

Amendment Proposal Forms (APFs)
Adopted by the Life Actuarial (A) Task Force
Intended for the 2027 *Valuation Manual*
*****WARNING: Not Yet Effective*****

Disclaimer: These *Valuation Manual* amendments have not been finally adopted by the Life Insurance and Annuities (A) Committee and/or the Executive Committee and Plenary. Therefore, these amendments are not yet effective, and until final adoption they are subject to further change or even non-adoption. If adopted, these amendments will be effective 1/1/2027 and thereafter. The NAIC is providing these to the general public for future reference purposes only, and they should not be relied upon until final adoption and inclusion in the 2027 *Valuation Manual* by a vote of the NAIC Plenary. Additionally, each year's adopted *Valuation Manual* determines the valuation minimum requirements that a company must satisfy for that year's valuation.

LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date	Page Number
2025-05	Guidance notes under VM-20 Sections 9.G.8 and VM-21 Sections 4.A.5	This amendment provides clearer definitions and examples of what constitutes as “contractually guaranteed” revenue sharing income.	10/2/25	3
2025-13	VM-20 Sections 3.C.1.h.i	This amendment clarifies the timing and documentation requirements for companies seeking approval to use a non-U.S. valuation mortality table in compliance with the Valuation Manual.	11/6/2025	6
2025-15	VM-20 Sections 9.F.3 and 9.F.4 and Appendix 2	This amendment updates guidance to reflect the use of the more granular NAIC Designation Category and corrects how NAIC calculation tables are accessed.	1/29/2026	8
2025-12	VM-22 Section 3.C and VM-31 Section 3.F.14	This amendment establishes attribution analysis requirements, strengthens disclosure expectations, and clarifies the role of the Standard Projection Amount (SPA). It also reinforces credibility standards for company assumptions and confirms that the SPA is not a safe harbor.	2/26/2026	12
2025-16	VM-20 Section 7.E.1.g, VM-21 Section 4.D.4.b, and VM-22 Section 4.D.3.b	This amendment implements consistent credit quality blend across VM-20, VM-21, and VM-22.	3/21/2026	15
2025-17	VM-20 Requirements Section 5.G	This amendment allows reflection of the aggregation benefit in the VM-20 stochastic reserve.	3/22/2026	17
2024-12	VM-50 Sections 2.B.2, 4.B.2, and 4.B.3 VM-51 Section 2 title and Section 2.E, New Section 3: Statistical Plan for Group Annuity Mortality, and New Appendix 5: Group Annuity Mortality Data Elements and Format	This amendment establishes a Statistical Plan for Group Annuity Mortality and designates the NAIC as the Experience Reporting Agent.	4/9/2026	18
2026-02	VM-21 Sections 4.A.7 and 4.D.1 and VM-22 Sections 4.A.7 and 4.D.1.iii	This amendment updates VM-21 and VM-22 references to reflect IMR being attributed to a group of policies or contracts, not a group of assets.	4/30/2026	49
2026-03	VM-22 Section 6.C.5 Full Surrenders	This amendment clarifies calculation mechanics in the VM-22 SPA dynamic lapse formula, specifically in the Market Factor and Rate Factor formulas.	4/30/2026	52

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

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

Identification:

Rachel Hemphill, Texas Department of Insurance
 Jacob Allensworth, Texas Department of Insurance
 Elaine Lam, California Department of Insurance
 Ben Slutsker, Minnesota Department of Commerce

Title of the Issue:

Modify the guidance notes under VM-20 Sections 9.G.8 and VM-21 Sections 4.A.5 to provide clearer definitions and examples of what constitutes as “contractually guaranteed” revenue sharing income

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

Guidance notes under VM-20 Sections 9.G.8 and VM-21 Sections 4.A.5

January 1, 2025 NAIC Valuation Manual

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted, or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

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

This APF adds additional examples of provisions in a revenue-sharing agreement that would prevent the revenue-sharing income from being considered “contractually guaranteed”. Specifically, the new examples highlight provisions where revenue-sharing payments depend on the status or balance of a particular plan or fund, making the income non-guaranteed. These additions aim to clarify what qualifies as "contractually guaranteed" revenue-sharing income and what does not.

Revise to take out of guidance notes and make regular text, as they clarify revenue-sharing requirements.

Dates: Received	Reviewed by Staff	Distributed	Considered
02/10/2025	S.O.		
Notes: APF 2025-05 2/20/25: Revised to include cover letter question on appropriateness of guidance note vs. language in body and clarification of including both affiliated and nonaffiliated entities. 3/22/25: Add a clarifying sentence in two places, and update to move text out of guidance notes. 4/24/25: replaced “level” with “rate” when referring to revenue-sharing income in two additional places for consistency <u>7/21/2025: After ACLI comment and discussion with a company, updates highlighted in yellow</u>			

VM-20, Section 9.G.8 (Editorial Note: also remove boxing around text.)

Guidance Note: Provisions ~~such as one~~ that gives the entity (affiliated or non-affiliated) paying the revenue-sharing income ~~GRSI~~ the option to unilaterally stop or change the ~~level~~-rate of income paid would prevent the income from being guaranteed. Similarly, if the revenue-sharing income is contingent upon the status of a particular plan or fund, and that plan or fund can be terminated, replaced, or not renewed by the paying entity without being replaced by a plan or fund that would result in the same level of guaranteed revenue-sharing income, the revenue-sharing income would not be considered guaranteed. Furthermore, if the ~~level~~rate of revenue-sharing income is tiered or otherwise depends on the total balances of a particular plan or fund, a portion or the entirety of the income (depending on the structure of the performance-based provisions) would not be considered guaranteed beyond the lowest tier unless all the tiers are guaranteed and explicitly modeled at such level of granularity. If the portion of the revenue-sharing income that is contingent can't be readily identified and separated, then the entirety of revenue sharing for the agreement should be considered non-guaranteed. However, if such ~~an~~ options, contingencies, or dependencies becomes available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed ~~up to the time until the point the option first becomes available at which any such options, contingencies, or dependencies first become available.~~

Guidance Note: If the agreement allows the company to unilaterally take control of the underlying fund fees that ultimately result in the revenue sharing, then the revenue is considered guaranteed up until the time at which the company can take such control. Since it is unknown whether the company can perform the services associated with the revenue sharing agreement at the same expense level, it is presumed that expenses will be higher in this situation. Therefore, the revenue-sharing income shall be reduced to account for any actual or assumed additional expenses.

VM-21, Section 4.A.5 (Editorial Note: also remove boxing around text.)

Guidance Note: Provisions ~~such as one~~ that gives the entity (affiliated or non-affiliated) paying the revenue-sharing income the option to unilaterally stop or change the ~~level~~-rate of income paid would prevent the income from being guaranteed. Similarly, if the revenue-sharing income is contingent upon the status of a particular plan or fund, and that plan or fund can be terminated, replaced, or not renewed by the paying entity without being replaced by a plan or fund that would result in the same level of guaranteed revenue-sharing income, the revenue-sharing income would not be considered guaranteed. Furthermore, if the ~~level~~rate of revenue-sharing income is tiered or otherwise depends on the total balances of a particular plan or fund, a portion or the entirety of the income (depending on the structure of the performance-based provisions) would not be considered guaranteed. If the portion of the revenue-sharing income that is contingent can't be readily identified and separated, then the entirety of revenue sharing for the agreement should be considered non-guaranteed beyond the lowest tier unless all the tiers are guaranteed and explicitly modeled at such level of granularity. However, if such ~~an~~ options, contingencies, or dependencies becomes available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed ~~up to the time the option first becomes available until the point at which any such options, contingencies, or dependencies first become available.~~

Guidance Note: If the agreement allows the company to unilaterally take control of the underlying fund fees that ultimately result in the revenue sharing, then the revenue is considered guaranteed up until the time at which the company can take such control. Since it is unknown whether the company can perform the services associated with the revenue sharing agreement at the same expense level, it is presumed that expenses will be higher in this situation. Therefore, the revenue-sharing income shall be reduced to account for any actual or assumed additional expenses.

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

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

Identification:

Rachel Hemphill, Texas Department of Insurance
 Fei Jiang, Texas Department of Insurance

Title of the Issue:

Modify VM-20 Sections 3.C.1.h.i to clarify the timing and documentation requirements for companies seeking approval to use a non-U.S. valuation mortality table in compliance with the Valuation Manual.

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

2025 Valuation Manual, VM-20 Sections 3.C.1.h.i

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted, or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

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

This proposal is necessary because, during the first instance in which LATF was asked to consider the use of non-U.S. mortality tables, the review process revealed two major challenges: (1) the requests were not submitted early enough in the review cycle, and (2) the supporting documentation provided was insufficient to establish confidence in the appropriateness of the proposed tables. As the use of non-U.S. mortality assumptions may become more frequent, this amendment aims to establish clearer expectations around both timing and the minimum supporting materials required for such requests, thereby improving transparency, consistency, and efficiency in future reviews.

Dates: Received	Reviewed by Staff	Distributed	Considered
<u>9/18/25</u>	<u>SO</u>		
Notes: <u>2025-13</u>			

VM-20, Section 3.C.1.h.i

The company shall use a non-U.S. valuation mortality table based on a non-U.S. industry mortality table developed as described in Section 9.C.3.b.i. Companies using these tables shall seek approval from the Life Actuarial (A) Task Force by addressing to the chair of the Life Actuarial (A) Task Force. For the non-U.S. mortality tables that are to be used in the year-end YYYY valuation the company shall submit its request by June 1st of YYYY accompanied by the following supporting documentation:

- a) An analysis of the valuation results before and after applying the non-U.S. mortality table and historical mortality improvement rates, with and without any adjustment factors.
- b) For any proposed adjustment factors (e.g., multiplicative scalars) to the published non-U.S. mortality table or historical mortality improvement rates, the company shall provide robust support that the resulting table and historical mortality improvement factors for the non-U.S. country are at least as conservative as the 2017 CSO and historical mortality improvement developed by the SOA and adopted by LATF for the U.S. population. For proposed adjustment factors that result in a lower mortality level than the base non-U.S. mortality table, the company shall provide robust support that there are large geographic or other clear segments of the non-U.S. country that have significantly more heterogeneous mortality than can be found in the U.S. population. Showing the company's A/E relative to the non-U.S. base table is not sufficient for this purpose.
- c) An Actual-to-Expected (A/E) analysis based on the company's historical experience and the proposed non-U.S. mortality table and historical mortality improvement rates, with and without any adjustment factors.
- d) Discussion and support for why mortality levels and mortality improvement rates are higher or lower in the local jurisdiction than in the relevant U.S. insured population.
- e) Copies of external studies or publications to provide support, whenever available.

The non-U.S. mortality tables that are to be used in the year-end YYYY valuation should be approved by the Life Actuarial (A) Task Force before September 30 of YYYY. ~~should be approved the Life Actuarial (A) Task Force before September of YYYY.~~ If this timeline is not met, the company shall use the relevant non-U.S. mortality tables used in the prior year; if there isare no relevant prior year non-U.S. mortality tables used, the company shall use the relevant U.S. mortality tables.

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

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

Identification:

Rachel Hemphill, Texas Department of Insurance

Title of the Issue:

Update VM-20 Section 9.F.3 and 9.F.4 and Appendix 2 to use the NAIC Designation Category

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

2026 Valuation Manual, VM-20 Sections 9.F.3 and Appendix 2

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted, or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

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

As noted in the older guidance notes, PBR credit ratings gave a more granular designation than what was used for NAIC designations. Now that the more granular NAIC Designation Category is available, a separate more granular determination is no longer needed.

Note that updates to VM-20 will automatically update what is used for VM-21 and VM-22, which point to these sections of VM-20.

Proposed mappings for residential mortgage loans and insured or guaranteed commercial or guaranteed loans are based on comparison of the RBC factors for these assets to those for commercial mortgages.

This APF also corrects references to which tables are currently published on the NAIC website and which are available upon request. The NAIC publishes the factors that are to be used. The tables documenting interim steps of the calculation are available upon request, but are not published to avoid inadvertent errors.

Dates: Received	Reviewed by Staff	Distributed	Considered
10/28/25	SO		
Notes: 2025-15			

VM-20, Section 9.F.3 and 9.F.4

3. Determination of PBR Credit Rating

- a. ~~Table K, referenced in Appendix 2 Section H, converts the ratings of NAIC approved ratings organizations (AROs) and NAIC designations to a numeric rating system from 1 through 20 that is to be used in the steps below. Except for assets covered by Section 9.F.3.b through 9.F.3.d below, the PBR credit rating is based on the NAIC Designation Category, as described in the instructions to the annual statement for Schedule D, with 1.A – 1.G mapped to 1 – 7, 2.A – 2.C mapped to 8 – 10, 3.A – 3.C mapped to 11 – 13, 4.A – 4.C mapped to 14 – 16, 5.A – 5.C mapped to 17 – 19, and 6 mapped to 20. A rating of 21 applies for any ratings of lower quality than those shown in the table.~~
- b. ~~For an asset with an NAIC designation that is derived solely by reference to underlying ARO ratings without adjustment, the company shall determine the PBR credit rating as the average of the numeric ratings corresponding to each available ARO rating, rounded to the nearest whole number.~~
- c. ~~For an asset that is not a commercial mortgage and that has an NAIC designation that is not derived solely by reference to underlying ARO ratings without adjustment, the company shall determine the PBR credit rating as the second least favorable numeric rating associated with that NAIC designation.~~
- d. ~~b. Except for assets covered by Section 9.F.3.d below, fFor a commercial or agricultural mortgage loan, the company shall determine the PBR credit rating as the Table K lookup of the numeric rating corresponding to the loan's NAIC commercial mortgages (CM) category, where the latter is assigned by the company in accordance with NAIC life RBC instructions is based on the NAIC Commercial Mortgage Designation, with 1 mapped to 7, 2 mapped to 10, 3 mapped to 11, 4 mapped to 12, 5 mapped to 13, and 6 – 7 mapped to [20].~~
- c. ~~Except for assets covered by Section 9.F.3.d below, fFor a residential mortgage loan, the PBR credit rating is based upon the description found in the Annual Statement, Asset Valuation Reserve Default Component Page, with Line 41 mapped to 7, Line 50 mapped to 10, and line 55 mapped to 11.~~
- e. ~~d. For a commercial or residential loan that is finsured or Gguaranteed, the PBR credit rating is mapped to 5.~~

Guidance Note: The 1 through 21 PBR credit rating system attempts to provide a more granular assessment of credit risk than has been used for establishing NAIC designations for RBC and asset valuation reserve (AVR) purposes. The reason is that unlike for RBC and AVR, the VM 20 reserve cash flow models start with the gross yield of each asset and make deductions for asset default costs. The portion of the yield represented by the purchase spread over Treasuries is often commensurate with the more granular rating assigned, such as A+ or A-. Thus, use of the PBR credit rating system may provide a better match of risk and return for an overall portfolio in the calculation of VM 20 reserves. However, for assets that have an NAIC designation that does not rely directly on ARO ratings, a more granular assessment consistent with the designation approach is not currently available.

Guidance Note: The Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), which establishes the rules for setting NAIC designations, underwent significant change during 2009-2010, particularly in the area of assessing the credit risk of structured securities. The NAIC Valuation of Securities (E) Task Force implemented an interim solution in 2009 to set designations for non-agency RMBS based on modeling

~~by a third party firm. The Task Force is developing a long term solution for these and other structured securities, such as commercial mortgage backed securities (CMBS), that may involve a combination of modeling and other methods, such as “notching up” or “notching down” the result derived by reference to ARO ratings. In all such cases where the ARO rating basis is either not used at all or is adjusted in some way, the intent is that paragraph (c) be used to determine the PBR credit rating. Another common example where (c) is to be used would be securities that are not Securities Valuations Office (SVO) filing exempt (FE), such as many private placement bonds. For example, a private placement that was not FE and was rated by the SVO as NAIC 1 would be assigned a PBR credit rating of 6 (second least favorable), equivalent to A2.~~

4. Special Situations

For an asset handled under Section 9.F.3-e and for which the NAIC designation varies depending on the company’s carrying value of the asset, the company must avoid overstatement of the net return of the asset when projecting future payments of principal and interest together with the prescribed annual default costs.

Guidance Note: For example, if a non-agency RMBS is rated NAIC 2 if held at a particular company’s carrying value but NAIC 4 if held at par, and that company’s cash-flow model first projects the full recovery of scheduled principal and interest, it would be more appropriate to then deduct annual default costs consistent with NAIC 4 rather than NAIC 2. If the company’s cashflow model has already incorporated a reduced return of principal and interest consistent with the company’s carrying value, then it would be more appropriate to deduct annual default costs consistent with NAIC 2. Modeling of assets with impairments is an emerging topic, and methods for handling in vendor and company projection models vary.

VM-20 Appendix 2 second paragraph

It is important to note up front that the development of prescribed default costs is based entirely on analysis of corporate bonds. Default costs for other fixed income securities and commercial and agricultural mortgages are assumed to follow those of corporate bonds with similar NAIC designations through a mapping tool called “PBR credit rating.” Designation Categories. Examples of other fixed income securities are structured securities, private placements and preferred stocks. ~~Discussions at the NAIC during 2009-2010, particularly at the Valuation of Securities (E) Task Force, focused on the observation that similarly rated assets of different types may have similar likelihood of default or loss of principal but may have a significantly different distribution of the severity of that loss. Discussions have particularly focused on the different drivers of severity between structured securities and corporate bonds. As a result, the Valuation of Securities (E) Task Force has been developing updated methods to assign NAIC designations for C-1 RBC purposes for structured securities in order to better take into account these differences. The VM-20 procedure to assign a PBR credit rating has been structured so that in the cases where the Task Force decides to go away from directly using the ratings of approved ratings organizations, the PBR credit rating will be based on the NAIC designation rather than underlying ratings. Where the Task Force continues to authorize use of underlying ratings, the PBR credit rating also will be based on those ratings. However, VM-20 uses the underlying ratings to assign the PBR credit rating in a somewhat different manner.~~

VM-20 Appendix 2, end of section A.4

Among tables ~~published or produced by~~ the NAIC ~~website and published on the NAIC website or available upon request~~ (See Section H):

- a. Table A shows baseline default costs using Moody's data.
- b. Table B shows the baseline default cost margin (Table A rates minus the historical mean rates).

VM-20 Appendix 2, end of section B.8

Among tables ~~published or produced by~~ the NAIC ~~website and available upon request~~ (See Section H):

- a. Table C shows empirical CTE 70 default rates from Moody's.
- b. Table D shows prescribed cumulative default rates derived from Moody's data.

VM-20 Appendix 2, end of section C.3

Among tables ~~published or produced by~~ the NAIC ~~website and available upon request~~ (See Section H):

- a. Table E1 shows a sorted version of "Exhibit 22 – Annual Average Defaulted Bond and Loan Recovery Rates, 1982–2007," and develops the CTE 70 recovery rates and the implied margin. Table E1 develops mean and CTE 70 recovery rates for all bonds, as well as for senior bank loans and five bond lien position categories that make up the All Bonds statistics. Implementation will be facilitated if VM-20 uses one recovery rate based on All Bonds rather than using all six lien position categories. Using the more detailed data would require either companies or the SVO to assign each asset to one of the categories. Table E1 also illustrates that bonds that are more senior in the issuer's capital structure tend to have higher recovery rates than bonds that are subordinated.
- b. Table E2 shows the final recovery rates that vary by PBR credit rating. This table was determined by assuming CTE 70 applies for Ba3/BB- and below, mean applies for Baa1/BBB+ and above, and interpolated recovery rates apply for ratings that are between Ba3/BB- and Baa1/BBB+. This approach recognizes that investment grade bonds are more likely to be senior in the issuer's capital structure, and below investment-grade bonds are more likely to be subordinated. Differentiating by actual seniority position of each bond was not considered practical. In addition, because recovery rates and default rates are not 100% correlated and the cumulative default rates were set at CTE 70, use of the mean recovery rate, at least for the higher-quality bonds, helps to avoid overly conservative prescribed default costs for those bonds.

VM-20 Appendix 2, Section H

Current and historical versions of Tables A, ~~F, G, H, I, and J through K~~ used for calculating asset default costs and asset spreads are available on the NAIC website home page (www.naic.org) under the Industry tab of the website in the Principle-Based Reserving Overview section. Tables B through E which document interim steps calculating these factors are available upon request.

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

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

VM-22 (A) Subgroup
Addressing LATF referral for the VM-22 Standard Projection Amount (SPA): Disclosures & Credibility

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

June 18, 2025
APF 2025-~~12XX~~
NAIC Valuation Manual, VM-22 Section 3.C and VM-31 Section 3.F.14.k

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attachment

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

On April 3, 2025, the NAIC Life Actuarial (A) Task Force voted to make a referral to the NAIC VM-22 Subgroup to address regulator concerns raised during the Subgroup discussion regarding the VM-22 Standard Projection Amount. These concerns were primarily focused on inserting the SPA as a floor mechanism upon no or limited credibility supporting actuarial assumptions, as well as enhanced disclosures if the SPA serves only as a disclosure item.

In the referral, LATF directed the VM-22 Subgroup to:

1. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA whenever an ASPA is indicated.
2. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA for all companies at least every 3 years.
3. Clarify that if an ASPA is indicated and the company is not strengthening their reserves in response to the SPA result, they need to provide support that the material drivers of the difference are due to company assumptions that can be supported based on reliable, relevant, and credible company data.
4. Reiterate that the SPA is not a safe harbor.

The edits outlined in this amendment proposal are intended to provide wording to address the four items above.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
6/17/25	S.O./ A.F.		
Notes: 2025-12 Exposed 6/20/25 by Ben Slutsker, Chair of VM-22 Subgroup for a 60-day comment period ending 8/19/25. Adopted by VM-22 Subgroup 9/17/25.			

VM-22 Section 3.C

C. The Additional Standard Projection Amount

The additional standard projection amount is determined by applying the standard projection method defined in Section 6.

Where an Additional Standard Projection Amount is indicated, the company should strengthen the assumptions and/or margins used for the SR until an ASPA would no longer be indicated, unless the Company can show that the difference between the SR and the SPA can be attributed to differences between the assumptions prescribed for the SPA and the company assumptions, for assumptions where the company assumption is based on company experience data that is reliable, relevant, and credible.

However, the SPA disclosure is not a safe harbor. An ASPA not being indicated does not automatically imply that the company does not need to strengthen the assumptions and/or margins used for the SR or DR are appropriate. The Company should have robust support for the development of all company assumptions and margins.

If an ASPA is not indicated, subject to the requirements in this subsection, the additional standard projection amount is only required for disclosure purposes pursuant to VM-31.

Guidance Note: ~~To further expand upon use of the Standard Projection Amount (SPA), the NAIC Life Actuarial (A) Task Force adopted a referral to the VM-22 (A) Subgroup on April 3, 2025 that states the following:~~

~~“LATF directs the VM-22 Subgroup to:~~

- ~~—1. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA whenever an ASPA is indicated.~~
- ~~—2. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA for all companies at least every 3 years.~~
- ~~—3. Clarify that if an ASPA is indicated and the company is not strengthening their reserves in response to the SPA result, they need to provide support that the material drivers of the difference are due to company assumptions that can be supported based on reliable, relevant, and credible company data.~~
- ~~—4. Reiterate that the SPA is not a safe harbor.”~~

~~Therefore, although not included in the NAIC Valuation Manual effective for 1/1/2026 due to time constraints, the VM-22 (A) Subgroup will develop language to address the above directive for the 1/1/2027 Valuation Manual. Upon such adoption by the Life Actuarial (A) Task Force, as feasible, companies are encouraged to incorporate such changes for 2026 reporting. The enhanced disclosures will ensure an effective SPA and enable the VM-22 (A) Subgroup and LATF to evaluate the SPA framework as adopted within three years.~~

k. Attribution Analysis for VM-22

- i. For groups of contracts that calculate a SR or DR under VM-22 requirements, where an ASPA is indicated and the Company can support not strengthening the assumptions and/or margins used for the SR or DR until an ASPA would no longer be indicated, the Company should provide an attribution analysis between the SR and the SPA, individually covering all material drivers and a residual impact. For any material drivers, support should be provided that the Company assumption is based on Company experience data that is reliable, relevant, and credible.
- ii. For groups of contracts that calculate a SR or DR under VM-22 requirements, where an ASPA is not indicated, the Company should provide an attribution analysis between the SR or DR and the SPA, individually covering all material drivers and a residual impact, at least every three years. For any material drivers, support should be provided that the Company assumption is based on Company experience data that is reliable, relevant, and credible.

Guidance Note: The VM-22 Subgroup and LATF will be reevaluating the decision to make the SPA a disclosure within three years. The strength and reliability of the SPA disclosures, including the attribution analysis, in initial years will be a key consideration for that reevaluation.

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

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

Rachel Hemphill, TDI, Update reinvestment guardrail for VM-20, VM-21, and VM-22.

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

VM-20 Section 7.E.1.g, VM-21 Section 4. D.4.b, VM-22 Section 4.D.3.b

Valuation Manual, January 1, 2026 Edition

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

VM-20 Section 7.E.1.g

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of at least:

- i. 5% Treasury
- ii. 15% PBR credit rating 3 (Aa2/AA)
- iii. 40% PBR credit rating 6 (A2/A)
- iv. 40% PBR credit rating 9 (Baa2/BBB)

~~a minimum credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).~~

VM-21 Section 4.D.4.b

b. Notwithstanding the above requirements, the SR shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of at least:

- i. 5% Treasury
- ii. 15% PBR credit rating 3 (Aa2/AA)
- iii. 40% PBR credit rating 6 (A2/A)
- iv. 40% PBR credit rating 9 (Baa2/BBB)

~~a minimum credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).~~

VM-22 Section 4.D.3.b

Notwithstanding the above requirements, the aggregate reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of at least:

- i. 5% Treasury
- ii. 15% PBR credit rating 3 (Aa2/AA)

- iii. 8040% PBR credit rating 6 (A2/A)
- iv. 40% PBR credit rating 9 (Baa2/BBB)

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

After adoption of a guardrail for VM-22 that was intended to be a compromise between the existing VM-20 and VM-21 guardrails and the Academy proposed guardrail of 5% Treasury, 15% PBR credit rating 3 (AA), 40% PBR credit rating 6 (A), and 40% PBR credit rating 9 (BBB), LATF planned to consider updating the guardrails for VM-20 and VM-21 to be consistent with the VM-22 guardrail. LATF members noted that they would not want to consider such a change without first reviewing impact testing. ACLI agreed to provide this impact testing. Since then, additional review has made clear that the compromise guardrail will not always give the intended compromise effect. As a result, I propose that LATF instead consider adopting the Academy guardrail for all of VM-20, VM-21, and VM-22. To address prior regulator concerns, I recommend that LATF not consider adoption of this proposal without reviewing impact testing of the updated proposal provided by ACLI. So, I am requesting the ACLI update the agreed-upon testing to now reflect the Academy guardrail for VM-20, VM-21, and VM-22. The initial exposure should be set to allow sufficient time for this testing to be completed.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
11/13/25	JR		
Notes:2025-16			

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

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

Rachel Hemphill, TDI, Update VM-20 stochastic reserve calculation to reflect aggregation.
- Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:

VM-20 Section 5.G

Valuation Manual, January 1, 2026 Edition

- Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

VM-20 Section 5.G

The SR equals the amount determined in Section 5.F. If the company includes policies from two or more VM-20 reserving ~~category~~ categories in a subgroup for aggregation purposes as described in Section 5.A, the company shall calculate the SR for policies from each VM-20 reserving category on a stand-alone basis by following the process of A through F above. Then, the final SR for the group of policies from a given VM-20 reserving category is determined by:

$$I_A = I_S * (T_A / T_S), \text{ if } T_S \neq 0$$

$$I_A = 0, \text{ if } T_S = 0$$

Where:

I_A = the SR for the policies from an individual VM-20 reserving category reflecting aggregation.

I_S = the SR for the policies from an individual VM-20 reserving category on a stand-alone basis.

T_A = the SR for the group of policies in aggregate.

T_S = the sum of I_S for the group of policies for the Term, ULSG, and All Other reserving categories.

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

Allow reflection of the aggregation benefit in the VM-20 stochastic reserve.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
11/14/25	JR		
Notes: 2025-17			

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

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

Seong-min Eom, NJ Division of Insurance
Pat Allison and Angela McNabb, NAIC

NAIC Collection of Group Annuity Mortality Experience

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

VM-50
Section 2.B
Section 4.B

VM-51
Section 2 title
Section 2.C
Section 2.D
New Section 3: Statistical Plan for Group Annuity Mortality
Appendices 1-4
New Appendix 5: Group Annuity Mortality Data Elements and Format

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attachment.

Note:

The NAIC relied on the following SOA work product, parts of which were reproduced with permission and used to draft this amendment to the *Valuation Manual* for group annuitant mortality experience:

- 2015 – 2018 Group Annuity Mortality Experience Report. Copyright 2022, The Society of Actuaries and Society of Actuaries Research Institute, Chicago, Illinois.

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

This amendment establishes a Statistical Plan for Group Annuity Mortality and designates the NAIC as the Experience Reporting Agent.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
10/25/24	SO		
Notes: APF 2024-12: Draft for 4 th exposure			

VM-50: Experience Reporting Requirements

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Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

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

assumptions and margins prescribed by regulators in the *Valuation Manual*.

6. The reliability of assumptions based on company experience is founded on reliable historical data from comparable characteristics of insurance policies including, but not limited to, underwriting standards and insurance policy benefits and provisions. As with all forms of experience data analysis, larger and more consistent statistical samples have a greater probability of producing reliable analyses of historic experience than smaller or inconsistent samples. To improve statistical credibility, it is necessary that experience data from multiple companies be combined and aggregated.
7. The collection of experience data allows state insurance regulators to identify outliers and monitor changes in company experience factors versus a common benchmark to provide a basis for exploring issues related to those differences.
8. PBR is an emerging practice and will evolve over time. Research studies other than those contemplated at inception may be useful to improvement of the PBR process, including increasing the accuracy or efficiency of models. Because the collection of experience data will facilitate these improvements, research studies of various types should be encouraged.
9. The collection of experience data is not intended as a substitute for a robust review of companies' methodologies or assumptions, including dialogue with companies' actuaries.

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

1. Model #820 provides the legal authority for the *Valuation Manual* to prescribe experience reporting requirements with respect to companies and lines of business within the scope of the model.
2. The statutes and regulations requiring data submissions generally apply to all companies licensed to sell life insurance, A&H insurance and deposit-type contracts. These companies must submit experience data as prescribed by the *Valuation Manual*.
3. Section 14A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

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

2. The NAIC is designated as Experience Reporting Agent for the following Statistical Plans:
 - a. Life Insurance Mortality, beginning Jan. 1, 2020
 - b. Group Annuity Mortality, beginning Jan. 1, 2027.
3. The designation of the NAIC as Experience Reporting Agent does not preclude state insurance regulators from independently engaging other entities for similar data required under this *Valuation Manual* or other data purposes.
4. The NAIC shall collect an annual fee from companies participating in the data collections.

Section 3: Experience Reporting Requirements

A. Statistical Plans

1. Consistent with state laws based on Section 13 of Model #820, the Experience Reporting Agent shall collect experience data based on statistical plans defined in the *Valuation Manual*.
2. Statistical plans are detailed instructions that define the type of experience data being collected (e.g., mortality; elective policyholder behavior, such as surrenders, lapses, premium payment patterns, etc.; and company expense data, such as commissions, policy expenses, overhead expenses etc.). The state insurance regulators serving on the Life Actuarial (A) Task Force and Health Actuarial (B) Task Force, or any successor body, will be responsible for prescribing the requirements for any statistical plan by applicable line of business. For each type of experience data being collected, the statistical plan will define the data elements and format of each data element, as well as the frequency of the collection of experience data. The statistical plan will define the process and the due dates for submitting the experience data. The statistical plan will define criteria that will determine which companies must submit the experience data. The statistical plan will also define the scope of business that is to be included in the experience data collection, such as lines of business, product types, types of underwriting, etc. Statistical plans are defined in VM-51 of the *Valuation Manual*. Statistical plans will be added to VM-51 of the *Valuation Manual* when they are ready to be implemented. Additional data elements and formats to be collected will be added as necessary, in subsequent revisions to the *Valuation Manual*.
3. Data must conform to common data definitions. Standard definitions provide for stable and reliable databases and are the basis of meaningful aggregated insurance data. This will be accomplished through a uniform set of suggested minimum experience reporting requirements for all companies.

B. Role and Responsibilities of the Experience Reporting Agent

1. Based on requirements of VM-51, the Experience Reporting Agent may design its data collection procedures to ensure it is able to meet these regulatory requirements. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for

the data submission.

2. The Experience Reporting Agent will aggregate the experience of companies using a common set of classifications and definitions to develop industry experience tables.
3. The Experience Reporting Agent will seek to enter into agreements with a group of state insurance departments for the collection of information under statistical plans included in VM-51. The number of states that contract with the Experience Reporting Agent will be based on achieving a target level of industry experience prescribed by VM-51 for each line of business in preparing an industry experience table.
 - a. The agreement between the state insurance department(s) and the Experience Reporting Agent will be consistent with any data collection and confidentiality requirements included within Model #820 and the *Valuation Manual*. Those state insurance departments seeking to contract with the Experience Reporting Agent will inform the Experience Reporting Agent of any other state law requirements, including laws related to the procurement of services that will need to be considered as part of the contracting process.
 - b. Use of the Experience Reporting Agent by the contracting state insurance departments does not preclude those state insurance departments or any other state insurance departments from contracting independently with another Experience Reporting Agent for similar data required under this *Valuation Manual* or other data purposes.
4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will be responsible for the content and maintenance of the experience reporting requirements. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force or a working group will monitor the data definitions, quality standards, appendices and reports described in the experience reporting requirements to assure that they take advantage of changes in technology and provide for new regulatory and company needs.
5. To ensure that the experience reporting requirements will continue to be useful, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will seek to review each statistical plan on a periodic basis at least once every five years. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force should have regular dialogue, feedback and discussion of this topic. In seeking feedback and engaging in discussions, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force shall include a broad range of data users, including state insurance regulators, consumer representatives, members of professional actuarial organizations, large and small companies, and insurance trade organizations.
6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company's request. In the event of a material deficiency identified in the external audit or in the event of an identified

security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D and/or Section 3.D. The term “good cause” shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;
2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;
3. Analyze data, including any summarized or aggregated data produced by the Experience Reporting Agent;
4. Create initial experience tables and any revised tables;
5. Provide feedback in the development and evaluation of requests for proposal for services related to the reporting of experience requirement;
6. Create statutory valuation tables as appropriate and necessary;
7. Determine and produce additional industry experience tables or reports that might be suggested by the data collected;
8. Work with the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force, in accordance with the *Valuation Manual* governance process, in developing new reporting formats and modifying current experience reporting formats;

9. Support a close working relationship among all parties having an interest in the success of the experience reporting requirement.

Section 4: Data Quality and Ownership

A. General Requirements

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

B. Specific Requirements

1. Once the data file is submitted by the company, the Experience Reporting Agent will perform a validity check of the data elements within each data record in the data file for proper syntax and verify that required data elements are populated. The Experience Reporting Agent will notify the company of all syntax errors and any missing data elements that are required. Companies are required to respond to the Experience Reporting Agent by submitting a corrected data file. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.
2. Each submission of data filed by a company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. ~~At a minimum, these control totals shall include applicable record counts, claim counts,~~

- ~~amounts insured and claim amounts.~~ Any submission that does not balance to the control totals shall be referred to the company for review and resolution.
- a. Control totals for the Statistical Plan for Life Insurance Mortality shall include applicable record counts, claim counts, amounts insured, and claim amounts.
 - b. Control totals for the Statistical Plan for Group Annuity Mortality shall include applicable certificate counts and annual income inforce.
3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent.
- a. For the Statistical Plan for Life Insurance Mortality, the reconciliation must include policy count and insurance amount.
 - b. For the Statistical Plan for Group Annuity Mortality, the reconciliation must include certificate counts, annual income inforce, and statutory reserves.
4. **Third-Party Administration Reporting**
- a. If a third-party administrator (TPA) that is not an insurance company or an insurance company not required to submit its direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
 - b. If the TPA is an insurance company that is required to submit its direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
 - c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or TPA must include lines indicating the amount of business that is being reported by the reinsurer or TPA. The NAIC will use this information to confirm that all in-scope business is reported and that there is no double counting of policies.
5. Validity checks are designed to identify:
- a. Improper syntax or incomplete coding (e.g., a numeric field that is not numeric, missing elements of a date field);
 - b. Data elements containing codes that are not contained within the set of possible valid codes;
 - c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code;
 - d. Required data elements that are not populated.
6. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is

desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.

7. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of ~~insurer~~ the insurance company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.
8. The Experience Reporting Agent will undertake reasonability checks that include the comparison of aggregate and company experience for underwriting class and type of coverage data elements for the current reporting period to company and aggregate experience from prior periods for the purpose of identifying potential coding or reporting errors. When reporting instructions are changed, newly reported data elements shall be examined to see that they correlate reasonably with data elements reported under the old instructions.
9. At a minimum, reasonability checks by the Experience Reporting Agent will include:
 - a. An unusually large percentage of company data reported under a single or very limited number of categories;
 - b. Unusual or unlikely reporting patterns in a company’s data;
 - c. Claim amounts that appear unusually high or low for the corresponding exposures;
 - d. Reported claims without corresponding policy values and exposures;
 - e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
 - f. Unusual shifts in the distribution of business from one reporting period to the next.
10. If a company’s unusual pattern under Section 4.B.98.a, Section 4.B. 98.b or Section 4.B. 98.c is verified as accurate (that is, the reason for the apparent anomaly is an unusual mix of business), then it is not necessary that a similar pattern for the same company be reconfirmed year after year.
11. The Experience Reporting Agent will keep track of the results of the validity and reasonability checks and may adjust thresholds in successive reporting years to maintain a reasonable balance between the magnitude of errors being found and the cost to companies.

12. Results that may indicate a likelihood of critical indications, as defined below, will be reported to the company with an explanation of the unusual findings and their possible significance. When the possible or probable errors appear to be of a significant nature, the Experience Reporting Agent will indicate to the company that this is a “critical indication.” “Critical indications” are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used in reports to the state insurance regulator and included in industry databases. It is intended that Experience Reporting Agents will have reasonable flexibility to implement this under the direction of the state insurance regulators. Also, under the direction of the state insurance regulators, the Experience Reporting Agent may grade the severity of indications, or it may simply identify certain indications as critical. While companies are expected to undertake a reasonable examination of all indications provided to them, they are not required to respond to every indication except for those labeled by the Experience Reporting Agent as “critical.”
13. The Experience Reporting Agent will use its discretion regarding the omission of data from reports owing to the failure of an ~~insurer~~-insurance company to respond adequately to unusual reasonability indications. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.
14. Companies shall acknowledge and respond to reasonability queries from the Experience Reporting Agent. This shall include specific responses to all critical indications provided by the Experience Reporting Agent. Other indications shall be studied for apparent errors, as well as for indications of systematic errors. Corrections for critical indications shall be provided to the Experience Reporting Agent or, when a correction is not feasible, the extent and nature of the error shall be reported to the Experience Reporting Agent.
15. **The Experience Reporting Agent will calculate Actual to Expected (A/E) ratios for each company based on the records deemed acceptable after the data review process has been completed. An accredited actuary is required to review and sign off on the reasonableness of the A/E ratios. The company shall correct and resubmit their data if A/E ratios are found to be unreasonable.**

C. Ownership of Data

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

be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

1. Using the data collected under statistical plans, as defined in the *Valuation Manual*, the Experience Reporting Agent produces aggregate databases as defined by this *Valuation Manual*. The Experience Reporting Agent, and/or other persons assisting the Experience Reporting Agent, will utilize those databases to produce industry experience tables and reports as defined in the *Valuation Manual*. In order to ensure continued relevance of reports, each defined data collection and resulting report structure shall be reviewed for usefulness at least once every five years since initial adoption or prior review.
2. Data compilations are evaluated according to four distinct, and often competing, standards: quality, completeness, timeliness and cost. In general, quality is a primary goal in developing any statistical data report. The priorities of the other three standards vary according to the purpose of the report.
3. The Experience Reporting Agent may modify or enlarge the requirements of the *Valuation Manual*, through recommendation to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force and in accordance with the *Valuation Manual* governance process for information to accommodate changing needs and environments. However, in most cases, changes to existing data reporting systems will be feasible only to provide information on future transactions. Requirements to submit new information may require that companies change their systems. Also, the Experience Reporting Agent may need several years before it can generate meaningful data meeting the new requirements with matching claims and insured amounts. The exact time frames for implementing new data requirements and producing reports will vary depending on the type of reports.

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

1. The Life Actuarial (A) Task Force or Health Actuarial (A) Task Force will designate basic types of reports to meet differing needs and time frames. Each statistical plan defined in VM-51 of the *Valuation Manual* will provide a detailed description of the reports, the frequency and time frame for the reports. Statistical compilations are anticipated to be the primary reports.

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

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.
2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

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

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

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

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

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

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

B. Treatment of Confidential Information

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

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

VM-51: Experience Reporting Formats

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Section 1: Introduction

- A. The experience reporting requirements are defined in Section 3 of VM-50. The experience reporting requirements state that the Experience Reporting Agent will collect experience data based on statistical plans that are defined in VM-51 of the *Valuation Manual*. Statistical plans are to be added to VM-51 of the *Valuation Manual* when they are ready to be implemented.
- B. Each statistical plan shall contain the following information:
1. The type of experience data to be collected (e.g., mortality experience; policy behavior experience, such as surrenders, lapses, conversions, premium payment patterns, etc.; and company expense experience, such as commission expense, policy issue and maintenance expense, company overhead expenses etc.);
 2. The scope of business to be included in the experience data to be collected (e.g., line(s) of business, such as individual or group, life, annuity or health; product type(s), such as term, whole life, universal life, indexed life, variable life, fixed annuity, indexed annuity, variable annuity, LTC or disability income; and type of underwriting, such as medically underwritten, simplified issue (SI), GI, accelerated, etc.);
 3. The criteria for determining which companies or legal entities must submit the experience data to be collected;
 4. The process for submitting the experience data to be collected, which will include the frequency of the data collection, the due dates for data collection and how the data is to be submitted to the Experience Reporting Agent;
 5. The individual data elements and format for each data element that will be contained in each experience data record, along with detailed instructions defining each data element or how to code each data element. Additional information may be required, such as questionnaires and plan code forms that will assist in defining the individual data elements that may be unique to each company or legal entity submitting such experience data elements;

6. The experience data reports to be produced.

Section 2: Statistical Plan for Life Insurance Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S. All values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 2.B.2. Assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, preneed, home service, credit life, and corporate-owned life insurance (COLI)/bank-owned life insurance (BOLI)/charity-owned life insurance (CHOLI).
2. In the event a reinsurer or TPA is responsible for administering a block of business, the reinsurer or TPA may submit that block of business on behalf of the direct writer. In this case, the reinsurer or TPA must be identified in Appendix 4 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 4 Item 2 - NAIC Company Code of Direct Writer.
 - a. As defined in VM-50 Section 4.B.43, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or TPAs must include lines indicating the amount of business that is being reported by the reinsurers and/or TPAs. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or TPAs to ensure that all business is included and that there is no double counting of policies.
 - b. If an insurance company is required to submit its direct written business and it also has reinsurance assumed business, it should only submit the assumed business if asked to do so by the ceding company since some ceding companies may not have been selected for data submission.
3. The direct writing company is ultimately responsible for all the data submitted for its company.

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

The Experience Reporting Agent, under the direction of the Life Actuarial (A) Task Force, will select companies that are required to submit experience data. The selection of companies will be based on achieving a target level of approximately 85% of industry mortality experience in scope. Companies selected to submit mortality experience data are expected to continue reporting their experience in future years, barring circumstances justifying an exemption. The list of companies selected is subject to change. Additional companies may be selected to maintain the target level of industry experience. Any additional companies selected will be given sufficient notice to prepare for the data submission.

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

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

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2024 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2023, which is the observation calendar year. ~~For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.~~

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

- i. Report policies in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

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

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

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

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

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

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

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by March 31 of the year after the observation year.

Plans of insurance should be carefully matched with the three-digit codes in item 20, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

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

- b) Certify that this requirement presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

F. Experience Data Reports Required by This Statistical Plan

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

Section 3: Statistical Plan for Group Annuity Mortality

A. Type of Experience Collected Under This Statistical Plan

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

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan includes direct written group annuity business issued by a company in the U.S. for lives in any country as well as reinsurance assumed written by a company in the U.S. for business written by non-US companies. ~~outside the U.S.~~ Product types include:
 - a. Group Pension Risk Transfer (PRT, as defined in VM-01) annuities originating from ongoing and terminated private and public defined benefit pension plans, including both participating and nonparticipating contracts where the insurance company bears mortality risk.
 - b. Purchased group annuities with mortality risk originating from defined contribution plans.
 - c. Immediate Participation Guarantee contracts for which the insurance company bears the mortality risk.
 - d. Longevity Reinsurance, as defined in VM-01.
 - e. Group Variable Payout Annuities, defined as group annuities that include a provision for benefit payments which vary in accordance with the rate of return of the underlying investment portfolio.
2. The intent is to align the scope of business collected under this statistical plan with the scope of VM-22. Therefore, the following types of business defined in VM-01 are excluded from data collection:
 - a. Guaranteed Investment Contracts
 - b. Synthetic Guaranteed Investment Contracts

- c. Funding Agreements
 - d. Stable Value contracts
 - e. Pre-Need Annuities
3. All values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 3.B.4. Assumption reinsurance of a line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan.
 4. In the event a reinsurer or TPA is responsible for administering a block of business, the reinsurer or TPA may submit that block of business on behalf of the direct writer. In this case, the reinsurer or TPA must be identified in Appendix 5 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 5 Item 2 - NAIC Company Code of Direct Writer.
 - a. As defined in VM-50 Section 4.B.4, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or TPAs must include lines indicating the amount of business that is being reported by the reinsurers and/or TPAs. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or TPAs to ensure that all business is included and that there is no double counting of records.
 - b. If an insurance company is required to submit its direct written business and it also has reinsurance assumed business, it should only submit the assumed business if asked to do so by the ceding company since some ceding companies may not have been selected for data submission.
 5. The direct writing company is ultimately responsible for all the data submitted for its company.

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

The Experience Reporting Agent, under the direction of the Life Actuarial (A) Task Force, will select companies that are required to submit experience data. The selection of companies will be based on achieving a minimum target level of approximately 90% of industry statutory reserves in scope. Companies selected to submit mortality experience data are expected to continue reporting their experience in future years, barring circumstances justifying an exemption. The list of companies selected is subject to change. Additional companies may be selected to maintain the target level of industry experience, or at the discretion of the Life Actuarial (A) Task Force. Any additional companies selected will be given sufficient notice to prepare for the data submission.

Companies with less than \$250 million of statutory reserves for in-scope group annuity business shall be exempted from reporting experience data required under this statistical plan. This threshold for exemption shall be reviewed annually and be subject to change by the Experience Reporting Agent.

Exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator.

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2027 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2026, which is the observation calendar year.

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

- i. Report records in force during or issued during calendar year 20XX.
- ii. Report terminations that were incurred in calendar year 20XX and reported before April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

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

Companies subject to reporting pursuant to Section 3.C are required to complete the Experience Data Elements and Formats as defined in Appendix 5.

F. Experience Data Reports Required by This Statistical Plan

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

3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company's experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.

Appendix 1: Life Insurance Preferred Class Structure Questionnaire

Appendix 2: Life Insurance Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

Company	NAIC Company Code
Name	Date

MORTALITY CLAIMS

1. If the data is provided using a reporting run-out that is other than ~~six~~ **three** months, what run-out period was used? mm/dd/yyyy

2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:
 - a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR
 Other (describe):
 If not as specified, indicate time period for which this occurred _____ - _____
 - b. Gross basis (before reinsurance) as specified OR Other
 (describe):
 If not as specified, indicate time period for which this occurred: _____ - _____
 Is this the same basis used for face amounts included in the study data? Yes No

3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?
 - a) Termination reported date
 If not reported date, indicate basis for dates provided Reported date Other (describe):
 - b) Actual termination date for death claims:
 Date of death Other (describe):
 If not date of death, indicate basis for dates provided

4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six-month run out are -to be included.

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

If no indicate time period for which this occurred: _____

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

Yes No

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

6. For death claims on policies issued before 1990:

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

If no, indicate approach used:

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

Appendix 3: **Life Insurance** Additional Plan Code Form

Appendix 4: **Life Insurance** Mortality Data Elements and Format

The table below provides descriptions of the required data fields. Further details and coding examples are provided in a data dictionary located on the NAIC’s website. The data dictionary is a living document and will be updated periodically as needed.

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
20	3	Plan	Coverage purchased under a Guaranteed Insurability Option: 110 = Exercised Guaranteed Insurability Option

Appendix 5: Group Annuity Mortality Data Elements and Format

The table below provides descriptions of the required data fields. Further details and coding examples are provided in a data dictionary located on the NAIC’s website. The data dictionary is a living document and will be updated periodically as needed.

It is expected that companies may not have all the requested data elements, so certain data elements may be left blank or approximated, as noted in the Description column. If key fields necessary to perform an experience study are left blank (e.g. date of termination, date of death) or are inconsistent, the Experience Reporting Agent may make approximations as described in the data dictionary.

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
1	9	Submitting Company ID	ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company’s Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, Items 1 and 2 must contain the same value.
2	5	NAIC Company Code of the Direct Writer of Business	The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, Items 1 and 2 must contain the same value.
3	4	Observation Year	Enter Calendar Year of Observation
4	20	Contract Number	Enter the Group Annuity Contract number. This must be carried through consistently for all observation years.
5	8	Contract Issue Date	Enter the numeric Group Annuity Contract issue date in YYYYMMDD format.
6	1	Plan Type	1 = PRT originating from Private Defined Benefit Plans 2 = PRT originating from Public Defined Benefit Plans 3 = Purchased Annuities with Mortality Risk Originating from Defined Contribution Plans 4 = Longevity Reinsurance 5 = Immediate Participation Guarantee contracts for which the insurance company bears the mortality risk 6 = Group Variable Payout Annuities

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			7 = Other Group Annuities with Mortality Risk Note that COLAs do not qualify as variable payout annuities.
7	1	Country Code	1 = United States 2 = Canada 3 = United Kingdom 4 = Other
8	20	Certificate Number	Enter a unique identifying number for the annuitant. This must be carried through consistently for all observation years. Certificate numbers must be encrypted. Actual certificate numbers cannot be used.
9	8	Certificate Issue Date	Enter the numeric Certificate issue date in YYYYMMDD format.
10	2	Issue Age	Enter the annuitant's issue age.
11	1	Beneficiary Indicator	1 = Primary 2 = Beneficiary 3 = Contingent (not yet in pay status) 4 = Unknown
12	1	Gender	1 = Male 2 = Female 3 = Unisex – Unknown Gender 4 = Unisex – Male 5 = Unisex – Female 6 = Unknown
13	8	Date of Birth	Enter the numeric date of birth in YYYYMMDD format.
14	8	Date of Entry	Enter the numeric date of entry in YYYYMMDD format. See the data dictionary for details.
15	1	Status Code when the Group Annuity Contract Was Purchased	1 = Retired (in payout status) 2 = Deferred (either terminated or active)
16	1	Status Code as of the Observation Year	1 = Retired (in payout status) 2 = Deferred (either terminated or active)
17	8	Date of Termination	Enter the numeric date of termination in YYYYMMDD format. Leave this field blank if there was no termination.
18	1	Mode of Termination	1 = Death 2 = Retirement 3 = Other 4 = No Termination

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
19	12	Amount of Annual Income	Provide the annual income amount to the nearest dollar as of the end of the observation year. Convert to US dollars if benefits are in any other currency.
20	1	Joint and Survivor	1 = 0% (Single Life) 2 = >0% - <=50% 3 = >50% - <=67% 4 = >67% - <=75% 5 = >75% - <=100% 6 = Joint percent unknown 7 = Joint indicator unknown
21	1	Benefit Class	1 = Life only 2 = Life only, plus Temporary life annuity 3 = Life with period certain 4 = Life with period certain, plus Temporary life annuity 5 = Cash refund 6 = Cash refund, plus Temporary life annuity 7 = Unknown or Not Applicable
22	2	Certain Period	Enter the Certain Period in years if Benefit Class = 3 or 4. For all other Benefit Classes, leave this field blank.
23	1	Job Classification	1 = Hourly 2 = Salaried 3 = Not Applicable 4 = Unknown
24	1	Union Classification	1 = Union 2 = Nonunion 3 = Not Applicable 4 = Unknown
25	6	NAICS Code	Enter the applicable North American Industry Classification System (NAICS) Code. Leave blank if unknown or not applicable.
26	4	SIC Code	Enter the applicable Standard Industrial Classification (SIC) Code. Leave blank if unknown or not applicable.
27	1	Separate Account/General Account	1=Separate Account, where assets are legally insulated from General Account claims 2=General Account
28	2	PRT Options	Was the participant exposed to any of the following immediately prior to, coincident with, or after the purchase of the annuity contract? Please consider offers that may have been made by either the insurer or by the pension plan that purchased the contract (to

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			<p>the extent such plan actions are known by the insurer and were considered when underwriting the contract).</p> <p>11 = A one-time voluntary full lump sum window 12 = A one-time voluntary partial lump sum window 13 = A one-time involuntary full lump sum window 14 = A one-time benefit enhancement 15 = A one-time option to convert the form of benefit to another form of benefit 16 = A one-time option to add or remove spousal benefits 17 = Any other one-time actions that the carrier considered potentially anti-selective to mortality when underwriting the contract 18 = More than one of the above codes apply 19 = Not applicable (use for non-PRT business) 20 = Unknown</p>
29	1	Availability of Full and/or Partial Lump Sums at Retirement	<p>1=No lump sums are available 2=Full and partial lump sums are available 3=Only full lump sums are available 4=Only partial lump sums are available 5=Full lump sums are available; Unknown whether partial lump sums are available 6=Unknown whether full lump sums are available; partial lump sums are available 7=Unknown whether full or partial lump sums are available 8 = Not applicable (use for non-PRT business)</p>
30	1	Cost of Living Increases	<p>Is there a cost of living or inflation increase feature?</p> <p>1 = Yes 2 = No 3 = Not Applicable (use for non-PRT business) 4 = Unknown</p>
31	1	Other Income Increases	<p>Is there a feature (other than a cost-of-living increase) that causes the benefit not to be level (e.g. Social Security integration, or level benefit option that would cause the benefit amount to change)?</p> <p>1 = Yes 2 = No 3 = Not Applicable (use for non-PRT business)</p>

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			4 = Unknown
32	1	Collar Type	<p>1 = White Collar 2 = Blue Collar 3 = Unknown Collar Type 4 = Not Applicable (use for non-PRT business)</p> <p>Enter the collar type as determined by the company. See the data dictionary for coding details.</p>
33	2	State of Residence	Use standard, two-letter state abbreviation codes (e.g. FL for Florida) for the state of the annuitant's domicile.
34	5	U.S. Zip Code	<p>For business issued in the U.S., provide the annuitant's 5-digit zip code. For non-U.S. business, leave this blank.</p>
35	6	Canadian Postal Code	<p>For business issued in Canada, provide the annuitant's 6-digit postal code. For non-Canadian business, leave this blank.</p>
36	2	UK Postcode Area	<p>For business issued in the UK, enter the 2-digit postcode area. For non-UK business, leave this blank. If Unknown, leave this blank.</p>

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

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

Identification:

Rachel Hemphill, Texas Department of Insurance

Title of the Issue:

Update VM-21 and VM-22 references to reflect IMR being attributed to a group of policies or contracts, not a group of assets.

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

2026 Valuation Manual, VM-21 Sections 4.A.7 and 4.D.1.iii and VM-22 Sections 4.A.7 and 4.D.1.iii

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted, or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

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

VM-21 and VM-22 refer to the IMR to be reflected as “attributable to the assets selected”.

VM-20, in contrast, refers to the IMR as being allocated to the model segment (e.g., see VM-20 Sections 4.A.1, 5.F, 7.D.7) with references such as “less the positive or negative PIMR balance at the valuation date allocated to the group of one or more policies being modeled”.

VM-20 also contains guidance on the allocation of IMR, while VM-21 and VM-22 do not.

This APF is to make VM-21 and VM-22 consistent with VM-20, and to add the guidance existing in VM-20 to VM-21 and VM-22. This will make it clear that the allocation of IMR is to the model segment, reflecting the policies or contracts.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/6/26	SO		
Notes: 2026-02			

VM-21 Section 4.A.7

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis. The determination of the PIMR allocation is subject to the following:

- a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.
- b. In performing the allocation to each model segment, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion. Any negative IMR that is admitted must be fully allocated by line of business and cannot be allocated to surplus. In the case of negative PIMR, since a negative amount is being added when determining the starting asset amount, the amount of starting assets is reduced by the absolute value of the allocated amount of negative PIMR and the absolute value of the allocated amount of negative PIMR is then added in as the final step in calculating the scenario reserves.
- c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-21, Section 4.D.1

D. Projection of Assets

1. Starting Asset Amount

a. For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection plus the allocated amount of PIMR attributable to the assets selected. Assets shall be valued consistently with their annual statement values. The amount of such asset values shall equal the sum of the following items, all as of the start of the projection:

- i. All of the separate account assets supporting the contracts;
- ii. Any hedge instruments held in support of the contracts being valued; and
- iii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections plus the allocated amount of PIMR attributable to the contracts being valued~~assets selected~~ less the amount in (i) and (ii).

VM-22 Section 4.A.7

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company's cash flow testing, and the amounts should be adjusted to a pre-tax basis. The determination of the PIMR allocation is subject to the following:

- a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.
- b. In performing the allocation to each model segment, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion. Any negative IMR that is admitted must be fully allocated by line of business and cannot be allocated to surplus. In the case of negative PIMR, since a negative amount is being added when determining the starting asset amount, the amount of starting assets is reduced by the absolute value of the allocated amount of negative PIMR and the absolute value of the allocated amount of negative PIMR is then added in as the final step in calculating the aggregate scenario reserves.
- a.c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-22, Section 4.D.1.iii

- iii. The allocated amount of PIMR attributable to the contracts being valued~~assets selected~~.

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

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

Elaine Lam, California Department of Insurance
Ben Slutsker, Minnesota Department of Commerce

Clarify calculation mechanics in the VM-22 SPA dynamic lapse formula, specifically in the Market Factor and Rate Factor formulas.

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

January 1, 2026 Edition of the *Valuation Manual* – VM-22 Section 6.C.5 Full Surrenders

3. Show what changes are needed by providing a red-line version of the original verbiage with deletions and identify the verbiage to be deleted, inserted or changed by providing a red-line (turn on “track changes” in Word®) version of the verbiage. (You may do this through an attachment.)

See attached.

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

In the current VM-22 SPA dynamic lapse formula, in order to get the intended result, the Market Factor accepted percentage inputs (for CR, MR, BF) as whole numbers rather than decimals. For example, 5% was expected to be input as 5, instead of 0.05. This input format caused confusion due to inconsistency with mathematical convention where percentages are typically expressed as decimals (e.g., 5% is 0.05, not 5).

This APF updates the formula for Market Factor to accept decimal inputs for percentages rather than whole number inputs, which follows mathematical convention. The formula for Rate Factor also requires updating, to output a decimal percentage rather than a whole number percentage (which again follows mathematical convention), to be correctly input into the Total Lapse formula. In the end, the Total Lapse result will be unchanged.

Mechanically, to end up with the same result, the changes being proposed are to:

- multiply the decimal percentage inputs of the Market Factor by 100
- divide the Rate Factor by 100 to turn it into a decimal percentage output

(Footnote: CR = Crediting Rate; MR = Market Rate; BF = Buffer Factor)

A subsequent update to the APF puts “ $\div 100$ ” into the Market Factor rather than the Rate Factor. This has the advantage of both the Market Factor and Rate Factor to consistently be decimals.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
3/10/26	S.O.		
Notes: 2026-03			

W:\National Meetings\2010\...\TF\LHA\

VM-22 Section 6.C.5 – Full Surrenders

(proposed changes in red)

...

$$Total\ Lapse = (Base\ Lapse \times GMIR\ Factor + Rate\ Factor \times MVA\ Factor) \times ITM\ Factor$$

...

Rate Factor

$$Rate\ Factor = Market\ Factor \times Max(0, 1 - 5 \times (1 - CSV/AV))$$

...

Market Factor

$$\begin{aligned} Market\ Factor &= -1.25 \times [100 \times (CR - MR)]^X \div 100 && \text{if } CR \geq MR \\ Market\ Factor &= 0 && \text{if } MR > CR \geq (MR - BF) \\ Market\ Factor &= 1.25 \times [100 \times (MR - BF - CR)]^X \div 100 && \text{if } CR < (MR - BF) \end{aligned}$$

X = 2.0 during Surrender Charge Period, 2.5 at Shock, and 2.5 thereafter