial Stability (E) Task Force, Oct. 17, 2024

2025 Proposed Charges

FINANCIAL STABILITY (E) TASK FORCE

The mission of the Financial Stability (E) Task Force is to consider domestic or global financial stability issues and their impact on the role of state insurance regulators.

Ongoing Support of NAIC Program, Products, or Services

1. The **Financial Stability (E) Task Force** will:
   A. Manage the macroprudential supervisory component of the NAIC financial solvency framework.
      i. Monitor the U.S. insurance industry's macroprudential risk levels.
      ii. Maintain macroprudential regulatory tools.
      iii. Identify data gaps and enhanced disclosure needs for the statutory financial statement and/or other reporting mechanisms.
      iv. Propose enhancements and/or additional supervisory measures to the Financial Condition (E) Committee or other relevant committees, and consult with such committees on implementation.
   B. Monitor U.S. macroprudential policy issues, and respond as appropriate.
      i. Support and work with the state insurance regulator representative to the Financial Stability Oversight Council (FSOC) to address confidential FSOC or other federal agency macroprudential work.
      ii. Participate in public FSOC or other federal agency macroprudential work.
   C. Monitor international macroprudential policy issues, and participate/respond as appropriate.
      i. Coordinate with the International Insurance Relations (G) Committee to address International Association of Insurance Supervisors (IAIS) or other international macroprudential work.

2. The **Macroprudential (E) Working Group** will:
   A. Oversee the implementation and maintenance of the Liquidity Stress Testing Framework (LST Framework).
   B. Monitor domestic and global activities, including those enumerated in the "Plan for the List of Macroprudential Working Group (MWG) Considerations" document.
   C. Execute the original Macroprudential Initiative (MPI) projects related to counterparty disclosures and capital stress testing.
   D. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions.
   E. Oversee the development, implementation, and maintenance process for a new macroprudential risk assessment system (i.e., policies, procedures, and tools) to enhance regulators' ability to monitor industry trends from a macroprudential perspective.
   F. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools.
   G. Provide the Task Force with updates to IAIS and other international initiatives as needed.

NAIC Support Staff: Tim Nauheimer/Todd Sells

Draft: 8/14/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Receivership and Insolvency (E) Task Force, Aug. 14, 2024

2025 Proposed Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

The mission of the Receivership and Insolvency (E) Task Force is to be administrative and substantive on issues concerning insurer insolvencies and insolvency guarantees. Such duties include, without limitation: 1) monitoring the effectiveness and performance of the state administration of receiverships and the state guaranty fund system; 2) coordinating cooperation and communication among state insurance regulators, receivers, and guaranty funds; 3) monitoring ongoing receiverships and reporting on such receiverships to NAIC members; 4) developing and providing educational and training programs in the area of insurer insolvencies and insolvency guarantees to state insurance regulators, professionals, and consumers; 5) developing and monitoring relevant model laws, guidelines, and products; and 6) providing resources for state insurance regulators and professionals to promote efficient operations of receiverships and guaranty funds.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Receivership and Insolvency (E) Task Force** will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), and other related groups on issues regarding international resolution authority.
   D. Monitor, review, and provide input on federal rulemaking and studies related to insurance receiverships.
   E. Provide an ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
   F. Monitor the work of other NAIC committees, task forces, and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referrals by other groups.

2. The **Receivership Financial Analysis (E) Working Group** will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote, and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise on the most appropriate regulatory strategies, methods, and/or action(s) regarding potential or pending receiverships.

3. The **Receivership Law (E) Working Group** will:
   A. Review and provide recommendations on any issues identified that may affect states' receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions, insurer insolvencies, federal rulemaking and studies, international resolution initiatives, or the work performed by or referred from other NAIC committees, task forces, and/or working groups).
   B. Discuss significant cases that may affect the administration of receiverships.

NAIC Support Staff: Jane Koenigsman

Draft: 7/22/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Reinsurance (E) Task Force, July 22, 2024

2025 Proposed Charges

REINSURANCE (E) TASK FORCE

The mission of the Reinsurance (E) Task Force is to monitor and coordinate activities and areas of interest that overlap to some extent the charges of other NAIC groups—specifically the International Insurance Relations (G) Committee.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Reinsurance (E) Task Force** will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
   C. Coordinate with the Mutual Recognition of Jurisdictions (E) Working Group on matters regarding reinsurance.
   D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
   E. Monitor reinsurance-related activities of other task forces and working groups at the NAIC.
   F. Consider any other issues related to the *Credit for Reinsurance Model Law* (#785), *Credit for Reinsurance Model Regulation* (#786), and *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
   G. Monitor the development of international principles, standards, and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup, and the Reinsurance Transparency Group.
   H. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   I. Continue to monitor the impact of reinsurance-related international agreements, including the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (EU Covered Agreement) and the "Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance" (UK Covered Agreement).

REINSURANCE (E) TASK FORCE *(Continued)*

2. The **Reinsurance Financial Analysis (E) Working Group** will:
   A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified or Reciprocal Jurisdiction Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. The process of reviewing applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
   D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified or reciprocal jurisdiction reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers, reciprocal jurisdiction reinsurers, and applicants.
   F. Provide advisory support on issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.

NAIC Support Staff: Jake Stultz/Dan Schelp

Draft: 7/24/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Risk Retention Group (E) Task Force, July 24, 2024

2025 Proposed Charges

RISK RETENTION GROUP (E) TASK FORCE

The mission of the Risk Retention Group (E) Task Force is to stay apprised of the work of other NAIC groups as it relates to financial solvency regulation and the NAIC Financial Regulation Standards and Accreditation Program. The Task Force may make referrals to the Financial Regulation Standards and Accreditation (F) Committee and/or other NAIC groups, as deemed appropriate.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Risk Retention Group (E) Task Force** will:
   A. Monitor and evaluate the work of other NAIC committees, task forces, and working groups that may affect the filing requirements or compliance of risk retention groups (RRGs) (e.g. actions that affect compliance with the NAIC Accreditation Standards Program.
   B. Monitor and review any federal activities, including any U.S. Government Accountability Office (GAO) reports, and consider any necessary action.
   C. Monitor the resources available to domiciliary and non-domiciliary state insurance regulators of RRGs, including educational programs or enhancements or the development of new resources.

NAIC Support Staff: Rodney Good/Andy Daleo

Draft: 8/13/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Condition (E) Committee, Oct. 24, 2024
Adopted by the Valuation of Securities (E) Task Force, Aug. 13, 2024

2025 Proposed Charges

VALUATION OF SECURITIES (E) TASK FORCE

The mission of the Valuation of Securities (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's credit assessment process for insurer-owned securities, as well as produce insightful and actionable research and analysis regarding insurer investments.

Ongoing Support of NAIC Programs, Products or Services

1. The **Valuation of Securities (E) Task Force** will:
   A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
   B. Maintain and revise the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions for investment-related regulatory issues for existing or anticipated investments.
   C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual*, as well as financial statement blanks and instructions, to ensure that the P&P Manual reflects regulatory needs and objectives.
   D. Consider whether improvements should be suggested to the measurement, reporting, and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.
   E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.
   F. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
   G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Statutory Accounting Principles (E) Working Group, the Blanks (E) Working Group, the Risk-Based Capital Investment Risk and Evaluation (E) Working Group, and the Valuation Analysis (E) Working Group—to formulate recommendations and make referrals to other NAIC regulator groups, ensuring expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of other groups and that the expertise of other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.
   H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives.
   I. Implement policies to oversee the NAIC's staff administration of rating agency ratings used in NAIC processes, including staff's discretion over the applicability of their use in its administration of filing exemption.
   J. Establish criteria to permit staff's discretion over the assignment of NAIC designations for securities subject to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives.
   K. Implement additional and alternative ways to measure and report investment risk.

NAIC Support Staff: Charles Therriault/Marc Perlman/Eric Kolchinsky

Draft: 11/16/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Financial Regulation Standards and Accreditation (F) Committee, Nov. 16, 2024

2025 Proposed Charges

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

The mission of the Financial Regulation Standards and Accreditation (F) Committee is both administrative and substantive, as it relates to the administration and enforcement of the NAIC Financial Regulation Standards and Accreditation Program. This includes, without limitation: 1) the consideration of standards and revisions of standards for accreditation; 2) the interpretation of standards; 3) the evaluation and interpretation of the states' laws and regulations, as well as departments' practices, procedures, and organizations as they relate to compliance with standards; 4) the examination of members for compliance with standards; 5) the development and oversight of procedures for the examination of members for compliance with standards; 6) the selection of qualified individuals to examine members for compliance with standards; and 7) the determination of whether to accredit members.

Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Regulation Standards and Accreditation (F) Committee** will:
   A. Maintain and strengthen the NAIC Financial Regulation Standards and Accreditation Program.
   B. Assist the states, as requested and as appropriate, in implementing laws, practices, and procedures and obtaining personnel required for compliance with the standards.
   C. Conduct a yearly review of accredited jurisdictions.
   D. Consider new model laws; new practices and procedures; and amendments to existing model laws, practices, and procedures required for accreditation. Determine the timing and appropriateness of the addition of new model laws, practices, procedures, and amendments.
   E. Render advisory opinions and interpretations of model laws required for accreditation and on substantial similarity of state laws.
   F. Review existing standards for effectiveness and relevancy, and make recommendations for change, if appropriate.
   G. Produce, maintain, and update the NAIC *Accreditation Program Manual* to provide guidance to state insurance regulators regarding the official standards, policies, and procedures of the program.
   H. Maintain and update the "Financial Regulation Standards and Accreditation Program" pamphlet.
   I. Perform enhanced pre-accreditation review services, including, but not limited to, additional staff support, increased participation, enhanced report recommendations, and informal feedback.
   J. Appoint and oversee the activities of the Accreditation Scope and Alignment (F) Working Group.

2. The **Accreditation Scope and Alignment (F) Working Group** will:
   A. Review the current scope of the NAIC Financial Regulation Standards and Accreditation Program to: 1) evaluate whether it aligns with the program's objectives; and 2) determine whether any multistate companies/activities are not currently covered in the program's scope.
   B. Analyze state regulations to understand how states regulate companies within the scope of the accreditation program and identify any discrepancies or unique regulatory practices across states. Maintain a resource that summarizes the results of this analysis.

NAIC Support Staff: Bailey Henning/Sara Franson/Dan Schelp/Sherry Shull

Draft: 10/23/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the International Insurance Relations (G) Committee, Nov. 17, 2024

2025 Proposed Charges

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

The mission of the International Insurance Relations (G) Committee is to: 1) coordinate NAIC participation in discussions on international activities and issues and the development of insurance regulatory and supervisory standards and other materials; 2) promote international cooperation; 3) coordinate on international insurance matters with the U.S. federal government, including the U.S. Department of the Treasury (Treasury Department), the Federal Reserve Board (FRB), the Office of the U.S. Trade Representative (USTR), the U.S. Department of Commerce (DOC), and other federal agencies; and 4) provide an open forum for NAIC communication with U.S. interested parties, stakeholders, and among its members on international insurance matters.

Ongoing Support of NAIC Programs, Products or Services

1. The **International Insurance Relations (G) Committee** will:
   A. Monitor and assess activities at international organizations, such as the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB), the Organisation for Economic Co-operation and Development (OECD), and the Sustainable Insurance Forum (SIF), that affect U.S. insurance regulation, U.S insurance consumers, and the U.S. insurance industry.
   B. Support and facilitate the participation of state insurance regulators and the NAIC in relevant workstreams of international organizations.
   C. Develop NAIC policy on international activities and issues, coordinating, as necessary, with other NAIC committees, task forces, and working groups and communicating key international developments to those NAIC groups.
   D. Coordinate and facilitate state efforts to participate in key bilateral and multilateral dialogues, projects, conferences, and training opportunities with international regulators and international organizations, both directly and in coordination with the federal government, as appropriate.
   E. Strengthen foreign regulatory systems and relationships by interacting with international regulators and sharing U.S. supervisory best practices, including conducting outreach, an International Fellows Program and educational (technical assistance) seminars to provide an understanding of the U.S. state-based system of insurance regulation.
   F. Coordinate the NAIC's participation in the International Monetary Fund (IMF)/World Bank Financial Sector Assessment Program (FSAP).
   G. Coordinate state efforts to assist in achieving U.S. international trade objectives through reviewing relevant materials, developing input, and providing assistance and expertise on insurance matters to the USTR and/or other federal entities.

NAIC Support Staff: Ryan Workman/Nikhail Nigam

Draft: 11/19/24
Adopted by Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Nov. 19, 2024

2025 Proposed Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

The mission of the Innovation, Cybersecurity, and Technology (H) Committee is to: 1) provide a forum for state insurance regulators to learn about and have discussions regarding: cybersecurity, innovation, data security and privacy protections, and emerging technology issues; 2) monitor developments in these areas that affect the state insurance regulatory framework; 3) maintain an understanding of evolving practices and use of innovation technologies by insurers and producers in respective lines of business; 4) coordinate NAIC efforts regarding innovation, cybersecurity and privacy, and technology across other committees; and 5) make recommendations and develop regulatory, statutory, or guidance updates, as appropriate.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Innovation, Cybersecurity, and Technology (H) Committee** will:
   A. Provide forums, resources and materials related to developments and emerging issues in innovation, cybersecurity, data privacy, and the uses of technology in the insurance industry in order to educate state insurance regulators on these developments and how they affect consumer protection, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
   B. Consider and coordinate the development of regulatory guidance and examination standards related to innovation, cybersecurity, data privacy, the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance, and technology, including drafting and revising model laws, white papers, and other recommendations as appropriate.
   C. Oversee the work of the Data Call Study Group to study the enhancement of regulator access to high-quality and timely data allowing for evidence-informed decisions, enhanced supervisory capabilities, and improved efficiency.
   D. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity, including the *Insurance Data Security Model Law* (#668), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), the *Privacy of Consumer Financial and Health Information Regulation* (#672), and the *Unfair Trade Practices Act* (#880) rebating language and providing assistance to state insurance regulators as needed.
   E. Coordinate and facilitate collaboration with and among other NAIC committees and task forces to promote consistency and efficiency in the development of regulatory policy, education, training, and enforcement materials and tools related to innovation; cybersecurity; data privacy; and the use of technologies, big data, and artificial intelligence (AI), including machine learning (ML), in the business of insurance. Evaluate and recommend certifications, continuing education (CE), and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.
   F. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE (*Continued*)

2. The **Big Data and Artificial Intelligence (H) Working Group** will:
   A. Research the use of big data and AI (including ML) in the business of insurance. Proactively communicate findings, and present recommendations to the Innovation, Cybersecurity, and Technology (H) Committee.
   B. Monitor state, federal, and international activities on AI, including working with the Innovation, Cybersecurity, and Technology (H) Committee to: 1) respond to such activities, where appropriate, and 2) address potential impacts on existing state insurance laws or regulations.
   C. Facilitate discussion to consider updates to the regulatory framework for the oversight of the use of AI by insured entities. Provide recommendations to the Innovation, Cybersecurity, and Technology (H) Committee in response to such activities.
      i. Monitor and support adoption of the *Model Bulletin on the Use of Artificial Intelligence Systems by Insurers.*
      ii. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of the use of AI in insurance and non-insurance industries.
      iii. Research, identify, and monitor the impacts of the use of AI systems by insurance companies to understand the potential benefits, value propositions, risks, and adverse consumer outcomes related to the use of AI systems.
   D. Facilitate discussion related to AI systems evaluation including:
      i. Identifying existing tools, resources, materials, and training that will assist and guide regulators in their review of AI systems used by licensees, including an insurer's AI program. This includes establishing a coordinated work plan and timeline for further development of those resources.
      ii. Develop new regulatory tools or regulatory guidance to assist regulators in their review of AI systems used by licensees, including an insurer's AI program.
      iii. Coordinate the development of review and enforcement tools, resources, guidelines, and training related to AI systems for regulators across the NAIC.
   E. Facilitate and coordinate foundational and contextual educational content for regulators on topics related to the use of big data and AI techniques, tools and systems in the insurance industry.

3. The **Cybersecurity (H) Working Group** will:
   Cybersecurity Charges
   A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices, and breaches with the potential to affect the insurance industry.
   B. Facilitate communication across state insurance departments regarding cybersecurity risks and events.
   C. Develop and maintain regulatory cybersecurity response guidance to assist state insurance regulators in the investigation of national insurance cyber events.
   D. Monitor federal and international activities on cybersecurity engaging in efforts to manage and evaluate cybersecurity risk.
   E. Coordinate NAIC committee cybersecurity work, including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology (IT) Examination (E) Working Group.
   F. Advise NAIC staff on the development of cybersecurity training for state insurance regulators.
   G. Work with the Center for Insurance Policy and Research (CIPR) to receive updates on cybersecurity research efforts, by the CIPR and others, and to analyze publicly available cybersecurity-related information.
   H. Support the states with implementation efforts related to the adoption of the *Insurance Data Security Model Law* (#668).
   I. Coordinate with NAIC staff to facilitate intelligence-driven cybersecurity tabletop exercises with state departments of insurance (DOIs) providing input on scope and timing as necessary.

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE (*Continued*)

Cyber Insurance Charges

A. Monitor industry trends pertaining to cyber insurance, including meeting with subject matter experts (SMEs) and evaluating data needs of state insurance regulators. Considerations should include the availability and affordability/pricing of cyber insurance, disclosures, limits and sub-limits in policies, policy language and trends in requirements, underwriting practices, and the role of reinsurance in the cyber insurance market.
B. Coordinate with NAIC work groups addressing cyber insurance related issues, such as the Casualty Actuarial and Statistical (C) Task Force.
C. Monitor federal and international activities related to cyber insurance and financing mechanisms for cyber risk.
D. Coordinate with NAIC staff to conduct analysis pursuant to the NAIC's Cyber Insurance Report. Review the NAIC's *Property & Casualty Annual Statement Cybersecurity and Identity Theft Supplement* recommending changes and/or developing reports to supplement data development as necessary. Consider and develop a guide for states on cyber insurance data analysis best practices.

4. The **Privacy Protections (H) Working Group** will:
   A. Use state insurance privacy protections regarding the collection, data ownership and use rights, and disclosure of information gathered in connection with insurance transactions to draft a new/revised Privacy Protections Model Act to replace/update NAIC models such as Model #670 and/or Model #672.
   B. Monitor state, federal, and international activities on privacy, engaging in efforts to manage and evaluate privacy.

5. The **SupTech/GovTech Subgroup** will:
   A. Facilitate technology, innovation, and SupTech/GovTech presentations from leading technology companies for state insurance regulators to provide them with insights into cutting-edge technology and innovation.
   B. Facilitate technology, innovation, and SupTech/GovTech presentations from specialized vendors for state insurance regulators to assist in identifying vendor solutions that may benefit regulators.

NAIC Support Staff: Miguel Romero/Scott Sobel/Scott Morris

Draft: 10/10/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Nov. 19, 2024
Adopted by the Third-Party Data and Models (H) Task Force, Oct. 10, 2024

2025 Proposed Charges

THIRD-PARTY DATA AND MODELS (H) TASK FORCE

The mission of the Third-Party Data and Models (H) Task Force is to develop and propose an optimal regulatory framework for the regulatory oversight of third-party data and predictive models.

Ongoing Support of NAIC Programs, Products, or Services:

1. The **Third-Party Data and Models (H) Task Force** will:
   A. Develop and propose a framework for the regulatory oversight of third-party data and predictive models.
   B. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of third-party data and model vendors and their products and services. Provide recommendations to the Innovation, Cybersecurity, and Technology (H) Committee regarding responses to such activities.

NAIC Support Staff: Kris DeFrain/Scott Sobel

Draft: 10/16/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the NAIC/Consumer Liaison Committee, Oct. 16, 2024

2025 Proposed Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2025 are closely aligned with the priorities of the NAIC/Consumer Participation Board of Trustees.

NAIC Support Staff: Lois E. Alexander

Draft: 10/15/24
Adopted by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the NAIC/American Indian and Alaska Native Liaison Committee, Oct. 15, 2024

2025 Proposed Mission Statement

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

The mission of the NAIC/American Indian and Alaska Native Liaison Committee is to provide a forum for ongoing dialogue between NAIC Members and the American Indian and Alaska Native communities concerning insurance issues of common interest. Specifically, the Liaison Committee will provide a forum for an exchange of information and views on issues surrounding the availability of insurance for American Indian and Alaska Native consumers and tribal interests, an opportunity for American Indian and Alaska Native groups to bring insurance consumer protection issues to the attention of NAIC Members, and a dialogue on best practices for dealing with insurance issues unique to sovereign tribal nations.

NAIC Support Staff: Lois E. Alexander

Draft: 8/1/24
Reaffirmed by the Executive (EX) Committee and Plenary, Dec. --, 2024
Reaffirmed by the Internal Administration (EX1) Subcommittee, Aug. 13, 2024
Reaffirmed by the Audit Committee, Aug. 1, 2024

2025 Proposed Committee Charter

AUDIT COMMITTEE

1. The **Audit Committee** will:
   A. Provide continuous audit oversight, including:
      i. Provide an open avenue of communication between the independent auditor and the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.
      ii. Confirm and ensure the independence of the independent auditor.
      iii. Inquire of management and the independent auditor about significant risks or exposures and assess the steps management has taken to minimize such risk.
      iv. Consider and review with the independent auditor:
         a. Significant findings during the year, including the status of previous audit recommendations.
         b. Any difficulties encountered during audit work, including any restrictions on the scope of activities or access to required information.
         c. The adequacy of internal controls, including computerized information system controls and security, as documented in the Statement on Auditing Standards (SAS) 115 letter from the independent auditor.
         d. Related findings and recommendations of the independent auditor with management's responses, as documented in the SAS 114 letter from the independent auditor.
      v. Meet periodically with the independent auditor in separate executive sessions to discuss any matters the Committee believes should be discussed privately with the Committee.
      vi. Report periodically to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on significant results of the foregoing activities.
      vii. Instruct the independent auditor that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee are the auditor's clients.
   B. Provide continuous oversight of reporting policies, including:
      i. Advise financial management and the independent auditor that they are expected to provide a timely analysis of significant current financial reporting issues and practices.
      ii. Inquire as to the auditor's independent qualitative judgments about the appropriateness, not just the acceptability, of the accounting principles and the clarity of the financial disclosure practices.
      iii. Inquire as to the auditor's views about whether management's choices of accounting principles are conservative, moderate, or aggressive from the perspective of income, asset and liability recognition, and whether those principles are common practices or minority practices.
      iv. Inquire as to the auditor's views about how choices of accounting principles and disclosure practices may affect NAIC members, the insurance industry, and public views and attitudes.
   C. Provide continuous oversight of financial management, including:
      i. Review the monthly consolidated financial statements and receive regular reports from executive management on the financial operations of the association.
      ii. Meet prior to, or at, each national meeting or more frequently, as circumstances require. The Committee may ask members of management or others to attend meetings and provide pertinent information, as necessary.
      iii. Report on significant results of the foregoing activities to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on a regular basis.

AUDIT COMMITTEE *(Continued)*

D. Provide continuous oversight of the service advisory firm that conducts the Service Organization Control (SOC) 1 and SOC 2 reviews.
   i. Receive annual audit reports provided by the service advisory firm.
   ii. Instruct the independent service advisory firm that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee are the auditor's clients.

E. Conduct scheduled audit activities, including:
   i. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
   ii. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
      a. The independent auditor's audit of the financial statements, accompanying footnotes, and its report thereon.
      b. Any significant changes required in the independent auditor's audit plans.
      c. Any difficulties or disputes with management encountered during the year under audit.
      d. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
   iii. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.

F. Conduct other activities when necessary, including:
   i. Review and approve needs-based funding allocations, as needed.
   ii. Review and update the Committee charter on at least an annual basis.
   iii. Review and approve requests for any management consulting engagement to be performed by the independent auditor and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.
   iv. Conduct and/or authorize investigations into any matters within the Committee's scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.
   v. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

Adopted by the Health Insurance and Managed Care (B) Committee – Nov. 19, 2024
Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024
Adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup – Oct. 17, 2024

Draft: 11/19/24
Model#171

The revisions to this draft reflect changes made from the existing model. Any comments on this draft should be sent by email only to Jolie Matthews at jmatthews@naic.org.

MODEL REGULATION TO IMPLEMENT THE ~~ACCIDENT AND SICKNESS~~SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC ~~Accident and Sickness~~ *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, ~~of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as "group supplemental health insurance"). This regulation is also intended~~ to facilitate public understanding and comparison of coverage, to eliminate provisions ~~contained in individual accident and sickness insurance policies and group supplemental health insurance~~ that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims~~:~~ and to provide for full disclosure in the marketing and sale of ~~individual accident and sickness insurance policies and group supplemental health insurance~~ supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner's jurisdiction over limited scope dental coverage and limited scope vision ~~plans~~coverage, and to provide for disclosure in the sale of those ~~plans~~coverages.

~~**Drafting Note**: States should determine if the phrase "individual accident and sickness insurance policies" is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. "subscriber contracts" of "nonprofit hospital, medical and dental associations") to cover these plans should choose terminology conforming to state statute.~~

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].

Section 3. Applicability and Scope

A. This regulation applies to all individual ~~accident and sickness insurance policies~~ and group ~~supplemental health~~insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as "supplementary health insurance," delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].

B. This ~~Act~~regulation ~~shall apply~~applies to limited scope dental ~~plans~~coverage and limited scope vision ~~plans~~coverage only as specified.

C. This regulation shall not apply to:

~~(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;~~

~~(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~

~~(3)~~(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];

~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; ~~or~~

~~(5)~~(3) TRICARE ~~Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, ~~t~~Title 10 of the United States Code) ~~(CHAMPUS)~~ supplement insurance policies; or

(4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

Drafting Note: ~~CHAMPUS~~TRICARE supplement insurance is not subject to federal regulation. ~~CHAMPUS~~TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to ~~CHAMPUS~~TRICARE benefits. In general, states regulate ~~CHAMPUS~~TRICARE supplement insurance policies under the state group or individual insurance laws.

D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.

Section 5. Definitions

For purposes of this regulation:

A. "Excepted benefits" means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.

B. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

C. "Short-term, limited-duration insurance" has the meaning stated in Section 3I of the Act.

Section ~~5~~6. Policy Definitions

A. (1) Except as provided in this regulation, ~~an individual accident and sickness insurance policy or group supplemental health insurance policy~~a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

~~B (1) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.~~

~~(2) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.~~

~~(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.~~

~~C~~B. "Convalescent nursing home," "extended care facility," ~~or~~ "skilled nursing facility," "assisted living facility" or "continued care retirement community" ~~shall be defined~~means in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;

(c) Be ~~primarily~~ engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Except for an "assisted living facility" or a "continued care retirement community," ~~Provide~~provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

(2) The definition of the home or facility ~~may provide that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged and/or for the care of ~~drug addicts or alcoholics~~individuals with a substance use disorder; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

C. "Home health care agency":

(1) Is an agency approved under Medicare;

(2) Is licensed to provide home health care under applicable state law; or

(3) Meets all the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;

(c) A physician or a registered nurse provides supervision of home health care services;

(d) It maintains clinical records on all patients; and

(e) It has a full-time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care, including the definition of required services.

~~C~~D. "Hospital" ~~may be defined~~means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" ~~may state that the term shall not be inclusive of~~ is permitted but is not required to exclude:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

(b) Facilities affording primarily custodial, educational or ~~rehabilitory~~rehabilitative care;

(c) Facilities for the aged~~, drug addicts or alcoholics~~ or individuals with a substance use disorder; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services ~~rendered on an emergency basis~~ where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

E. (1) "Injury" means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.

(2) The definition shall not use words such as "external, violent, visible wounds" or similar words of characterization or description.

(3) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

(4) The definition may provide that "injury" shall not include an injury for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

~~E. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.~~

F. "Mental or nervous disorder" ~~shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind~~ means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

G. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "advance practice nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection J.

H. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. "Partial disability" ~~shall be defined in relation to~~ means that, due to a disability, an individual:

(1) ~~the individual's inability~~ Is unable to perform one or more but not all ~~of~~ the "major," "important" or "essential" duties of the individual's employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) Is in fact engaged in work for wage or profit.

J. (1) "Physician" ~~may be defined by~~means and ~~including~~includes words such as "qualified physician" or "licensed physician~~.~~" and may not be defined more narrowly than applicable state licensing laws. ~~The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~

(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

K. "Preexisting condition" ~~shall not be defined more restrictively than the following: "Preexisting condition~~ means ~~the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or~~ a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

~~States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the "federal fallback" provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.~~

L. "Residual disability" ~~shall be defined~~means in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

M. "Sickness" ~~shall not be defined to be more restrictive than the following: "Sickness~~ means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.~~"~~ The definition may be ~~further~~ modified to exclude sickness or disease for which benefits are provided under a ~~worker's~~workers' compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section ~~6~~7. Prohibited Policy Provisions

A. (1) Except as provided in ~~Section 5K~~this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which ~~no~~ coverage ~~is provided~~ under the policy is excluded or restricted.~~, subject to the further exception that~~

(2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.

(3) ~~a~~A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the ~~reproduction~~reproductive organs, varicose veins, adenoids, ~~appendix~~ and tonsils, except when~~. However, the permissible six-month exception shall not be applicable where~~ the specified diseases or conditions are treated on an emergency basis. ~~Accident policies shall not contain probationary or waiting periods.~~

~~B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.~~

~~(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

~~C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.~~

~~**Drafting Note:** Where the state has enacted the NAIC Individual Accident and *Sickness Insurance Minimum Standard Act*, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.~~

~~D~~B. A disability income protection policy may contain a "return of premium" or "cash value benefit" option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

~~E~~C. Policies providing hospital ~~confinement~~ indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

~~F~~D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~for the following permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug ~~addition~~addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, in Paragraph (2) of this subsection above and Paragraph (4) of this subsection, in short-term, limited-duration insurance policies and disability income protection insurance policies.

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~7H~~8C of this regulation;

(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Non-commercial or recreational ~~A~~aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

(5) Cosmetic surgery, except ~~that "cosmetic surgery" shall not include~~ for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly ~~of a covered dependent child~~ that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;

(7) Chiropractic ~~C~~care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Drafting Note: States should examine any existing "freedom of choice" statutes that require reimbursement of treatment provided by chiropractors~~,~~ and make adjustments if needed.

(8) ~~Treatment provided in a government hospital; b~~Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal ~~workmen's~~workers' compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

(9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;

(10) Eye-glasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations; ~~and~~

(12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and

(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

~~G~~E. Notwithstanding Subsection D of this section, ~~This~~this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

~~**Drafting Note:** States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.~~

~~H~~F. The enumeration in this section of specific precluded ~~Policy~~policy provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section ~~3~~4B of the ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

G. A policy providing a type of supplementary health insurance that is not defined as a "plan" under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

H. A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section ~~7~~8. ~~Accident and Sickness~~ Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. ~~An individual accident and sickness insurance policy or group supplemental~~A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section ~~8L~~9H of this regulation.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5~~A and~~B and C of the NAIC ~~Accident and *Sickness*~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual ~~accident and sickness~~supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the

event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term "spouse" in paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section ~~8~~9A~~(1)~~.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual ~~accident and sickness~~supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

~~(c) An individual accident and sickness or individual accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty five (65) while actively and regularly employed.~~

~~(d)~~(c) Except as provided ~~above~~in subparagraph (d) of this paragraph, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(d) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may be designated as "guaranteed renewable" if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement and, as defined under the federal Social Security Act.

(3) In an individual ~~accident and sickness~~supplementary policy covering ~~both husband and wife~~a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to "married couple" and "civil union couple" in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage ~~as defined under~~ subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the federal Affordable Care Act (ACA), ~~or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B~~PHSA ~~Section~~§ 2742 (42 U.S.C. § 300gg-42)~~of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law~~, unless it is an excepted benefit as described in ~~Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA~~ PHSA § 2791(c) (42 U.S.C. § 300gg-91(c))~~or~~. ~~a~~Applicable state law may impose requirements that mirror or exceed the federal requirements.

(4) When accidental death and dismemberment coverage is part of the individual ~~accident and sickness~~supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) ~~In the event the insurer cancels or refuses to renew, p~~Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization ~~shall not~~may condition the benefits upon admission to the convalescent or extended care facility within a ~~period of~~ specified time after discharge from the hospital, as long as the required admission date is not less than ~~fourteen (14) days~~thirty (30) days after discharge from the hospital.

(8) In individual ~~accident and sickness~~supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation or physical handicap~~intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days ~~of~~ after the date the ~~company~~insurer receives due proof of the ~~incapacity~~disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy shall be without prejudice ~~of to~~to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing

coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

~~B. Basic Hospital Expense Coverage~~

~~"Basic hospital expense coverage" is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

~~(1) Daily hospital room and board in an amount not less than the lesser of:~~

~~(a) [80%] of the charges for semiprivate room accommodations or~~

~~(b) [$100] per day;~~

~~**Drafting Note**: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: "except that $[insert amount] may be reduced to $[insert amount] outside the area." Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.~~

~~(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [$3,000] or [ten] times the daily hospital room and board benefits; and~~

~~(3) Hospital outpatient services consisting of:~~

~~(a) Hospital services on the day surgery is performed,~~

~~(b) Hospital services rendered within seventy two (72) hours after injury, in an amount not less than [$150]; and~~

~~(c) X ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [$100] if rendered to an in-patient of the hospital.~~

~~(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [$100].~~

~~C. Basic Medical Surgical Expense Coverage~~

~~"Basic medical surgical expense coverage" is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:~~

~~(1) Surgical services:~~

~~(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule].up to a maximum of at least [$1000] for a one procedure; or~~

~~(b) Not less than [80%] of the reasonable charges.~~

~~(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:~~

~~(a) In an amount not less than [80%] of the reasonable charges; or~~

~~(b) [15%] of the surgical service benefit.~~

~~(3) In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than [80%] of the reasonable charges, or [$50] per day for not less than twenty-one (21) days during one period of confinement.~~

~~D. Basic Hospital/Medical-Surgical Expense Coverage~~

~~"Basic hospital/medical-surgical expense coverage" is a combined coverage and must meet the requirements of both Subsections B and C.~~

~~E~~B. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital ~~confinement~~ indemnity or other fixed indemnity coverage" ~~is a policy of accident and sickness insurance that~~ provides ~~daily~~ benefits ~~for~~as a result of hospital confinement or other health-related events and based on a fixed dollar amount, ~~on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy~~ regardless of the amount of expenses incurred, without coordination with any other health coverage.

(2) "Hospital indemnity coverage" may provide a single lump sum benefit for hospital confinement of not less than $[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than $[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

~~(2)~~(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

~~(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.~~

Drafting Note: Hospital ~~confinement~~ indemnity or other fixed indemnity coverage is ~~recognized as supplemental~~supplementary coverage. Any hospital ~~confinement~~ indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts…." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage purchased by the insured.

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product's benefits could be mistaken for comprehensive major medical coverage.

Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or ~~a~~ replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

~~F. Individual Major Medical Expense Coverage~~

~~(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

~~(f) Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and~~

~~(g) Not fewer than three (3) of the following additional benefits:~~

~~(i) In-hospital private duty registered nurse services;~~

~~(ii) Convalescent nursing home care;~~

~~(iii) Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) Out of hospital prescription drugs and medications.~~

~~(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by~~

this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

G. Individual Basic Medical Expense Coverage

(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:

(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty-one (31) days during continuous hospital confinement;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(g) Not fewer than three (3) of the following additional benefits:

(i) In-hospital private duty graduate registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physiotherapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

(v) Artificial limbs or eyes, casts, splints, trusses or braces;

(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or

(vii) Out-of-hospital prescription drugs and medications.

(2) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments,

~~mandated benefits required by law and those services covered under 7G(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, anindividual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~H~~C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, ~~weekly or monthly~~no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that ~~periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62)~~ a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

(2) Contains an elimination period no greater than:

(a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;

(b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year ~~or less~~;

~~(b)~~(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

~~(c)~~(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a ~~maximum~~ period of time of at least three (3) months for which it is payable during disability ~~of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month~~. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period~~. Section 7F does not apply to those policies providing business buy-out coverage~~; and

(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

~~I~~D. Accident Only Coverage

"Accident only coverage" is a policy that provides coverage, singly or in combination, for death, dismemberment, disability, injury, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least ~~[$1,000]~~$[X] and a single dismemberment amount shall be at least ~~[$500]~~$[X].

~~J~~E. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases~~,~~ directly caused or aggravated by ~~the~~a specified disease~~s~~ or the treatment of the specified disease.

(d) Individual ~~accident and sickness~~supplementary policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

(g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(h) ~~Except for the NAIC uniform provision regarding other insurance with this insurer, benefits~~ Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as ~~supplemental~~supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge," "expense," or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." or "actual expenses."

(k) "Preexisting condition" shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless ~~the~~a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a ~~facility~~provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least ~~$50~~$[X] per day; and

(III) A lifetime maximum benefit limit of at least ~~$10,000~~$[X].

(iii) Hospice care does not cover non-terminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental ~~diseases or~~ disorders ~~or care for the~~, who are aged, or ~~substance abusers~~who have a substance use-related disorder.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of ~~[$250]~~$[X] and an overall aggregate benefit limit of no less than ~~[$10,000]~~$[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(iii) Private duty services of a ~~registered~~licensed nurse ~~(R.N.)~~;

(iv) ~~X-ray, radium and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for ~~local~~ service to or from a ~~local~~ hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

~~(viii) The rental of an iron lung or similar mechanical apparatus;~~

~~(ix)~~(viii) ~~Braces, crutches and wheel chairs as are~~ Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(x)~~(ix) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

~~(xi)~~(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than ~~[$25,000]~~$[X] payable at the rate of not less than ~~[$50]~~$[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage ~~for each insured person~~on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage ~~in~~may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of ~~[$250]~~$[X], ~~and~~ an overall aggregate benefit

limit of not less than ~~[$10,000]~~$[X], and a benefit period of not less than three (3) years ~~shall provide at least the following minimum provisions:~~.

(b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

~~(a)~~(i) Treatment by, or under the direction of, a ~~legally qualified~~licensed physician, ~~or~~ surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

~~(b)~~(ii) ~~X-ray, radium chemotherapy and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

~~(c) Hospital room and board and any other hospital furnished medical services or supplies;~~

~~(d)~~(iii) Blood transfusions and their administration, including expense incurred for blood donors;

~~(e)~~(iv) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

~~(f) Professional ambulance for local service to or from a local hospital;~~

~~(g)~~(v) Private duty services of a ~~registered~~licensed nurse provided in a hospital;

~~(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;~~

~~(i)~~(vi) ~~Braces, crutches and wheelchairs~~Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(j)~~(vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

~~(k)~~(viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. ~~The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:~~

~~(I) It is primarily engaged in providing home health care services;~~

~~(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;~~

~~(III) A physician or a registered nurse provides supervision of home health care services;~~

~~(IV) It maintains clinical records on all patients; and~~

~~(V) It has a full time administrator.~~

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

~~(ii)~~(II) Home health care includes, but is not limited to:

~~(I)~~a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

~~(II)~~b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

~~(III)~~c. Physical, occupational or speech and hearing therapy; and

~~(IV)~~d. Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital~~.~~;

~~(l)~~(ix) Physical, speech, hearing and occupational therapy;

~~(m)~~(x) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, ~~chux~~disposable absorbent pads, oxygen, surgical dressings, rubber shields, colostomy and ~~eleostomy~~ileostomy appliances;

~~(n)~~(xi) Prosthetic devices including wigs and artificial breasts;

~~(o)~~(xii) Nursing home care for noncustodial services; ~~and~~

~~(p)~~(xiii) Reconstructive surgery when deemed necessary by the attending physician;

(xiv) Hospice services, as defined in paragraph (2)(m) above~~.~~;

(xv) Hospital room and board and any other hospital furnished medical services or supplies; and

(xvi) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition.

(c) A policy may include coverage of any other expenses necessarily incurred in the treatment of the disease.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least ~~[$100]~~$[X] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment ~~equal to one half~~of at least [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

(iii) A fixed-sum payment of at least ~~$50~~$[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to ~~confinement~~receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:

(i) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to ~~one fourth~~[X%] the hospital in-patient benefit for each day of home health care for at least 100 days.

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

(a) These coverages must pay indemnity benefits ~~on behalf of insured persons of~~for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of ~~$1,000~~$[X].

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should ~~be sensitive to this possibility in approving policies~~avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease ~~with one exception. In the case~~ unless there are ~~of~~ clearly identifiable subtypes with significantly lower treatment~~s~~ costs, in which case lesser amounts may only be payable ~~so long as~~if the policy clearly differentiates that subtype and its reduced benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving ~~skin cancer or other~~ exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

~~K~~F. Specified Accident Coverage

"Specified accident coverage" is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than ~~[$1,000]~~$[X] for accidental death, ~~[$1,000]~~$[X] for double dismemberment ~~[$500]~~$[X] for single dismemberment.

~~L~~G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, ~~C,~~ D, ~~E,~~ and F~~, G, I and K~~. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L~~8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section ~~7J~~7E and shall not be offered for sale as ~~a~~ "limited benefit health coverage."

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited ~~benefit health~~long-term care insurance ~~plans~~policies, and should be subject to the ~~NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation~~ *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation for disclosures that this coverage is supplementary coverage.

H. Short-Term, Limited-Duration Health Insurance Coverage

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided to residents of the state pursuant to a contract with a health carrier, regardless of the situs of the contract, that has an expiration date specified in the contract that is less than [X] [days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration no longer than [X] [days or months] after the original effective date of the contract.

(2) (a) Short-term, limited-duration health insurance must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Section 7D(2) and Section 7D(4) of this regulation, should be permitted exclusions to short-term, limited-duration insurance policies.

(b) A short-term, limited-duration health insurance policy or certificate must have:

(i) An annual or lifetime limit of no less than [$1,000,000];

(ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and

(iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

(3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration health insurance policy or certificate for more than [X] months [in any 12-month period].

(4) Short-term, limited-duration health insurance, including individual policies and group certificates:

(a) May not be marketed as guaranteed renewable;

(b) Must be marketed as either nonrenewable, or renewable for a limited time without re-underwriting;

(c) Must clearly state the duration of the initial term and the total maximum duration, including any renewal options;

(d) May not be modified after the date of issuance, except by signed acceptance of the policyholder or the certificate holder, if the policy holder or the certificate holder contributes to the premium; and

(e) If the coverage is renewable, the individual policy or group certificate must:

(i) Include a statement that the insured has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;

(ii) Include a statement that the carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and

(iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.

(5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period.

(6) A carrier may not rescind a short-term limited duration health insurance policy or certificate during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under the rescinded policy or certificate.

Drafting Note: States should be aware that the language in paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

(7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate during the coverage period except in the following circumstances:

(a) Nonpayment of premium;

(b) Violation of the carrier's published policies approved by the commissioner;

(c) An insured's commitment of fraudulent acts as to the carrier;

(d) An insured's material breach of the insurance contract; or

(e) A change or implementation of a federal or state law or regulation that no longer permits the continuing offering of the coverage.

(8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance policy or certificate, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. In addition, states should review any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section ~~8~~9. Required Disclosure Provisions

A. General Rules

(1) (a) All applications, policies, and certificates for coverage~~s specified in Sections 7B, C, D, E, G, I, J, K and L~~ of supplementary or short-term health insurance shall ~~contain~~include a prominent disclosure statement, ~~by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~ as required by this section, that reflects the type of coverage being provided.

(b) The disclosures required by this section may be modified only as needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage.

~~"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."~~

(c) The disclosure statement shall be in a sans serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.

(d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block.

(e) In the policy and certificate, the disclosure statement shall be placed on the first page.

(f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are accessible to potential applicants, including those with disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(2) Any disclosures, and the documents to which they refer, shall be delivered in the written medium (digital or heard copy) the applicant requests. These documents shall be provided before the applicant submits a completed application.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state's requirements.

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state's requirements.

~~(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."~~

~~(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."~~

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "while you are disabled" made prominent:

"This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully."

(6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "from a covered accident" made prominent:

"This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "of a covered disease" made prominent:

"This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "for a specifically identified type of accident" made prominent:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "limited benefits and only for the events specified" made prominent:

"The [policy] [certificate] pays limited benefits and only for the events specified in the [policy] [certificate]. These limited benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all dental expenses." made prominent:

"The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility."

(11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all vision expense." made prominent:

"The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility."

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word "Important" and the sentence "It is not comprehensive health insurance." made prominent:

"Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
  - Preexisting conditions; or
  - Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care).

- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs for this policy.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

~~(4)~~(13) Each policy of individual ~~accident and sickness insurance and group supplemental health insurance~~ supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

~~(5)~~(14) ~~Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all~~All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirement~~s~~ in this paragraph ~~apply~~applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

~~(6)~~(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.

~~(7)~~(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and a clear ~~an~~ explanation of the terms in its accompanying outline of coverage.

~~(8)~~(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall ~~appear as~~be clearly explained in a separate paragraph of the policy or certificate ~~and be~~ labeled ~~as~~ "Preexisting Condition~~s~~ Limitations."

~~(9) All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:~~

~~"Notice to Buyer: This is an accident only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."~~

~~Accident only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(10)~~(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating ~~in substance~~clearly that the policy~~holder~~ or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This ~~section~~paragraph should be included only if ~~the~~ it is consistent with applicable state law~~has legislation granting authority~~.

~~(11)~~(19) If age is to be used as a determining factor ~~for reducing~~to reduce the ~~maximum aggregate~~ benefits made available in the policy or certificate as originally issued, ~~that fact~~a clear explanation of how age is used shall be prominently set forth in the outline of coverage.

~~(12)~~(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall ~~indicate the~~clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person ~~by whom~~who may exercise the conversion privilege ~~may be exercised~~. The provision shall clearly specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

~~(13)~~(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital ~~confinement~~ indemnity or other fixed indemnity (Section ~~7E~~8B), specified disease (Section ~~7J~~8E), or limited benefit health coverages (Section ~~7L~~8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections ~~F~~D and ~~J~~F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence "This is not a Medicare Supplement policy." made prominent:

This ~~IS NOT A MEDICARE SUPPLEMENT~~is not a Medicare Supplement policy. If you are eligible for Medicare, ~~review~~ask the company for the Guide to Health Insurance for People ~~W~~with Medicare ~~available from the company~~.

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

(b) An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*].

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies should review how insurers should provide the notices required under paragraph (21)(a) to these individuals.

~~(14)~~(22) Insurers~~, except direct response insurers,~~ shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery. ~~Direct response insurers shall provide the Buyer's Guide upon request but not later than the time that the policy or certificate is delivered.~~

Drafting Note: Paragraph (22) only applies if a state has such a Buyer's Guide.

~~(15) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows: Notice to Buyer: This is specified disease [policy] [certificate].This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide.~~

~~**Drafting Note:** The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.~~

~~(16) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached~~

to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(19) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(20) All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This is a basic hospital/medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:

"Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."

(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:

"Notice to Buyer: This [policy] [certificate] provides dental benefits only."

~~(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides vision benefits only."~~

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant ~~or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans~~ all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point sans serif type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:

"NOTICE: Read this outline of coverage carefully. It is ~~not identical to~~different from the outline of coverage ~~provided upon~~you received when you [~~application~~applied][~~enrollment~~enrolled]~~,~~. ~~and the~~The coverage ~~originally~~you applied for ~~has~~was not ~~been~~ issued."

~~(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.~~

~~(4)~~(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

~~(5)~~(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

~~C. Basic Hospital Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations~~

of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

E. Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital outpatient services;

(d) Surgical services;

(e) Anesthesia services;

~~(f) In-hospital medical services; and~~

~~(g) Other benefits, if any.]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~
~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~F~~C. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7E~~8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~HOSPITAL CONFINEMENT INDEMNITY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully.~~—~~ This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important feature~~s of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) [Hospital ~~confinement~~ indemnity] [Other fixed indemnity] coverage is designed to ~~provide, to persons insured, coverage in the form of~~pay a fixed ~~daily~~dollar benefit as a result of a ~~during periods of~~ covered ~~hospitalization resulting from a~~ [hospital stay] [event] due to a ~~covered accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.~~ The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief, but clear and specific, description of the benefits in the following order:

(a) ~~Daily benefit payable during hospital confinement~~When the benefits are payable; ~~and~~

(b) The d~~D~~uration of benefits described in (a); and

(c) The fixed dollar amount of the benefits.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [~~Any~~A clear description of any benefits provided in addition to the ~~daily~~fixed dollar [hospital] [event] benefit.]

~~G. Individual Major Medical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!]~~

~~(2) Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services,~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services,~~

~~(f) Out-of-hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~H. Individual Basic Medical Expense Coverage~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services,~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services,~~

~~(f) Out-of-hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]~~

~~(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]~~

~~I~~D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section ~~7H~~8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~DISABILITY INCOME PROTECTION COVERAGE~~
Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy] [certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important features ~~of your policy~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR POLICY CAREFULLY~~read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to ~~provide, to persons insured, coverage~~pay a benefit for disabilities resulting from a covered ~~accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in the ways described in the [policy] [certificate].~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~ The benefit might not fully replace your income.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits contained in ~~this~~the [policy] [certificate].]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~J~~E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section ~~7I~~8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~ACCIDENT-ONLY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to supplement your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of the coverage~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Accident-only coverage ~~is designed to provide, to persons insured, coverage~~pays benefits for ~~certain losses resulting~~covered injuries from a covered accident ~~ONLY, subject to any limitations contained in the policy~~. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~

(3) [~~A brief~~Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~K~~F. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections ~~7J~~8E and ~~K~~F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE~~

~~THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Specified Disease or Specified Accident Coverage (Outline of Coverage)

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) ~~This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.~~ Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Drafting Note: States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.

(2) Read ~~Y~~your [policy] [certificate] ~~[Outline of Coverage]~~ ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(3) [Specified disease][Specified accident] coverage is designed to ~~provide, to persons insured, restricted coverage paying benefits ONLY~~ pay limited benefits ~~when certain losses occur~~ as a result of the diagnosis or treatment [of a ~~[specified diseases~~covered disease] or [resulting from a ~~[specified accidents~~specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.] Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

~~L~~G. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections ~~7~~8B, D and G~~C, D, E, F, G, I and K~~ of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~LIMITED BENEFIT HEALTH COVERAGE~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND~~
~~ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~
Limited Benefit Health Coverage
The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of your policy~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Limited benefit health coverage ~~is designed to provide, to persons insured, limited or supplemental coverage~~ pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

(4) [A clear description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

(3) [Brief, but clear and specific, description of the benefits in the following order:

(a) Benefits covered by the policy or certificate, including required cost-sharing;

(b) Benefits that are not covered by the policy or certificate; and

(c) Duration of benefits described above.]

(4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.

(5) [A clear description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above.]

(6) [A clear description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~M~~I. Limited Scope Dental ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear ~~descripton~~description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~N~~J. Limited Scope Vision ~~Plans~~Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision ~~plan~~care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~ This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear description of any ~~policy~~ provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph ~~(1)~~(3) above.]

~~(4)~~(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section ~~9~~10. Requirements for Replacement of Individual ~~Accident and Sickness Insurance~~Supplementary and Short-Term Health Insurance Coverage

~~**Drafting Note:** Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.~~

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other ~~accident and sickness~~supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. ~~In no event, h~~However, ~~will the~~this notice~~s be~~is not required in the solicitation of ~~the following types of policies:~~ accident-only policies or the replacement of ~~and~~ single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~ end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with a policy ~~to be issued by~~the [insert company name] Insurance Company will issue. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~which you may~~that you might ~~presently~~ have~~,~~ now (preexisting conditions) or ~~may~~might not ~~be immediately or fully covered under the new policy~~cover them right away. ~~This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy~~ A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) ~~You may wish to secure the advice of your present insurer or its agent~~Talk with your current insurance agent ~~regarding the proposed replacement of your present~~or company representative about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing your present~~how replacing your policy could affect your future coverage.

(3) If~~, after due consideration, you still wish to terminate your present~~ you decide to buy a new policy~~, and replace it with new coverage, be certain~~be sure to truthfully and completely answer all questions on the application ~~concern~~about your medical/health history. ~~Failure to include all material medical information on an application may provide a basis for~~If you do not, the company ~~to~~could deny any future claims and ~~to~~ refund your premium as though your policy had never been in force. ~~After the~~Check that the information on your application ~~has been completed~~is complete and correct ~~and~~ before you sign it~~, reread it carefully to be certain that all information has been properly recorded~~.

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____
(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

~~NOTICE TO APPLICANT REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with the attached policy ~~delivered herewith~~ issued by [insert company name] Insurance Company. ~~Your new policy provides~~You have thirty days ~~within which you may~~to decide ~~without~~at no cost ~~whether you desire to~~if you want to keep the new policy. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover ~~Health~~health conditions ~~that~~ you ~~may presently~~ have~~,~~ now (preexisting conditions) ~~may not be immediately or fully covered under the new policy~~or might not cover them right away. ~~This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~A new policy might cover some but not all the costs related to preexisting conditions.

(2) ~~You may wish to secure the advice of your present insurer or its~~ Talk with your insurance agent or company representative ~~regarding the proposed replacement of your present~~about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interest~~s~~ to ~~make~~be sure you understand ~~all the relevant factors involved in replacing~~how replacing your policy could affect your ~~present~~future coverage.

(3) [To be included only if the application is attached to the policy]. If~~, after due consideration,~~ you ~~still wish to terminate your present~~decide to buy a new policy~~,~~ ~~and replace it with new coverage,~~ read the copy of the attached application ~~attached to your new policy~~ and be sure that all questions are answered fully and correctly. ~~Omissions or misstatements in the application could cause~~If they are not, the company could refuse to pay an otherwise valid claim ~~to be denied~~. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left ~~out of~~off the application.

[COMPANY NAME]

Drafting Note: The sentence "You have thirty days to decide at no cost if you want to keep the new policy." should only be required if the state has adopted Section 9A(18).

Section ~~10~~11. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

PROJECT HISTORY

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#171)

1. Description of the Project, Issues Addressed, etc.

Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing existing NAIC models related to health insurance to determine whether they needed to be amended, considering all the changes made by the ACA. During that review process, Model #170 and its companion model regulation, Model #171, were added to the list of NAIC models to be considered for revision, given the model's provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and Model #171. At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled *Managed Care Network Adequacy Model Act* (#74), now the *Health Benefit Plan Network Access and Adequacy Model Act* (#74), to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished that work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA's future, given congressional proposals to repeal, replace, and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. The Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019.

The Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered excepted benefits, and therefore, not subject to the ACA's requirements. The Model #170 revisions also added short-term, limited-duration plans to the model because there was no other vehicle available to add those products and the Subgroup did not want to create a whole new model for them.
Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024. The Regulatory Framework (B) Task Force adopted the revisions on Nov. 4 and the Health Insurance and Managed Care (B) Committee adopted the revisions during a meeting on Nov. 19.

The revisions to Model #171 revise the model for consistency with the revisions to Model #170. The revisions also add standards for short-term, limited-duration (STLD) plans. Because the Subgroup did not want to dictate what benefits and coverages these plans must include, the standards specify that short-term, limited-duration plans must provide the benefits and coverages required by the state. The revisions also clarify provisions on consumer disclosure and outline of coverage requirements making them much more understandable for consumers, including requiring specific language stating that these plans are supplemental and are not intended to be major medical coverage.

2. Name of Group Responsible for Drafting the Model and States Participating

The Accident and Sickness Insurance Minimum Standards (B) Subgroup drafted the revisions to Model #171. At the time of adoption on Oct. 17, 2024, the Subgroup members were: Oklahoma, Co-Chair; Texas, Co-Chair; District of Columbia; Florida; Louisiana; Maine; Missouri; Nebraska; South Carolina; Utah; Vermont; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. The Subgroup adopted the revisions to Model #170 in July 2018. Soon after completing its work on Model #170, with Oklahoma and Minnesota as co-chairs, the Subgroup began discussing revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus starting in late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup, with Oklahoma and Nebraska as co-chairs, resumed its meetings in June 2021. In late 2022, the Subgroup lost Nebraska as co-chair but resumed its meetings in early 2023, with Texas replacing Nebraska as co-chair. The Subgroup continued meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September 2024. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings and discussions of the comments received in June 2021. The Subgroup met on a regular basis to discuss the comments received on Model #171 until it adopted the model revisions Oct. 17, 2024.

During the last few months of 2022, the Subgroup's discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for STLD plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans.

The Subgroup resumed its meetings in February 2023, reviewing and discussing comments received on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24, 2023, comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup's review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup is completing work on Section 9—Required Disclosure Provisions. In October 2023, the Subgroup completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171.

The Subgroup resumed its meetings in January 2024 to discuss the comments received. The Subgroup completed that review in April 2024 and distributed a final draft, dated May 3, to stakeholders in anticipation of adopting the proposed revisions in June. The Subgroup received additional comments on that draft, and as a result, it resumed its meetings in June 2024 to discuss the comments. The Subgroup completed its review of those comments in September 2024 and distributed another final draft in anticipation of adopting the revisions to Model #171 during a meeting in October. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited)

Throughout the drafting process the Subgroup solicited comments from stakeholders, which included consumer and industry representatives, as well as state insurance regulators. The Subgroup discussed and reviewed those comments during public meetings. All the comments received were posted on the Subgroup's webpage. Each proposed revision draft was also posted on the Subgroup's web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Among the issues debated during the drafting process concerned the purpose of excepted benefit products and the fact that they are not intended to be comprehensive major medical coverage. In addressing this issue, the Subgroup enhanced the consumer disclosure provisions and outline of coverage provisions to ensure consumers will be aware that excepted benefit products are

not meant to be comprehensive health insurance coverage. The Subgroup also included additional language in the draft highlighting that insurers should not offer, market, or sell excepted benefit products as a substitute for, or alternative to, comprehensive major medical coverage.

In addition, during the drafting process, the Subgroup and stakeholders involved had to keep in mind that the model sets minimum standards, which means the states and insurance carriers can go above them. In addressing another issue that arose during the process concerning potential and recurring federal changes related to hospital indemnity or other fixed indemnity plans and STLD plans, the Subgroup included in the revisions suggestions that, prior to adopting the model revisions, states review any relevant federal regulations, establishing that requirements for these products that could differ from the state's requirements.

One significant issue discussed and addressed during the drafting process related to the provisions establishing standards for STLD plans, including what benefits should be included. In resolving this issue, the STLD plan provisions rely on a state's requirements for benefits and coverage under such plans.

Another significant issue discussed concerned a provision in the model that allows plans to exclude mental health and substance use coverage from excepted benefit plans. During this discussion, it was highlighted that these are excepted benefit products, not major medical coverage subject to the ACA's guarantee issue and preexisting condition exclusion requirements. Excepted benefit plans are medically underwritten and subject to preexisting condition exclusions. It was also noted that this provision is optional, which means states can require such coverage if they feel it is appropriate. In addition, as already noted, for short-term, limited-duration plans, the benefits and coverages for these plans are tied to a state's requirements. If a state requires these plans to include mental health and substance use benefits, then they must include the coverage. As a compromise to address these concerns, before its adoption of the Model #171 revisions, the Health Insurance and Managed Care (B) Committee added language to a drafting note in Section 7D—Prohibited Policy Provisions making it clear that states should carefully consider whether to permit mental health and substance use coverage exclusions for STLD plans and disability income protection policies given the importance of such coverage. The Committee added similar language to a drafting note in Section 8H—Short-Term, Limited-Duration Health Insurance Coverage.

7. List the key provisions of the model (sections considered most essential to state adoption)

This is not applicable. All the sections are essential to state adoption.

8. Any Other Important Information (e.g., amending an accreditation standard)

This is not an accreditation model.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Summary of Findings and Determination

Canada Office of the Superintendent of Financial Institutions (OSFI)

Evaluation as a Jurisdiction that Recognizes and Accepts the U.S. Group Capital Calculation

Issued for Public Comment By:

Mutual Recognition of Jurisdictions (E) Working Group

October 24, 2024

I. Executive Summary & Recommendation

The Mutual Recognition of Jurisdictions (E) Working Group of the National Association of Insurance Commissioners (NAIC) has completed this Summary of Findings and Determination with respect to the evaluation of the Canada Office of the Superintendent of Financial Institutions (OSFI) as a jurisdiction that Recognizes and Accepts the U.S. Group Capital Calculation ("Recognize and Accept Jurisdiction"). It is the recommendation of the Working Group that the NAIC approve the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI. These recommendations are based on the following analysis:

II. Procedural History

The Working Group is responsible for overseeing the process for evaluating jurisdictions and maintaining a listing of jurisdictions that meet the NAIC requirements for recognizing and accepting the US approach to the Group Capital Calculation (GCC). As background, on December 9, 2020, the NAIC adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implement the GCC filing requirements for insurance groups at the level of the ultimate controlling person for the purpose of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC's GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions) if its groupwide supervisor "recognizes and accepts" the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor. To further implement the GCC provisions of Model #440 and Model #450, the Working Group adopted the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* (Recognize and Accept Process) on December 15, 2021.

Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

> (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction "recognizes the U.S. state regulatory approach to group supervision and group capital" or
>
> (b) <u>If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation</u>.

As of this date, the only jurisdictions that have been deemed to meet the standards are the current Reciprocal Jurisdictions (European Union member states, United Kingdom, Bermuda, Japan, and Switzerland).

On November 9, 2023, the DIFS requested that the Working Group perform a review of the OSFI under the NAIC Recognize and Accept Process, and further that the DIFS agreed to act as the Lead State. The relevant provisions with respect to the review procedure are summarized, as follows:

- The Working Group will follow the Procedure for Evaluation of Non-U.S. Jurisdictions as set forth in paragraph 8 of the Recognize and Accept Process. This will include public notice on the NAIC website, and consideration of public comments from state regulators, U.S. insurance groups, and any other interested parties. Relevant U.S. state and federal authorities will be notified of the Working Group's decision to evaluate the OSFI.

- Following these public actions, the Working Group will prepare a Preliminary Evaluation Report and Final Evaluation Report in regulator-to-regulator session, followed by a public Summary of Findings and Determination recommending that the OSFI be included on the list of Recognize and Accept Jurisdictions.

- The Working Group may rely on written confirmation by the OSFI that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction. This may be done by signature to the letter template found in the Appendix of the Process. The Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

- Finally, the OSFI and Michigan must have a memorandum of understanding to share applicable information with each other, which Michigan as the lead state would share with other NAIC states. Both the OSFI and DIFS are signatories to the IAIS Multilateral Memorandum of Understanding, which we have concluded to be satisfactory for these purposes.

- Upon the NAIC's adoption of an affirmative recommendation with respect to the Summary of Findings and Determination, the OSFI will be added to the NAIC List of Recognize and Accept Jurisdictions. Once approved, a Recognize and Accept Jurisdiction is subject to periodic annual review under an abbreviated process.

To conduct the review, NAIC staff reviewed any public information that was available, focusing on the *June 2019 International Monetary Fund (IMF) Financial System Stability Assessment (FSAP)* and the *January 2020 IMF FSAP Technical Note—Insurance Sector: Regulation and Supervision*. During the review, it was noted that the domestic financial regulator for insurance companies that are domiciled in Quebec is the Quebec Autorité des marchés financiers (AMF), while any companies domiciled in any of the other nine Canadian provinces are regulated by OSFI. The scope of this review only covers OSFI.

The review that was conducted only focused on any issues that would cause the jurisdiction to not meet the standards in Model #440 and Model #450 pertaining to the ability to recognize and accept the U.S. approach to the group capital calculation. During review of the IMF reports, there were no issues noted that would cause any concerns for the OSFI. In addition to the review performed by NAIC staff, the Working Group received a letter from OSFI dated April 9, 2024, confirming the following requirements in the Recognize and Accept Process:

- OSFI recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction.

- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and OSFI, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

- OSFI will immediately notify the NAIC upon any changes to the assurances provided in this letter.

III. Summary of Findings and Recommendation

Therefore, it is the recommendation of the Mutual Recognition of Jurisdictions (E) Working Group that the NAIC recognize the OSFI as a Recognize and Accept Jurisdiction and place it on the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation*, to be effective immediately. Finally, the Working Group recommends that the Department of Insurance and Financial Services for the State of Michigan (DIFS) be the Lead State for purposes of regulatory cooperation and information sharing with the OSFI.

