

REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2017

Prepared by the NAIC Actuarial Opinion (C) Working Group
of the Casualty Actuarial and Statistical (C) Task Force

The NAIC Actuarial Opinion (C) Working Group (Working Group) of the Casualty Actuarial and Statistical (C) Task Force believes that the Statement of Actuarial Opinion (Actuarial Opinion), Actuarial Opinion Summary (AOS), and Actuarial Report are valuable tools in serving the regulatory mission of protecting consumers. This Regulatory Guidance document supplements the NAIC *Annual Statement Instructions – Property/Casualty (Instructions)* in an effort to provide clarity and timely guidance to companies and Appointed Actuaries regarding regulatory expectations on the Actuarial Opinion, AOS, and Actuarial Report.

An Appointed Actuary has a responsibility to know and understand both the *Instructions* and the expectations of state insurance regulators. One expectation of regulators clearly presented in the *Instructions* is that the Actuarial Opinion, AOS, and supporting Actuarial Report and workpapers be consistent with relevant Actuarial Standards of Practice (ASOPs).

There are no significant changes to the *Instructions* for 2017. The Working Group used this opportunity to make changes to this year's Regulatory Guidance document. The document has been restructured to improve readability. In addition, content that is no longer relevant has been removed, and additional information has been added in certain sections. The Working Group's goal is to keep the guidance useful and timely.

The Regulatory Guidance document is now divided into three sections: The first contains general comments; the second has comments specific to the Actuarial Opinion and Actuarial Report; and the third has comments specific to the AOS.

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I. [General comments](#)

A. [Reconciliation between documents](#)

If there are any differences between the values reported in the Actuarial Opinion, AOS, Actuarial Report, and Annual Statement, the Working Group expects Appointed Actuaries to include an explanation for these differences in the appropriate document (Actuarial Opinion, AOS, or Actuarial Report). The use of a robust peer review process by the Appointed Actuary should reduce reporting errors and non-reconciling items.

One situation in which a legitimate difference might arise is in the case of non-tabular discounting: The direct and assumed loss reserves on line 3 of the Actuarial Opinion's Exhibit A come from Schedule P, Part 1, which is gross of non-tabular discounting, while the Actuarial Report and AOS might present the direct and assumed loss reserves on a net of discounting basis.

B. [Role of illustrative language in the *Instructions*](#)

While the *Instructions* provide some illustrative language, the Working Group encourages Appointed Actuaries to use whatever language they believe is appropriate to clearly convey their opinion and the basis for that opinion. In forming their opinion, Appointed Actuaries should consider company-specific characteristics such as intercompany pooling arrangements; recent mergers or acquisitions; and significant changes in operations, product mix, or reinsurance arrangements.

C. [Replacement of an Appointed Actuary](#)

The *Instructions* require two letters when the Board replaces an Appointed Actuary: one addressed from the insurer to the domiciliary commissioner, and one addressed from the former Appointed Actuary to the insurer. The insurer must provide both of these letters to the domiciliary commissioner.

The detailed steps are as follows:

1. Within 5 business days, the insurer shall notify its domiciliary insurance department that the former Appointed Actuary has been replaced.
2. Within 10 business days of the notification in step 1, the insurer shall provide the domiciliary commissioner with a letter stating whether in the 24 months preceding the replacement, there were disagreements with the former Appointed Actuary. The *Instructions* describe the types of disagreements required to be reported in the letter.
3. Within the same 10 business days referred to in step 2, the insurer shall, in writing, request that its former Appointed Actuary provide a letter addressed to the insurer stating whether the former Appointed Actuary agrees with the statements contained in the insurer's letter referenced in step 2.
4. Within 10 business days of the request from the insurer described in step 3, the former Appointed Actuary shall provide a written response to the insurer.
5. The insurer shall provide the letter described in step 2 and the response from the former Appointed Actuary described in step 4 to the domiciliary commissioner.

Regarding the disagreements referenced in step 2 above, regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary's analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary's analysis may go through several iterations, and an insurer's comments on the Appointed Actuary's draft Actuarial Report may prompt the Appointed Actuary to make changes to the report. While regulators are interested in material disagreements regarding differences between the former Appointed Actuary's final estimates and the insurer's carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary's work.

D. [Reporting to the Board of Directors](#)

The Appointed Actuary is required to report to the insurer's Board every year, and the *Instructions* were amended in 2016 to require the Board's minutes to specify the manner in which the Appointed Actuary presented the required information. This may be done in a form of the Appointed Actuary's choosing, including, but not limited to, an executive summary or PowerPoint presentation. The Working Group strongly encourages the Appointed Actuary to present his or her analysis in person so that the risks and uncertainties that underlie the exposures and the significance of the Appointed Actuary's findings can be adequately conveyed and discussed. Regardless of how the Appointed Actuary presents his or her conclusions, the Actuarial Report must be made available to the Board.

Management is limited to reporting single values on lines 1 and 3 of the Liabilities, Surplus, and Other Funds page of the balance sheet. However, actuarial estimates are uncertain by nature, and point estimates do not convey the variability in the projections. Therefore, the Board should be made aware of the Appointed Actuary's opinion regarding the risk of material adverse deviation, the sources of risk, and what amount of adverse deviation the Appointed Actuary judges to be material.

E. [Requirements for pooled companies](#)

Effective with the 2014 *Instructions*, requirements for companies that participate in intercompany pools are as follows:

For all intercompany pooling members:

- Text of the Actuarial Opinion should include the following:
 - Description of the pool
 - Identification of the lead company
 - A listing of all companies in the pool, their state of domicile, and their respective pooling percentages
- Exhibits A and B should represent the company's share of the pool and should reconcile to the financial statement for that company

For intercompany pooling members with a 0% share of the pooled reserves:

- Text of the Actuarial Opinion should be similar to that of the lead company
- Exhibits A and B should reflect the 0% company's values
 - Response to Exhibit B, Item 5 (materiality standard) should be \$0
 - Response to Exhibit B, Item 6 (risk of material adverse deviation) should be "not applicable"
- Exhibits A and B of the lead company should be filed with the 0% company's Actuarial Opinion
- Information in the AOS should be that of the lead company

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share reinsurance agreement. The regulator must approve these affiliate agreements as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

For intercompany pooling members with a greater than 0% share of the pooled reserves, regulators encourage the Appointed Actuary to display values in the AOS on a pooled (or consolidated) basis in addition to the statutory entity basis. This can be accomplished by displaying two tables of information.

F. [Explanation of adverse development](#)

1. [Comments on unusual Insurance Regulatory Information System \(IRIS\) ratios in the Actuarial Opinion](#)

The Appointed Actuary is required to provide comments in the Actuarial Opinion on factors that led to unusual values for IRIS ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to “reserve strengthening” or “adverse development” and expects the Appointed Actuary to provide insight into the company-specific factors which caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the Actuarial Opinion.

2. [Comments on persistent adverse development in the AOS](#)

The Appointed Actuary is required to comment on persistent adverse development in the AOS. Comments can reflect common questions that regulators have, such as:

- Is development concentrated in one or two exposure segments, or is it broad across all segments?
- How does development in the carried reserve compare to the change in the Appointed Actuary’s estimate?
- Is development related to specific and identifiable situations that are unique to the company?
- Does the development or the reasons for development differ depending on the individual calendar or accident years?

G. [Revisions](#)

When a material error in the Actuarial Opinion or AOS is discovered by the Appointed Actuary, the company, the regulator, or any other party, regulators expect to receive a revised Actuarial Opinion or AOS.

Regardless of the reason for the change or refiling, the company should submit the revised Actuarial Opinion in hard copy to its domiciliary state and electronically to the NAIC. The company should submit the revised AOS in hard copy to the domiciliary state but should not submit the document to the NAIC.

A revised Actuarial Opinion or AOS should clearly state that it is an amended document, contain or accompany an explanation for the revision, and include the date of revision.

II. [Comments on Actuarial Opinion and Actuarial Report](#)

A. [Review date](#)

The illustrative language for the Scope paragraph includes “... and reviewed information provided to me through XXX date.” This is intended to capture the ASOP No. 36 requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion (the review date), if it differs from the date the Actuarial Opinion is signed. When the Appointed Actuary is silent regarding the review date, this can indicate either that the review date is the same as the date the Actuarial Opinion is signed or that the Appointed Actuary overlooked this disclosure requirement. When the Appointed Actuary’s review date is the same as the date the Actuarial Opinion is signed, regulators suggest the Appointed Actuary clarify this in the Actuarial Opinion by including a phrase such as “... and reviewed information provided to me through the date of this opinion.”

B. [Making use of another’s work](#)

If the Appointed Actuary makes use of the work of another not within the Appointed Actuary’s control for a material portion of the reserves, the *Instructions* say that the Appointed Actuary must provide the following information in the Actuarial Opinion:

- The person's name;
- The person's affiliation;
- The person's credential(s), if the person is an actuary; and
- A description of the type of analysis performed, if the person is not an actuary.

Furthermore, Section 4.2.f of ASOP No. 36 says that the actuary should disclose whether he or she reviewed the other's underlying analysis and, if so, the extent of the review. Though this is not mentioned in the ASOP, the Working Group encourages the Appointed Actuary to consider discussing his or her conclusions from the review.

Section 3.7.2 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to make use of the work of another. One of these items is the amount of the reserves covered by the other's analyses or opinions in comparison to the total reserves subject to the actuary's opinion. The Working Group encourages the Appointed Actuary to disclose these items in the Actuarial Opinion by providing the dollar amount of the reserves covered by the other's analyses or opinions and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.

C. [Points A and B of the Opinion paragraph when opinion type is other than reasonable](#)

Regulators encourage Appointed Actuaries to think about their responses to point A (meet the requirements of the insurance laws of the state) and point B (computed in accordance with accepted actuarial standards and principles) of the Opinion paragraph when they issue an Actuarial Opinion of a type other than "Reasonable."

D. [Conclusions on a net versus a direct and assumed basis](#)

Unless the Appointed Actuary states otherwise, regulators will assume that the Appointed Actuary's conclusion on the type of opinion rendered, provided in points C and D of the Opinion paragraph, applies to both the net and the direct and assumed reserves. If the Appointed Actuary reaches different conclusions on the net versus the direct and assumed reserves, the Appointed Actuary should include narrative comments to describe the differences and clearly convey a complete opinion. The response to Exhibit B, Item 4 should reflect the Appointed Actuary's opinion on the net reserves.

Similarly, the materiality standard in Exhibit B, Item 5 and the RMAD conclusion in Exhibit B, Item 6 should pertain to the net reserves. If the Appointed Actuary reaches a different conclusion on the risk of material adverse deviation in the net versus the direct and assumed reserves, the Appointed Actuary should include a Relevant Comments paragraph to address the differences. Regulators understand that a net versus a direct and assumed RMAD will have different meanings and, potentially, different materiality standards.

E. [Unearned premium for long duration contracts](#)

Exhibit A, Items 7 and 8 require disclosure of the unearned premium reserve for long duration contracts, and the *Instructions* require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material. However, regulators have noted that some Actuarial Opinions include point D regardless of materiality. The Working Group expects that Appointed Actuaries will either add point D if they can and are indeed expressing an opinion on the reasonableness of this reserve and/or add a Relevant Comments paragraph about these unearned premium reserves and state whether the amounts are material or immaterial.

F. [Other premium reserve items](#)

With regard to "Other Premium Reserve Items" in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial.

G. [The importance of Relevant Comments paragraphs](#)

The Working Group considers the Relevant Comments paragraphs to be the most valuable information in the Actuarial Opinion. Relevant Comments help the regulator interpret the Actuarial Opinion and understand the Appointed Actuary's reasoning and judgment. In addition to the required Relevant Comments, the Appointed Actuary should consider providing information on other material items such as reinsurance with affiliates, mergers or acquisitions, other premium reserves, and catastrophe risk.

H. [Risk of Material Adverse Deviation](#)

The Relevant Comments paragraphs on the Risk of Material Adverse Deviation (MAD or RMAD) are particularly useful to regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to regulators. The second two stem from regulators' reviews of Actuarial Opinions.

1. [No company-specific risk factors](#) – The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe that there are any company-specific risk factors, the Appointed Actuary should state that.
2. [Mitigating factors](#) – Regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company's application of controls or use of mitigation techniques. The company's risk management behaviors may, however, affect the Appointed Actuary's conclusion on whether there is a significant risk of MAD.
3. [Consideration of carried reserves, materiality standard, and reserve range when making RMAD conclusion](#) – When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.
4. [Materiality standards for intercompany pool members](#) – With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate Actuarial Opinion with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

I. [Regulators' use of the Actuarial Report](#)

Regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with ASOP No. 41 can provide a foundation for efficient reserve evaluation during a statutory financial examination. This expedites the examination process and may provide cost savings to the company.

1. [Schedule P reconciliation](#)

The Working Group acknowledges that myriad circumstances (such as mergers, acquisitions, changes in claim systems, and the use of underwriting year data in the analysis) may make it difficult for the Appointed Actuary to reconcile the analysis data to Schedule P. The Working Group encourages Appointed Actuaries to disclose reconciliation issues in the Actuarial Report. If the data cannot be reconciled, the Appointed Actuary should document the reasons.

The Working Group believes that:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity and the methods used by the Appointed Actuary.
- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and should provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis and that there is often not a direct correspondence between analysis segments and Schedule P lines of business.
- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate.

The Working Group draws a distinction between two types of data checks:

- The Schedule P reconciliation performed by the Appointed Actuary. The purpose of this exercise is to show the user of the Actuarial Report that the data significant to the Appointed Actuary's analysis ties to the data in Schedule P.
- Annual testing performed by independent CPAs to verify the completeness and accuracy of the data in Schedule P or the analysis data provided by the company to the Appointed Actuary.

One key difference is that independent CPAs generally apply auditing procedures to loss and loss adjustment expense activity that occurred in the current calendar year (for example, tests of payments on claims for all accident years that were paid during the current calendar year). Projection methodologies used by Appointed Actuaries, on the other hand, often use cumulative loss and loss adjustment expense data, which may render insufficient a testing of activity during the current calendar year alone.

Along similar lines, regulators encourage Appointed Actuaries to consider whether a reconciliation of incremental payments during the most recent calendar year for all accident/report years combined provides sufficient assurance of the integrity of the data used in the analysis, given that development factors are generally applied to cumulative paid losses by accident/report year.

2. [Change in estimates](#)

The Working Group expects the Appointed Actuary to discuss any significant change in the Appointed Actuary's total estimates from the prior Actuarial Report. However, an explanation should also be included for any significant fluctuations within accident years or segments. When preparing the change-in-estimates exhibits, the Appointed Actuary should choose a level of granularity that provides meaningful comparisons between the prior and current year's results.

3. [Narrative](#)

The narrative section of the Actuarial Report should clearly convey the significance of the Appointed Actuary's findings and conclusions, the uncertainty in the estimates, and any differences between the Appointed Actuary's estimates and the carried reserves.

4. [Support for assumptions](#)

Appointed Actuaries should support their assumptions. The use of phrases like "actuarial judgment," either in the narrative comments or in exhibit footnotes, is not sufficient. A descriptive rationale is needed.

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have

little value if items such as rate actions, tort reform, schedule rating adjustments, or program revisions have materially affected premium adequacy.

5. [Support for roll forward analyses](#)

The Working Group recognizes that the majority of the analysis supporting an Actuarial Opinion may be done with data received prior to year-end and “rolled forward” to year-end. By reviewing the Actuarial Report, the regulator should be able to clearly identify why the Appointed Actuary made changes in the ultimate loss selections and how those changes were incorporated into the final estimates. A summary of final selections without supporting documentation is not sufficient.

J. [Exhibits A and B](#)

1. [“Data capture format”](#)

The term “data capture format” in Exhibits A and B of the *Instructions* refers to an electronic submission of the data in a format usable for computer queries. This process allows for the population of an NAIC database that contains qualitative information and financial data. Appointed Actuaries should assist the company in accurately completing the electronic submission.

2. [Scope of Exhibit B, Item 12](#)

Exhibit B, Item 12 requests information on extended loss and unearned premium reserves for all property/casualty lines of business, not just medical professional liability. The Schedule P Interrogatories only address extended loss and unearned premium reserves associated with medical professional liability coverage.

3. [Scope of Exhibit B, Item 13](#)

Regulators are cognizant that property and casualty insurers may have long term care (LTC) and other health insurance exposure. Given that LTC blocks are long duration in nature and have recently exhibited adverse experience, industry providers of this coverage are experiencing significant reserve strengthening in recent years. It would seem prudent for the Appointed Actuary to provide commentary regarding the insurer’s exposure to LTC and other health insurance segments.

Currently, insurers may be reporting LTC liabilities as loss and loss adjustment expense reserves on Annual Statement page 3, lines 1 and 3; as unearned premium reserves/active life reserves on Annual Statement page 3, line 9; and/or as premium deficiency reserves on Annual Statement page 3, write in line. Liabilities related to health insurance coverage, particularly LTC, that are reported in the Property and Casualty Annual Statement should be identified in Exhibit B, Item 13 of the Actuarial Opinion and commented upon in the Relevant Comments paragraph.

K. [Long term care reserves](#)

On August 9, 2017, the NAIC’s Executive (EX) Committee and Plenary adopted Actuarial Guideline LI, The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG LI), requiring stand-alone asset adequacy analysis of large blocks of LTC business. The effective date of the AG LI is December 31, 2017. The AG LI states that it shall apply to a company with over 10,000 inforce lives covered by LTC insurance contracts as of the valuation date. This requirement is applicable to all life insurers having LTC business at year-end 2017. Although AG LI implicitly includes P&C insurers, the 2017 *Instructions* will not incorporate this requirement for Property and Casualty insurers for year-end 2017 due to the late adoption date.

Despite this, regulators encourage P&C insurers to follow the guidance in AG LI due to the well-recognized uncertainties associated with the adequacy of LTC insurance reserves.

III. [Comments on Actuarial Opinion Summary](#)

A. [Confidentiality](#)

The AOS is a confidential document and should be clearly labeled and identified prominently as such. The AOS is not submitted to the NAIC. The Working Group advises the Appointed Actuary to provide the AOS to company personnel separately from the Actuarial Opinion and to avoid attaching the related Actuarial Opinion to the AOS.

B. [Different requirements by state](#)

Not all states have enacted the NAIC Property and Casualty Actuarial Opinion Model Law (#745), which requires the AOS to be filed. Nevertheless, the Working Group recommends that the Appointed Actuary prepare the AOS regardless of the domiciliary state's requirements, so that the AOS will be ready for submission should a foreign state – having the appropriate confidentiality safeguards – request it.

Most states provide the Annual Statement contact person with a checklist that addresses filing requirements. The Working Group advises the Appointed Actuary to work with the company to determine the requirements for its domiciliary state.

C. [Format](#)

The purpose of the AOS is to show a comparison between the company's carried reserves and the Appointed Actuary's estimates. Because the AOS is a synopsis of the conclusions drawn in the Actuarial Report, the content of the AOS should reflect the analysis performed by the Appointed Actuary. Therefore, all of the Appointed Actuary's calculated estimates, including actuarial central estimates and ranges, are to be presented in the AOS consistent with estimates presented in the Actuarial Report.

The American Academy of Actuaries' Committee on Property and Liability Financial Reporting provides illustrative examples in its annual practice note "Statements of Actuarial Opinion on Property and Casualty Loss Reserves" that show how the Appointed Actuary might choose to display the required information. These examples present the numerical data in an easy-to-read table format.

Adopted by the Actuarial Opinion (C) Working Group on Oct. 5, 2017

IV. [Appendix: Actuarial Guideline LI](#)

The following is the content of Actuarial Guideline LI from *Accounting Practices & Procedures Manual as of March 2018*:

Actuarial Guideline LI

**THE APPLICATION OF ASSET ADEQUACY TESTING TO LONG-TERM CARE
INSURANCE RESERVES**

Background

The *Health Insurance Reserves Model Regulation (#010)* and the *NAIC Valuation Manual (VM-25)* contain requirements for the calculation of long-term care insurance (LTC) reserves. Regulators have observed a lack of uniform practice in the implementation of tests of reserve adequacy and reasonableness of LTC reserves. The reserve adequacy testing required by Model #10 and VM-25 does not provide regulators comfort as to the reserve adequacy of companies with material blocks of LTC business. As such, regulators must rely upon asset adequacy analysis required by the *NAIC Valuation Manual (VM-30)* to evaluate the solvency position of companies with sizable blocks of LTC business. This Guideline is intended to provide uniform guidance and clarification of requirements for the appropriate support of certain assumptions for the asset adequacy testing applied to a company's LTC block of contracts. In particular, this Guideline:

- (1) Specifies that the appropriate form of asset adequacy analysis may be in the form of a gross premium valuation or in a more robust form, such as cash-flow testing, with Actuarial Standards of Practice providing guidance in this area;
- (2) Clarifies the type of adequacy testing methods that must be used for aggregation with other blocks of business to be allowed for asset adequacy analysis purposes;
- (3) Requires a uniform approach to supporting acceptable assumptions regarding future LTC premium rate increases;
- (4) Provides requirements for documentation of assumptions associated with all key LTC risks; and
- (5) Provides requirements for documentation of standalone LTC asset adequacy testing results.

Note: It is anticipated that the requirements contained in this Guideline will be incorporated into the *NAIC Valuation Manual (VM-30)* at a future date, effective for a future valuation year. This Guideline will cease to apply to annual statutory financial statements at the time the corresponding VM-30 requirements become effective.

Text

1. Effective Date

This Guideline shall be effective for reserves reported with the December 31, 2017, and subsequent annual statutory financial statements.

2. Authority

Pursuant to Section 1, paragraph 3, of *VM-30* of the *NAIC Valuation Manual*, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

3. Scope

This Guideline shall apply to a company with over 10,000 inforce lives covered by long-term care insurance contracts as of the valuation date. All long-term care insurance contracts, whether directly written or assumed through reinsurance are included. Accelerated death benefit products or other combination products where the substantial risk of the product is associated with life insurance or an annuity are not subject to this Guideline.

4. Asset Adequacy Analysis of LTC Business

A. As stated in Actuarial Standard of Practice (ASOP) No. 22, multiple asset adequacy analysis methods, including cash-flow testing and gross premium valuation, are available to actuaries for this analysis.

The method of analysis used for LTC shall conform with ASOP No. 22 in recognition of the typical significant asset and liability-related risks associated with LTC.

B. Asset adequacy analysis specific to all inforce LTC business, and without consideration of results for other block of business within the company, must be performed for valuations associated with the December 31, 2017, and subsequent annual statutory financial statements. The analysis shall comply with applicable Actuarial Standards of Practice, including standards regarding identification of key risks. Material assumptions associated with the LTC business shall be determined testing moderately adverse deviations in actuarial assumptions.

C. When determining whether additional reserves are necessary:

1. A reserve deficiency in the LTC block may be aggregated with sufficiencies in the company's other blocks of business for the purposes of developing an actuarial opinion, if cash-flow testing is used for both the LTC business and for all significant blocks of non-LTC business within a company. If a reserve deficiency in the LTC block is not offset with sufficiencies in the company's other blocks of business, then additional reserves shall be established as required by section 2.C.2. of *VM-30*.
2. If cash-flow testing is not used for testing of the LTC business, then a reserve deficiency revealed from another method, e.g., a gross premium valuation, utilized for purposes of asset adequacy analysis of the LTC block under this Guideline shall not be offset with sufficiencies in the company's other blocks of business. The additional reserves under this Guideline shall be established based only upon the adequacy of the reserves in the LTC block.

- D. When determining the effect of investment returns or the time value of money:
1. In the case where cash-flow testing is used, the company must allocate investment income to the LTC block of business consistently with the way investment income generated by the General Account is managed. If, however, a segment of the General Account is used to manage the investment risk for LTC business, the investment income generated by assets from that segment should be appropriately represented within the asset adequacy analysis.
 2. In the case where a gross premium valuation method is used or asset cash flows are not explicitly modeled, the discount rate used by the actuary must reflect consideration of the yield on current assets held to support the liability as well as future yields on assets purchased with future premium income and reinvestments or anticipated divestiture of existing assets.
- E. The analysis shall only anticipate premium rate increases based upon a rate increase plan that is documented, is supported by and has been approved by management, is highly likely to be undertaken, and contains rate increase requests and timelines by jurisdiction. The assumptions used in the analysis should reflect a reasonable estimate of regulatory approved amounts and implementation timelines.

5. Documentation Required

The documentation requirements below are to be incorporated as a separate section of the appointed actuary's Actuarial Memorandum required by the *VM-30* or in a special Actuarial Memorandum containing LTC-specific information and shall be submitted to the commissioner of the company's state of domicile. The separate section of the companywide Actuarial Memorandum or the special Actuarial Memorandum shall be available to other state insurance commissioners in which the company is licensed upon request to the company. The confidentiality provisions regarding the Actuarial Memorandum contained in *VM-30* are applicable to the separate section of the Actuarial Memorandum and to the special Memorandum.

- A. Results of the asset adequacy analysis of the LTC business shall be reported and documented in the separate section of the Actuarial Memorandum or the special Memorandum, as appropriate.
- B. Assumptions on mortality shall be documented to state the reference standard valuation table, if applicable, and explicitly cite adjustments, select factors, and mortality improvement factors, where applicable. If a reference standard valuation table is not used in setting the mortality assumption, then a table of rates and comparison of the applied rates to rates from an unmodified standard mortality table for sample issue ages shall be provided. A summary of experience or other actuarial support of assumptions used shall be documented.
- C. Assumptions on voluntary lapse shall be documented in table format by duration band and by other factors such as gender, marital status, with versus without inflation rider, and length of benefit period impacting the lapse assumption, where applicable. A summary of experience or other support of assumptions shall be documented.

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- D. Assumptions on morbidity shall be documented and actuarial support of the assumption shall be provided. If an outside source is used as the basis for morbidity assumptions, then the rationale for the applicability of that source and any adjustments to the factors from that source shall be documented.
 - E. Assumptions on investment returns and interest rates shall be documented. If a simplified approach is applied, such as implicit reflection of projected investment returns through the use of discount rates in a gross premium valuation as contemplated in Section 4.D.2., then justification shall be provided.
 - F. Any rate increases already approved shall be documented by jurisdiction with approved implementation timelines. Assumptions on future rate increases shall be documented by policy form or policy grouping. Such documentation should adequately describe the way in which future rate increase assumptions are developed. Unless the appointed actuary has operational responsibility for carrying out the rate increase plan specified in Section 4.E., the Memorandum shall contain a signed and dated reliance statement from the person with operational responsibility for carrying out such actions that the rate increase plan(s) provided to the appointed actuary appropriately reflects management's plan.
 - G. Documentation of any other material assumptions shall be provided.
 - H. Documentation shall be provided for assumptions that have significantly changed from the prior year's analysis.