EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Dec. 11, 2025, Minutes

- Adopted the NAIC 2026 Proposed Budget (Attachment One)
- Adopted the NAIC 2026 Proposed Committee Charges (Attachment Two)
- Adopted the 2026 Generally Recognized Expense Table (GRET) (Attachment Three)
- Adopted the Amendments to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest Sold on or After December 14, 2020* (AG 49-A) (Attachment Four)
- Adopted the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) (Attachment Five)
- Adopted the Homeowners Market Data Call Template and Definitions (Attachment Six)
- Adopted the 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts (Attachment Seven)
- Report on States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Eight)

Draft Pending Adoption

Draft: 12/17/25

Executive (EX) Committee and Plenary
Hollywood, Florida
December 11, 2025

The Executive (EX) Committee and Plenary met in Hollywood, FL, Dec. 11, 2025. The following Committee and Plenary members participated: Jon Godfread, Chair (ND); Scott A. White, Vice Chair (VA); Elizabeth Kelleher Dwyer, Vice President (RI); Jon Pike, Secretary-Treasurer (UT); Dean L. Cameron, Most Recent Past President (ID); Heather Carpenter (AK); Mark Fowler (AL); Jimmy Harris represented by Chris Erwin (AR); Peter M. Fuimaono (AS); Maria Ailor (AZ); Ricardo Lara (CA); Michael Conway (CO); Jared Kosky (CT); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro (DE); Michael Yaworsky (FL); John F. King represented by Martin Sullivan (GA); Michelle B. Santos (GU); Scott Saiki (HI); Doug Ommen (IA); Ann Gillespie represented by Adam Flores (IL); Holly W. Lambert (IN); Vicki Schmidt represented by Eric Turek (KS); Sharon P. Clark (KY); Timothy J. Temple (LA); Michael T. Caljouw (MA); Marie Grant (MD); Robert L. Carey (ME); Anita G. Fox (MI); Grace Arnold represented by Julia Dreier (MN); Angela L. Nelson (MO); Remedio C. Mafnas (MP); Mike Chaney represented by David Browning (MS); James E. Brown (MT); Mike Causey represented by Jacqueline Obusek (NC); Eric Dunning (NE); D.J. Bettencourt (NH); Justin Zimmerman represented by Trish Wallace (NJ); Alice T. Kane represented by Viara Ianakieva (NM); Ned Gaines represented by Diana Branciforte (NV); Kaitlin Asrow (NY); Judith L. French (OH); Glen Mulready (OK); TK Keen (OR); Michael Humphreys (PA); Suzette M. Del Valle (PR); Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jon Pike (UT); Tregenza A. Roach (VI); Kaj Samsom (VT); Patty Kuderer (WA); Nathan Houdek (WI); Allan L. McVey represented by Robert Grishaber (WV); and Jeff Rude (WY).

1. Received the Report of the Executive (EX) Committee

Commissioner Godfread reported that the Executive (EX) Committee met Dec. 10 and adopted the Dec. 8 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committee adopted its Sept. 12 meeting report.

The Committee adopted the reports of its task forces: 1) Climate and Resiliency (EX) Task Force; 2) Government Relations (EX) Leadership Council; and 3) Risk-Based Capital Model Governance (EX) Task Force.

The Committee also: 1) adopted its 2026 proposed charges; and 2) approved a request to amend the *Insurance Holding Company System Regulatory Act* (#440) and/or *Insurance Holding Company System Model Regulation with Form and Instructions* (#450).

The Committee approved the appointment of Director Heather Carpenter (AK) and Commissioner Ned Gaines (NV) to the Consumer Board of Trustees.

The Committee received a status report on model law development efforts for amendments to the *Privacy of Consumer Financial and Health Information Regulation* (#672).

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

2. Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Summer National Meeting

Commissioner Lara made a motion, seconded by Commissioner Mulready, to adopt by consent the committee, subcommittee, and task force minutes of the Summer National Meeting. The motion passed unanimously.

3. Adopted the NAIC 2026 Proposed Budget

Commissioner White presented the NAIC 2026 proposed budget for approval by the Membership and noted that this marks the final step of a detailed, collaborative, and transparent process that began in May.

Commissioner White reported that the proposed budget includes $175.2 million in operating revenues and $186.3 million in operating expenses, resulting in an operating margin loss of $11.1 million. After factoring in $3.6 million in investment income, the 2026 budget reflects a reduction in net assets of $7.5 million. This reduction aligns with the NAIC's commitment to fund operations and strategic investments using existing resources where possible.

The proposed budget includes five fiscal impact statements supporting key member-focused initiatives: 1) support continued work on the centralized data portal, additional migration of data to the Enterprise Data Platform, and development of next-phase solvency tools to modernize quarterly financial analysis profiles; 2) support ongoing modernization of the System for Electronic Rates & Forms Filing (SERFF) platform; 3) build on the successful proof-of-concept approved as part of the 2025 budget and propose funding for full-scale implementation of a modernized financial data system; 4) provide temporary contingent funding for the State Based System (SBS) team should additional jurisdictions onboard to the platform; and 5) request regulatory and operational staffing, including four positions to support the investment framework approved earlier this year, two positions to further support Valuation Manual (VM)-22 principle-based reserving (PBR), three to address growing member needs related to catastrophe and flood work, and several additional roles to support the membership and organization.

Based on strong projected 2025 results, which are expected to increase net assets by approximately $5 million, the NAIC's net asset balance at the end of 2026 is projected to be $207.5 million.

Commissioner White also noted that during the public exposure period, the NAIC received one comment letter from the National Association of Mutual Insurance Companies (NAMIC), and it expounded on its written comments during the public hearing. Overall, NAMIC was supportive of the proposed 2026 budget and the NAIC's work in supporting its members and state-based insurance regulation.

Commissioner White made a motion, seconded by Director Cameron, to adopt the NAIC 2026 proposed budget (Attachment One). The motion passed unanimously.

4. Adopted the NAIC 2026 Proposed Committee Charges

Commissioner White made a motion, seconded by Commissioner Lara, to adopt the NAIC 2026 proposed committee charges (Attachment Two). The motion passed unanimously.

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

Director French reported that the Life Insurance and Annuities (A) Committee met Dec. 9 and adopted its Nov. 21 minutes. During this meeting, the Committee took the following action: 1) adopted its Summer National Meeting minutes; 2) adopted its 2026 proposed charges; 3) adopted the 2026 proposed charges of the Life Actuarial (A) Task Force; 4) adopted the 2026 Generally Recognized Expense Table (GRET); and 5) adopted revisions to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest Sold on or After December 14, 2020* (AG 49-A), limiting the disclosure of hypothetical index returns in years prior to an index's existence.

The Committee also: 1) adopted the reports of the Life Actuarial (A) Task Force and the Annuity Suitability (A) Working Group; 2) heard a presentation on the generator of economic scenarios (GOES), including discussion of

its origins, continuing importance, and future direction; and 3) heard an update on the Society of Actuaries (SOA) and Center for Insurance Policy and Research (CIPR) project on the use of criminal history in life insurance underwriting. CIPR will be working with Commissioner Mark Fowler (AL) on a letter for commissioners to send encouraging life insurers to participate in the research project.

6. Adopted the 2026 Generally Recognized Expense Table (GRET)

Director French reported that the SOA Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year.

The GRET is used by around 40% of companies for sales illustration purposes. To develop the GRET, the SOA takes average industry expense data for the most recent two years for each distribution channel. The SOA's methodology has been consistent since 2015.

No concerns were raised with this year's SOA updates, and the 2026 GRET was adopted by the Life Insurance and Annuities (A) Committee during its Nov. 21 meeting.

Director French made a motion, seconded by Commissioner Mulready, to adopt the 2026 GRET (Attachment Three). The motion passed unanimously.

7. Adopted Amendments to *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest Sold on or After December 14, 2020* (AG 49-A)

Director French reported that on Nov. 21, the Life Insurance and Annuities (A) Committee adopted revisions to the additional disclosures section of AG 49-A.

These targeted revisions were drafted and adopted by the Life Actuarial (A) Task Force to address an issue identified by an informal group of regulators, where multiple historical averages were displayed in tables alongside the maximum illustrated rate. These "historical averages" were sometimes based on backcast or simulated historical performance, despite indices having only been recently created. The updates require the disclosure of 25 years of actual historical data.

Director French made a motion, seconded by Commissioner Rude, to adopt the amendments to AG 49-A (Attachment Four). The motion passed unanimously.

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

Commissioner Mulready reported that the Health Insurance and Managed Care (B) Committee met Dec. 11. During this meeting, the Committee: 1) adopted its Summer National Meeting minutes; and 2) adopted its Nov. 20 minutes, which included the following action: a) adopted its 2026 proposed charges, including the 2026 proposed charges for the Consumer Information (B) Working Group, Health Innovations (B) Working Group, Health Actuarial (B) Task Force, Regulatory Framework (B) Task Force, and Senior Issues (B) Task Force.

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

The Committee also: 1) adopted the *Prior Authorization White Paper*; 2) heard a presentation from the Center on Health Insurance Reforms (CHIR) on state-level actions to mitigate projected coverage losses and premium impacts from H.R. 1—One Big Beautiful Bill Act (OBBA) and other federal changes impacting the individual market; 3) heard a presentation from the Wakely Consulting Group on the emerging 2025 individual market risk pool; 4)

received a status update on the Health Innovation (B) Working Group's work to develop guidance on state flexibility and the Affordable Care Act (ACA) innovation waivers; and 5) heard an update from the federal Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) on its recent activities of interest to the Committee.

9. Adopted the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework)

Commissioner Mulready reported that at the Summer National Meeting, the Health Insurance and Managed Care (B) Committee adopted revisions to the Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework). The key revisions to the LTCI MSA Framework are: 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options (RBOs), to the Senior Issues (B) Task Force.

After completion of the LTCI MSA Framework pilot project, industry and regulator feedback suggested that revisions were needed. Revisions were drafted and discussed in open session multiple times, and all revisions were exposed for public comment. The new cost-sharing formula increases the cost-sharing burden for the company as the cumulative rate increases over time. This change addresses concerns regarding the existing cost-sharing formula, which allows high rate increases when the cumulative rate increases over time. This tends to occur for people aged 85 and older who have held on to their policies for 25 or more years. The revised cost-sharing formula increases the company cost-sharing burden from 50% to 85% when cumulative rate increases get high.

Commissioner White made a motion, seconded by Director Cameron, to adopt the LTCI MSA Framework (Attachment Five). The motion passed, with Washington abstaining.

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

Commissioner Conway reported that the Property and Casualty Insurance (C) Committee met Dec. 11. During this meeting, the Committee: 1) adopted its Summer National Meeting minutes; and 2) adopted its Nov. 21 minutes, which included adoption of its 2026 proposed charges.

The Committee adopted the reports of its task forces and working groups: Casualty Actuarial and Statistical (C) Task Force, Homeowners Market Data Call (C) Task Force, Surplus Lines (C) Task Force, Cannabis Insurance (C) Working Group, Catastrophe Insurance (C) Working Group, NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group, Terrorism Insurance Implementation (C) Working Group, Title Insurance (C) Working Group, Transparency and Readability of Consumer Information (C) Working Group, and Workers' Compensation (C) Working Group.

The Committee also: 1) adopted the Homeowners Market Data Call template and definitions; 2) received an update on the *Affordability and Availability Playbook*; 3) heard a presentation from Verisk/Insurance Services Office (ISO) on regulator data calls and tools; 4) heard a presentation from Brava on roof resilience; and 5) heard a presentation from the American Bankers Association (ABA) on disaster savings accounts.

11. Adopted the Homeowners Market Data Call Template and Definitions

Commissioner Conway reported that the Property Casualty and Insurance (C) Committee adopted the revised Homeowners Market Data Call template and definitions. The adoption followed a comment period, during which seven comment letters were received and reviewed. The Homeowners Market Data Call (C) Task Force made changes based on those comments and adopted the documents on Oct. 28. Regulators believe the revised

template and definitions will provide additional data to regulators while also clarifying definitions and improving the way data is requested.

To support the updated scope and capture industry trends, the 2026 data call will require eight years of data (2018–2025). Policy forms for HO4, HO6, and HO7 are now being requested. Other new data elements include: 1) count of paid claims and losses paid by type of peril; 2) company-initiated cancellations collected by time period similar to the Market Conduct Annual Statement (MCAS); 3) written and returned premium for canceled policies; and 4) count of policies in force and average percentage of state required mitigation discounts for various types of discounts.

Improvements were made to the definitions, including a change to emphasize that policies in force are being collected as of year-end.

Commissioner Conway noted that the Task Force also decided on a threshold mirroring the $50,000 written premium threshold used in the MCAS. The Task Force expects the data call to be issued early next year, with a due date next summer.

Commissioner Conway made a motion, seconded by Commissioner Lara, to adopt the Homeowners Market Data Call template and definitions (Attachment Six). The motion passed unanimously.

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

Commissioner Cameron reported that the Market Regulation and Consumer Affairs (D) Committee met Dec. 11. During this meeting, the Committee 1) adopted its Nov. 21 minutes, which included the following action: a) adopted its 2026 proposed charges; b) adopted the 2026 proposed charges of the Antifraud (D) Task Force; and c) adopted the 2026 proposed charges of the Producer Licensing (D) Task Force; and 2) adopted its Summer National Meeting minutes.

The Committee received an update on the *Pharmacy Benefit Manager (PBM) Licensure and Regulation Guidelines for Regulators* document, which the Pharmacy Benefit Management (D) Working Group adopted on Dec. 9. The update included the development of PBM examination standards, which the Working Group exposed on Nov. 25 for a public comment period ending Jan. 16, 2026.

The Committee received an update from the Market Actions (D) Working Group on marketplace issues.

The Committee also received an update from the Market Conduct Examination Guidelines (D) Working Group on the development of a Cybersecurity Incident Response Framework. The purpose of this initiative is to assist NAIC Members in assessing the significance of cybersecurity events and to develop protocols for multistate coordination following a cybersecurity event. An initial draft of the framework is anticipated to be exposed for public comment in the first quarter of 2026.

The Committee heard a presentation from the Insurance Regulatory Examiners Society (IRES), which included an overview of its history and objectives.

The Committee also discussed the following producer licensing issues: 1) the plan to circulate a revised NAIC consumer agent/broker search proposal in 2026; 2) NIPR's implementation of the revised NAIC Uniform Producer Licensing Applications, which are anticipated to be in production in the second quarter of 2026; 3) the Template for 1033 Written Consent Process document, which has been referred back to the Producer Licensing (D) Task Force for additional discussion regarding the definition of "conviction" and what information an applicant may be

required to disclose; and 4) the NAIC's Personalized Information Capture System (PICS) alerts for the NIPR Attachment Warehouse.

The Committee adopted the reports of the following task forces and working groups: Antifraud (D) Task Force; Producer Licensing (D) Task Force; Market Analysis Procedures (D) Working Group; Market Conduct Annual Statement Blanks (D) Working Group; Market Conduct Examination Guidelines (D) Working Group; Market Information Systems (D) Working Group; Market Regulation Certification (D) Working Group; Pharmacy Benefit Management (D) Working Group; and Speed to Market (D) Working Group.

The Committee received an update from the Big Data and Artificial Intelligence (H) Working Group on the development of an artificial intelligence (AI) systems evaluation tool. The tool is designed as an interim solution to help regulators evaluate the use of AI while they study longer-term updates to the market and financial-related processes.

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

Commissioner Houdek reported that the Financial Condition (E) Committee met Dec. 11. During this meeting, the Committee: 1) adopted its Summer National Meeting minutes; 2) adopted its Nov. 20 minutes; and 3) adopted its Nov. 5 minutes, which included adoption of its 2026 proposed charges.

The Committee adopted the reports of its task forces and working groups: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Financial Stability (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Valuation of Securities (E) Task Force; Mutual Recognition of Jurisdictions (E) Working Group; NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; and the Restructuring Mechanisms (E) Working Group.

The Committee also: 1) adopted a list of Qualified Jurisdictions and Reciprocal Jurisdictions; 2) adopted the *NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation (GCC)*; 3) discussed a general timeline of possible action on collateral loan obligations (CLOs) by the Risk-Based Capital Investment Risk and Evaluation (E) Working Group in 2025 and 2026, and the Invested Assets (E) Task Force in 2026; 4) adopted the Statutory Accounting Principles (E) Working Group item 2024-06: Risk Transfer Analysis of Combination Reinsurance Contracts as modified to clarify that it should be accounted for as a change in accounting principles; and 5) adopted a *Restructuring Mechanisms White Paper* drafted by the Restructuring Mechanisms (E) Working Group.

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

14. Adopted Item 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts

Commissioner Houdek reported that during the Summer National Meeting, the Statutory Accounting Principles (E) Working Group adopted Item 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts, which was intended to clarify the accounting for combination coinsurance and yearly renewable term reinsurance

contracts. The Accounting Practices and Procedures (E) Task Force also adopted this item in an overwhelming majority vote of 30 to two.

The Financial Condition (E) Committee received this item for consideration at the same meeting but decided to defer action to give Committee members an opportunity to learn more about this issue. Following the meeting, the Committee held four hour-long calls to delve deeper into the issue and its technical aspects. During one of those meetings, an alternative proposal was presented and subsequently exposed for a comment period.

Commissioner Houdek made a motion, seconded by Commissioner Ommen, to adopt item 2024-06: Risk Transfer Analysis on Combination Reinsurance Contracts (Attachment Seven). The motion passed unanimously.

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

Commissioner Clark reported that the Financial Regulation Standards and Accreditation (F) Committee met Dec. 9. During this meeting, the Committee reported that it met Dec. 8 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Idaho, Kentucky, Oklahoma, and Vermont.

The Committee adopted its Summer National Meeting minutes.

The Committee adopted the report of the Accreditation Scope and Alignment (F) Working Group, which met Oct. 2 and Aug. 26 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department's compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to develop, conduct, and discuss surveys to collect information to help understand each state's domestic industry.

The Committee adopted revisions to the review team guidelines and the self-evaluation guide, which add new guidelines related to conflicts of interest and confidentiality protections when using contract resources.

The Committee also adopted revisions to the self-evaluation guide to add new items to be reported by states when submitting interim annual reviews, including additional details pertaining to domestic multistate insurance companies and staffing fluctuations.

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

Director Dunning reported that the International Insurance Relations (G) Committee met Dec. 10. During this meeting, the Committee adopted its Nov. 7, Sept. 25, and Summer National Meeting minutes. During these meetings, the Committee took the following action: 1) adopted a motion to approve NAIC comments on the International Association of Insurance Supervisors (IAIS) public consultation on the draft application paper on operational resilience objectives and tool kit; and 2) adopted its 2026 proposed charges and those of the Aggregation Method Implementation (G) Working Group.

The Committee adopted the report of the Aggregation Method Implementation (G) Working Group.

The Committee also: 1) heard a presentation from FSD Africa on inclusive insurance programs in the African region; 2) heard an update on IAIS activities; and 3) heard an update on international cooperation activities, including regional supervisory cooperation efforts and updates from the Organisation for Economic Co-operation and Development (OECD) and Sustainable Insurance Forum (SIF).

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

Commissioner Yaworsky reported that the Innovation, Cybersecurity, and Technology (H) Committee met Dec. 11 and adopted its Nov. 17 and Summer National Meeting minutes. During its Nov. 17 meeting, the Committee took the following action: 1) adopted its 2026 proposed charges.

The Committee adopted the reports of its subgroups and working groups.

The Committee heard a presentation from Conning on AI use in the insurance industry.

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

Commissioner Godfread referred attendees to the written report for updates on states' implementation of NAIC-adopted model laws and regulations (Attachment Eight).

19. Heard the Results of the 2026 NAIC Zone Officer Elections

The Executive (EX) Committee and Plenary received the results of the 2026 zone officer elections: Midwest Zone: Director Eric Dunning, Chair (NE); Director Larry D. Deiter, Vice Chair (SD); and Director Ann Gillespie, Secretary (IL). Northeast Zone: Commissioner Justin Zimmerman, Chair (NJ); Commissioner D.J. Bettencourt, Vice Chair (NH); and Commissioner Marie Grant, Secretary (MD). Southeast Zone: Commissioner Mike Chaney, Chair (MS); Commissioner John F. King, Vice Chair (GA); and Commissioner Michael Yaworsky, Secretary (FL). Western Zone: Commissioner Ricardo Lara, Chair (CA); Commissioner Patty Kuderer, Vice Chair (WA); and Commissioner Ned Gaines, Secretary (NV).

20. Elected the 2026 NAIC Officers

The NAIC Membership elected the 2026 NAIC officers: Commissioner Scott A. White, President (VA); Director Elizabeth Kelleher Dwyer, President-Elect (RI); Commissioner Jon Pike, Vice President (UT); and Director Michael Wise, Secretary-Treasurer (SC).

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

SharePoint/NAIC Support Staff Hub/Member Meetings/2025 NAIC Meetings/Fall National Meeting/Plenary/Minutes – EX-PLenary.docx

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2026 BUDGET
EXECUTIVE SUMMARY

Expected Results for 2025

Based on actual operating results through June 30, 2025, the NAIC projects an operating loss of $9.1 million compared to a budgeted negative operating margin of $11.5 million, an improvement of $2.4 million. Investment income is projected to be a gain of $14.1 million. When combining results of operations and investment returns, net assets are expected to increase $5.0 million, resulting in $215.0 million in projected net assets at year-end. While investment income is projected at $10.8 million over budget at year-end, it is important to note that $8.0 million is based on market valuations. Markets remain volatile and increasing uncertainty may impact future financial performance.

2026 Budget

The operating budget reflects revenues of $175.2 million and expenses of $186.3 million, which represent a 7.0% and 6.3% increase, respectively, from the 2025 budget, resulting in $11.1 million in projected expenses over revenues. Viewed in relation to the 2025 projected totals, the 2026 budget represents an operating revenue increase of 4.0% and operating expense increase of 5.0%. Additional information is included in the detailed footnotes of the budget.

Included within this budget are five fiscals – detailed analysis prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of $100,000 or more either in the current budget or within the following few years' budgets, or which require more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative, its benefits, deliverables, and an assessment of the financial impact to the organization. The total financial impact of the five fiscals included in the 2026 budget is $161,000 in revenues, $6.5 million in expenses, and $11.7 million in capital spending. Additional information about each initiative is included in the fiscal section of the budget.

The budget also includes $3.6 million in investment income from the NAIC's long-term investment portfolio and cash equivalent investments. Investment income is composed of interest and dividends earned, reduced by investment management fees. Investment gains and losses are volatile and therefore are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the budget has a reduction in net assets of $7.5 million, with projected net assets of $207.5 million at the end of 2026.

Ensuring Financial Stability

The NAIC maintains an operating reserve designed to ensure organizational financial stability in the face of emerging business risks and uncertainties, while also providing the capacity to fund new priority initiatives identified by membership. The association's reserve status is a paramount consideration in the budgeting process, reflecting the NAIC's commitment to strong and prudent financial management of its assets.

To support this commitment, the NAIC has adopted a rigorous, long-term methodology for determining its operating reserve target. Developed in consultation with an independent financial advisory firm and informed by an evaluation of comparable organizations, the framework considers three key components: the working capital required to sustain daily operations for a three-month period; funding needed to

mitigate potential organizational risks; and the resources necessary to advance strategic initiatives over a three-year horizon.

Operating Reserve Target

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

Based on the most recent comprehensive analysis, NAIC's current operating reserve target is set at $174.9 million. This reserve not only safeguards operational continuity and risk preparedness but also ensures the association can continue investing in the modernization of its critical information technology and technical infrastructure. These forward-looking investments are detailed throughout the 2026 budget.

Preparing for the Unknown

The budget and operating reserve includes all activities anticipated to occur in 2026. However, situations or additional strategic or emerging projects may arise that require additional funding. In such an event, a funding request will be prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration and direction. Supplemental funding can also come from the Regulatory Modernization and Initiatives Fund, which is an extra layer of protection established in 2005 to manage requests that arise following the adoption and implementation of an annual budget. This fund is based on 1.5% of the NAIC's projected net assets as of December 31, 2025, or $3.2 million.

Contact Information

The NAIC appreciates the opportunity to present this budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming year. A summary of the key components of the 2026 budget is included in the budget overview.

Please contact Carol Thompson, Director of Finance, at cthompson@naic.org, should you have any questions or need additional information.

2026 BUDGET
REVENUE AND EXPENSE BY LINE

Description	2024 Actual	2025 6/30/2025 Actual	2025 12/31/2025 Projected	2025 Budget	2025 Projected Variance	2026 **2026 Budget**	2026 Increase (Decrease) from 2025 Budget	2026 %	2026 Increase (Decrease) from 2025 Projected	2026 %
Member Assessments	$2,131,205	$1,138,266	$2,420,261	$2,420,261	$0	**$2,569,487**	$149,226	6.2%	$149,226	6.2%
Database Filing Fees	43,661,649	50,196,842	50,196,842	48,301,095	1,895,747	**51,608,868**	3,307,773	6.8%	1,412,026	2.8%
Publications and Insurance Data Products	18,572,122	11,321,722	17,427,116	17,548,935	(121,819)	**17,951,457**	402,522	2.3%	524,341	3.0%
Valuation Services	36,584,490	12,548,428	35,204,596	33,937,575	1,267,021	**36,292,645**	2,355,070	6.9%	1,088,049	3.1%
Transaction Filing Fees	22,417,878	12,668,591	23,062,162	23,278,074	(215,912)	**25,654,702**	2,376,628	10.2%	2,592,540	11.2%
National and Major Meetings	2,676,014	905,752	2,753,252	2,973,225	(219,973)	**2,806,200**	(167,025)	-5.6%	52,948	1.9%
Education and Training	334,555	88,885	287,056	350,290	(63,234)	**326,855**	(23,435)	-6.7%	39,799	13.9%
License Fees and Administrative Services	34,461,539	18,830,657	36,966,732	34,637,821	2,328,911	**37,859,434**	3,221,613	9.3%	892,702	2.4%
Other	546,872	(19,754)	74,344	254,016	(179,672)	**123,670**	(130,346)	-51.3%	49,326	66.3%
Total Operating Revenues	161,386,324	107,679,389	168,392,361	163,701,292	4,691,069	**175,193,318**	11,492,026	7.0%	6,800,957	4.0%
Salaries	71,776,305	37,051,979	77,686,303	78,187,077	(500,774)	**84,404,149**	6,217,072	8.0%	6,717,846	8.6%
Temporary Personnel	727,763	211,188	614,939	491,094	123,845	**788,331**	297,237	60.5%	173,392	28.2%
Payroll Taxes	5,333,113	3,087,760	5,847,450	6,185,220	(337,770)	**6,235,197**	49,977	0.8%	387,747	6.6%
Employee Benefits	13,648,018	7,921,411	16,151,750	15,233,753	917,997	**17,054,927**	1,821,174	12.0%	903,177	5.6%
Employee Development	778,423	294,314	788,596	867,413	(78,817)	**921,056**	53,643	6.2%	132,460	16.8%
Professional Services	20,372,959	9,815,070	25,261,626	23,070,789	2,190,837	**23,501,322**	430,533	1.9%	(1,760,304)	-7.0%
Computer Services	8,796,559	4,685,976	9,610,064	9,077,896	532,168	**10,026,796**	948,900	10.5%	416,732	4.3%
Travel	5,923,211	2,385,976	5,968,487	6,535,262	(566,775)	**6,425,705**	(109,557)	-1.7%	457,218	7.7%
Occupancy and Rental	4,756,516	2,449,737	4,943,881	4,718,456	225,425	**5,041,011**	322,555	6.8%	97,130	2.0%
Software License Fees	10,778,698	5,817,405	11,934,708	11,740,488	194,220	**12,455,724**	715,236	6.1%	521,016	4.4%
Depreciation and Amortization	4,004,987	3,038,551	6,462,049	6,841,100	(379,051)	**6,678,603**	(162,497)	-2.4%	216,554	3.4%
Operational	1,974,732	1,035,876	1,974,836	1,884,769	90,067	**2,066,296**	181,527	9.6%	91,460	4.6%
Library Reference Materials	401,187	221,387	425,953	419,982	5,971	**456,252**	36,270	8.6%	30,299	7.1%
National and Major Meetings	6,337,213	2,530,104	5,682,112	5,552,320	129,792	**5,796,993**	244,673	4.4%	114,881	2.0%
Education and Training	90,855	33,722	173,847	264,816	(90,969)	**231,076**	(33,740)	-12.7%	57,229	32.9%
Grant and Zone	2,390,961	593,245	2,493,489	2,525,000	(31,511)	**2,672,600**	147,600	5.8%	179,111	7.2%
Other	1,168,116	1,035,249	1,448,117	1,615,715	(167,598)	**1,528,008**	(87,707)	-5.4%	79,891	5.5%
Total Operating Expenses	159,259,616	82,208,950	177,468,207	175,211,150	2,257,057	**186,284,046**	11,072,896	6.3%	8,815,839	5.0%
Revenues Over/(Under) Expenses before Investment Income	2,126,708	25,470,439	(9,075,846)	(11,509,858)	2,434,012	**(11,090,728)**	419,130		(2,014,882)	
Investment Income	14,539,189	9,451,274	14,065,480	3,276,000	10,789,480	**3,624,000**	348,000		(10,441,480)	
Revenues Over/(Under) Expenses	$16,665,897	$34,921,713	$4,989,634	($8,233,858)	$13,223,492	**($7,466,728)**	$767,130		($12,456,362)	

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

2026 BUDGET
FISCAL IMPACT STATEMENTS

Fiscal Number	Description	2026 Budget: Capital Expenditures	2026 Budget: Revenues	2026 Budget: Expenses	**Net Impact 2026 Budget**
	Total Revenues Over/(Under) Expenses Before Fiscals and Investment Income	$4,699,203	$175,032,068	$179,996,846	**($4,964,778)**
1	Regulatory Data Integration and Enhancement of Solvency Related Tools			1,398,948	**(1,398,948)**
2	SERFF Modernization – 2026 Transition Stages	5,157,789		1,479,948	**(1,479,948)**
3	Financial Data Repository (FDR) Modernization	6,541,000			**0**
4	SBS Implementations – 2026		161,250	1,695,910	**(1,534,660)**
5	Regulatory Support and Operational Resources			1,712,394	**(1,712,394)**
	Total Fiscal Revenues Over/(Under) Expenses	11,698,789	161,250	6,287,200	**(6,125,950)**
	Investment Income		3,624,000		**3,624,000**
	Total Revenues Over/(Under) Expenses After Fiscals and Investment Income	$16,397,992	$178,817,318	$186,284,046	**($7,466,728)**

Date: November 20, 2025

To: All NAIC Members and Interested Parties

From: Scott White, Commissioner, Virginia Bureau of Insurance and NAIC-President Elect
Jeff Johnston, NAIC Interim Chief Executive Officer
Carol Thompson, NAIC Director of Finance

Re: Summary of Comments on the Proposed 2026 NAIC Budget

In response to the Executive (EX) Committee's and Internal Administration (EX1) Subcommittee's request for comment on the NAIC's proposed 2026 budget, the NAIC received one comment letter from the National Association of Mutual Insurance Companies (NAMIC) (Attachment One). This memorandum summarizes the submitted comments and includes NAIC's responses.

A public hearing will be held on November 24th at 12:00 p.m. CT to discuss these comments. Participation instructions for the public hearing can be accessed at https://content.naic.org/about_budget.htm.

Opening Remarks

NAMIC reiterated its support for a modernized state-based system of insurance regulation and recognized NAIC's central role in that framework. NAMIC noted that it has participated in the NAIC budget process for many years because it values the NAIC's contributions to defending and advancing state-based insurance regulation. They also acknowledged rising labor and service costs faced by the NAIC and expressed appreciation for tools and services that help insurance departments operate more efficiently and effectively.

However, NAMIC also expressed concern about the scale of the NAIC's financial growth in recent years, noting net assets have increased from 2019 to 2024 and that several key revenue sources have also grown over that period. While reaffirming support for efforts that help regulators maintain reliable and financially sound insurance markets, NAMIC encouraged continued attention to budget growth as the costs associated with regulatory tools and services are borne initially by insurers and ultimately by policyholders.

NAIC Response:

The NAIC appreciates NAMIC's continued engagement in the budget process and its long-standing support for the state-based system of insurance regulation. NAIC additionally values NAMIC's recognition that many NAIC services significantly reduce burdens on individual jurisdictions by providing shared tools and infrastructure that support efficient and effective supervision.

The NAIC also recognizes the importance of managing organizational growth and related fee structures. Revenue requirements support member-directed initiatives, multi-year technology projects, and the prudent development of reserves to secure continuity of operations, and ultimately, to support members in their efforts to maintain solvent and active insurance markets.

It is important to note that $57 million of the $80 million of the NAIC's net asset growth over this timeframe is largely attributable to investment performance rather than through revenue sources. Given the volatility of financial markets, reliance on this revenue source to fund the important operations of the NAIC has been minimal. This volatility is evident by the $23 million loss in the NAIC's portfolio valuation at the end of 2022. While the portfolio valuation recovered in the following year, significant drops in market values are not uncommon.

However, the NAIC remains extremely mindful that costs ultimately affect policyholders, which is evident through the planned reduction of net assets in 2026. Further, the planned reduction aligns with the commitment to fund operations and strategic investments using existing resources to the extent possible.

1. Regulatory Support and Operational Resources

NAMIC focused on the NAIC's planned increase in headcount in the 2026 budget, noting that the NAIC proposes to add numerous positions, viewing this in the context of a broader trend in organizational growth. NAMIC acknowledged that the stated goal is to improve regulatory support and operational capabilities and encourages that growth remains proportionate to member needs and aligned with the NAIC's core mission of supporting insurance regulation.

NAMIC emphasized its view that the NAIC's greatest strength lies in relationships, governance processes, and the tools and services it provides to regulators, rather than in the size of its staff alone. NAMIC cautioned that the continued development of national-level expertise in areas such as data analysis and actuarial support should not lead to a concentration of activities that belong with insurance regulators or result in activities that could blur the line between NAIC support versus regulatory oversight.

NAIC Response:

The NAIC appreciates NAMIC's comments regarding staffing and the importance of ensuring that organizational growth remains aligned with the NAIC's mission to support, rather than substitute for, state-based insurance regulation. The staffing changes reflected in the 2026 budget are intended to directly respond to member priorities, strengthen the NAIC's capacity to deliver requested services, and improve coordination and support for insurance departments across all jurisdictions. These additions are focused on enhancing existing functions, improving internal processes, and better organizing the assistance the NAIC provides to regulators.

The NAIC also recognizes the concern that increases in staff could, if not carefully managed, create the perception that regulatory activities are moving away from insurance departments. The NAIC does not possess regulatory authority and does not supervise insurers. Staff with technical, analytical, or operational responsibilities serve to assist member committees and regulators at their sole discretion and direction. Decisions regarding regulatory policy, supervisory actions, and oversight of licensed entities remain solely with insurance regulators.

The NAIC agrees that relationships, governance structures, and clear processes are central to the strength of the state-based system. As new roles are implemented, the NAIC will continue to emphasize transparency regarding their purpose, ensure that responsibilities are framed around supporting members, and review staffing levels and functions on an ongoing basis. The NAIC remains committed to maintaining clear boundaries between analytical and operational support provided by staff and the regulatory authority exercised exclusively by insurance regulators, while continuing to provide the tools, services, and coordination that members have identified as essential to effective supervision.

2. Regulatory Data Integration and Enhancement of Solvency Related Tools

NAMIC commented on the proposed investment to upgrade the enterprise data platform, develop a centralized data portal, and enhance solvency analysis tools. They noted the planned use of modern technologies, including artificial intelligence, and recognized that these efforts are intended to improve access to supervisory information, reduce redundancy, and support consistency across jurisdictions. NAMIC acknowledged that such improvements could provide regulators with clearer, more timely insights into emerging risks while consolidating information that is currently dispersed across multiple systems. At the same time, NAMIC expressed concern about the overall scale, complexity, and cost of the initiative and the potential for large technology projects to extend beyond their original timelines or budgets.

NAMIC further noted that centralizing data and modernizing tools can offer tangible efficiency gains and strengthen solvency oversight by creating a more streamlined view of insurer financial information. However, NAMIC emphasized that this centralization must be paired with strong governance, clear accountability, and appropriate oversight, particularly because sensitive regulatory data would be managed within the NAIC. NAMIC underscored the importance of transparency around how data is managed, who may access it, and what safeguards are in place to protect confidentiality and cybersecurity. They also cautioned that technology cannot replace the judgment, experience, and local market knowledge required for effective financial analysis. While AI-driven features and enhanced search capabilities may help identify patterns or expedite review, NAMIC noted that these tools do not, on their own, ensure better supervisory outcomes and must be supported by sound regulatory expertise.

NAIC Response:

NAMIC's recognition of the intent behind the enterprise data and solvency tools initiative is appreciated. The enhancements are designed to provide regulators with more timely and accessible information and reflect member direction to reduce duplicative systems and modernize technology in support of more effective oversight.

The NAIC understands the concerns raised regarding the cost and complexity of multi-year technology projects. To address these considerations, the initiative is being advanced in phases with defined milestones, regular reporting to member committees, and established financial oversight to help ensure that development remains aligned with member expectations. Transparency around progress and resource needs will continue throughout the project.

With respect to governance and data protection, safeguarding sensitive regulatory information remains a core priority. Confidentiality agreements with member jurisdictions, established security controls, and ongoing enhancements to the NAIC's information security program guide how data is handled as systems evolve. Technology tools, including natural language search and AI-assisted features, are intended to support regulatory review, not to replace supervisory judgment or jurisdiction-specific expertise. Accordingly, the NAIC remains committed to ensuring that these enhancements reinforce the state-based system, respect jurisdictional authority, and provide regulators with effective tools that support their responsibilities.

3. SERFF Modernization – 2026 Transaction Stages

NAMIC provided comments on the SERFF modernization project, noting that the 2026 budget includes additional capital and expense funding for the fifth year of the transition, with work expected to extend into a sixth year. NAMIC recognized that SERFF is essential to the day-to-day work of insurers and regulators in rate and form filings and reiterated support for modernization because of the potential to reduce filing times, improve speed-to-market, and enhance workflow and communication.

NAMIC welcomed anticipated improvements such as better document management, built-in quality checks, and expanded AI capabilities. However, they also expressed concern about the length of time required to complete the project. NAMIC commented that offers from companies that use SERFF daily to provide expert input have not been fully utilized. NAMIC encouraged NAIC to adopt a more collaborative approach that includes more active engagement with end users so the modernized platform reflects real-world filing needs.

NAIC Response:
NAMIC's continued support for the SERFF modernization initiative is appreciated. SERFF remains one of the most widely used regulatory tools in the state-based system, and its modernization is intended to improve filing efficiency, strengthen workflow capabilities, and support more consistent and timely review processes. The scope of the project reflects both the breadth of SERFF's user base and the need to ensure that updated functionality can be introduced without disrupting ongoing regulatory operations.

The multi-year timeline, while longer than originally anticipated, reflects a phased approach designed to balance progress with stability. Replacing a twenty plus year old platform that supports rate and form filings across virtually all jurisdictions requires extensive testing, careful sequencing, and accommodation of differing jurisdictional requirements. This structure extends the development period but is intended to deliver a reliable, durable system that meets the needs of both filers and regulators. The upcoming transitions planned for 2026 represent an important milestone in moving from development to broader adoption. The phased approach also allows the NAIC to ensure training and support can be provided to the large number of industry users moving to the new platform, to respond effectively to their feedback, and to continue enhancing the system.

The SERFF modernization initiative emphasizes extensive engagement with industry users to ensure the platform functions effectively. The project team actively gathers input through existing avenues such as NAIC meetings, monthly product steering committee calls (averaging 175 attendees), and presentations to industry groups and forums. An in-person workshop was planned for 2025 but cancelled due to lack of interest. However, the team consistently engages with industry users representing a wide variety of experience and perspectives and plans to schedule additional opportunities for feedback in 2026. As the project moves into the early adopter phase, the team will involve users in focused requirements sessions and user testing.

As noted, this is a critically important system and the NAIC remains committed to delivering a modernized SERFF platform that supports accurate, efficient filings and strengthens the regulatory review process. Ongoing collaboration with regulators, filers, and industry groups will continue to guide development as the project advances.

4. Financial Data Repository (FDR) Modernization
NAMIC expressed support for modernizing FDR and acknowledged its central role in helping regulators monitor the financial condition of insurers and identify early signs of distress. NAMIC stated that upgrades can improve accessibility and reliability of financial data and enhance automation, validation, and usability, streamlining regulatory workflows and strengthening solvency and market conduct oversight.

NAMIC also emphasized the size and duration of the proposed investment, noting the projected initial cost in 2026 and the estimated long-term cost over a ten-year period. They stated that, given this scale, stakeholders should have a clear understanding of how recurring costs will be managed and how benefits

will be measured. NAMIC further raised concerns about the centralization of sensitive financial data with a private organization and called for strong transparency and accountability to ensure that data stewardship remains aligned with the public interest.

NAIC Response:
NAMIC's support for the FDR modernization initiative is appreciated, as is its recognition of the platform's central role in solvency oversight. Modernization is necessary to address increasing reporting demands and to ensure regulators continue to receive timely, reliable financial information. The current system has reached the limits of its architecture, and comprehensive redevelopment is the most practical and cost-effective way to meet long-term supervisory needs.

Cost considerations remain an important part of this work. The modernization strategy incorporates the use of cloud-based infrastructure and managed service arrangements to help stabilize future costs and shift certain support responsibilities to a specialized provider. This approach reduces the need for internal infrastructure investments, shortens development and deployment timelines, and lessens the long-term maintenance burden that would otherwise fall directly on the NAIC.

Oversight of value and performance will continue to be a focus throughout development. Performance indicators related to timeliness, accuracy, usability, and workflow support are being developed in coordination with members. These measures will help ensure that efficiencies gained through modernization, such as improved data quality, faster processing, and reduced reliance on legacy systems, offset the long-term operating costs associated with a modern platform. A significant benefit of the vendor system is its ability to facilitate statutory financial statement filings, Market Conduct Annual Statement filings, and filings from other data collection projects.

Safeguarding sensitive financial information remains a vital consideration. Data submitted through the vendor's collection system will reside in the NAIC's internal data warehouse. Thus, all reports, applications and tools to provide access to and analysis of the submitted data will be sourced from the NAIC. Existing controls governing the handling of financial data are grounded in agreements with member jurisdictions and long-standing regulatory expectations. Modernization provides an opportunity to update these protections with current security capabilities, strengthened access controls, and enhanced monitoring. Throughout this process, NAIC will continue to operate solely as a support organization, with use of FDR data occurring under the authority and in the support of insurance departments.

5. State Based Systems (SBS) Implementations - 2026
NAMIC addressed the fiscal for SBS implementations planned for 2026 and acknowledged that SBS provides a centralized platform for licensing, enforcement, consumer services, and revenue management and that it allows participating jurisdictions to modernize operations while maintaining jurisdiction-specific customization.

NAMIC recognized that expanding SBS to three additional jurisdictions, as detailed in the fiscal, offers potential efficiency gains. At the same time, they noted the upfront cost of the fiscal and that most related revenue is expected in later years. NAMIC also observed that the initiative relies heavily on external consultants and expressed concern about long-term continuity and cost control.

NAIC Response:
The NAIC appreciates NAMIC's recognition of the benefits that SBS provides to participating jurisdictions and agrees that careful oversight of implementation costs is important. SBS has been developed at the

direction of regulators to support key workflows in a configurable manner, and the planned 2026 expansion reflects jurisdictions that specifically requested to adopt this shared infrastructure.

While the fiscal includes upfront implementation expenses, these costs are variable and incurred only when a jurisdiction elects to join the system. If a member chooses not to proceed with an implementation, the associated expenses will not materialize. Consultant support is often used during initial transitions to ensure specialized technical expertise is available for configuration and data migration, but NAIC's long-term support model relies primarily on internal staff. Implementation projects include structured knowledge transfer to help ensure continuity and cost control over time.

As always, the configuration and use of SBS remain under the authority of each participating jurisdiction. Licensing decisions, enforcement actions, and other supervisory activities are made by regulators, and SBS serves as a tool to support these responsibilities rather than shift or centralize regulatory authority. The NAIC will continue to work closely with jurisdictions to ensure that SBS aligns with regulatory frameworks and that resources are deployed efficiently and only when requested.

Concluding Comments

NAIC appreciates NAMIC's engagement and the perspectives shared in its comments. Openness and collaboration remain central to the NAIC's work, and these principles continue to guide the budget development process. Each year, the proposed budget is shaped through input from NAIC staff, officers, the Executive (EX) Committee, and all members to ensure it supports the needs of insurance departments and the broader regulatory framework.

As part of this commitment, the NAIC publishes the proposed budget for public review and provides structured opportunities for interested parties to offer observations. These comments are carefully considered and reflected upon through written responses and during a public hearing. This approach helps maintain clarity around the NAIC's operations and reinforces the organization's role in supporting regulators as they work to protect policyholders and uphold the financial stability of insurance markets.

NAMIC®
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

317.875.5250 | [F] 317.879.8408
3601 Vincennes Road, Indianapolis, Indiana 46268

202.628.1558 | [F] 202.628.1601
20 F Street N.W., Suite 510 | Washington, D.C. 20001

November 14, 2025

Carol Thompson, Director of Finance
CC: Jim Pinegar, Assistant Director – Strategic Business Initiatives
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

VIA Email Transmission: cthompson@naic.org; jpinegar@naic.org

RE: NAMIC Comments – NAIC Proposed 2026 Budget

Dear Ms. Thompson:
cc: Mr. Pinegar:

The following comments are submitted on behalf of the member companies of the National Association of Mutual Insurance Companies[1] regarding the NAIC's proposed 2026 budget.

NAMIC supports a reformed and modernized state-based regulatory system and recognizes the NAIC's central role in that effort. For years, NAMIC has participated in the NAIC budget process, because we value the NAIC's contributions to the defense and advancement of state-based insurance regulation. Like many organizations, the NAIC faces rising labor and service costs, and we appreciate its efforts to provide responsive tools and services that help insurance departments operate more efficiently and effectively.

That said, the NAIC has grown immensely over the past years. From 2019 to 2024, its net assets have increased from $130 million to $210 million – a 60% rise. Over that period, key revenue sources grew significantly: database fees rose 41%, valuation services and transaction filing fees grew 45%, and license and administrative services increased 77%. In the 2026 budget, only the database fees are projected to grow beyond 2024 levels. It is important to be mindful that the cost to provide the added regulatory products and services are financed by insurers initially and by the insurance-buying public ultimately. Although we are concerned about the overall growth in the budget, particularly the fee

[1] The National Association of Mutual Insurance Companies (NAMIC) is the foremost trade association representing the property/casualty insurance industry. Serving more than 1,300 member companies – including local and regional insurers as well as some of the nation's largest carriers – NAMIC members collectively write $383 billion in annual premiums, representing 61% of the homeowners and 48% of the automobile insurance markets. For more than 130 years, NAMIC has been the leading voice advancing public policy solutions and regulatory frameworks that promote a strong, competitive market and protect our members and their policyholders.

portion of the database services, we remain committed to supporting efforts that help regulators maintain a reliable and financially sound insurance market. With that in mind, we offer the following comments on specific fiscal proposals.

Regulatory Support and Operational Resources
The NAIC plans to increase its staff headcount by 17 positions in 2026, rising from 559 to 576 employees, and the associated expense growth of $1.7 million in 2026 and $2.1 million in 2027. Understanding the stated goal is to improve regulatory support and operational capabilities, these additions are part of a broader trend of organizational growth in both personnel and financial resources. While we appreciate the intent behind adding 17 new employees next year, NAMIC submits that the NAIC's greatest strength lies in relationships, not just headcount. NAMIC applauds the addition of a Relationship Manager, provided that instruction and guidance to new Commissioners include essential background on insurance fundamentals; this includes specifically advising against the politicalization of regulation, focusing on the state-based authority to regulate for inadequate rates and insurer insolvencies, and identifying reliable data sources.

Additionally, the proposed role for a Process Improvement and Governance Manager is warranted, particularly if essential duties involve advising members and staff on the NAIC's bylaws. Deliberately developed to ensure compliance with the regulatory framework established under the McCarran-Ferguson Act and to preserve the state-based regulatory system, the by-laws are not mere procedural documents. They are there to prevent any delegation of regulatory authority away from the states to the NAIC staff themselves. State insurance regulation is designed to be performed by public officials accountable to the citizens of each state. When the NAIC increases its internal capacity to interpret data, conduct actuarial reviews, or shape regulatory policy through national-level staffing, it risks centralizing activities that should remain in the hands of state regulators. This shift may reduce transparency, weaken state oversight, and create potential accountability issues.

Regulatory Data Integration and Enhancement of Solvency Related Tools
The NAIC's 2026 budget proposes a $1.4 million investment to upgrade its enterprise data platform, build a centralized data portal, improve solvency analysis tools, and modernize legacy systems with features like AI-driven analytics and natural language search. While these upgrades aim to support regulators, the high upfront cost, along with additional spending planned for 2027 and beyond, raises some concerns. Projects of this size often involve complex data migrations and system redesigns that can run over budget or fall behind schedule, potentially leading to wasted resources or unfinished tools.

The effort to centralize data access and eliminate redundant systems could make regulatory work more efficient by providing faster, clearer access to supervisory insights. It could also improve

consistency across states to help maintain accreditation standards. But centralization must be balanced with strong governance and accountability. Handing sensitive regulatory data to a private organization creates new risks for the insurance industry, including reduced oversight by the primary public regulators. It also introduces challenges around data transparency and cybersecurity that must be addressed.

Enhancements to solvency tools can be helpful, especially when they provide more current data and enable quicker detection of solvency risks. That supports the core purpose of solvency regulation: identifying financially weak insurers before problems worsen. Still, financial analysis depends on more than technology. It requires sound judgment, experience and understanding of local market conditions that no software can replicate.

New features like AI and natural language search are intended to make the system easier to use, particularly for non-technical staff. These tools may help identify trends or speed up reviews, but faster oversight doesn't always mean better oversight. Additionally, the presence of a pattern in the data doesn't guarantee the right conclusion will be drawn through technology alone; proper oversight and expertise is still needed to analyze results before drawing any conclusions.

SERFF Modernization – 2026 Transition Stages

Included in the NAIC's proposed budget is an additional $5.2 million in capital outlay and $1.5 million in expense for the ongoing SERFF modernization effort. This marks the fifth year (and planned to go into year six) of transition to overhaul SERFF, a platform that is essential to the day-to-day operations of insurers and state regulators alike. Plans for 2026 focus on rolling out functionality to the first group of jurisdictions, with a second group of jurisdictions scheduled for implementation by year's end.

NAMIC continues to support this initiative because it directly benefits our members. SERFF is a critical tool for filing insurance rates and forms, and modernizing it has the potential to significantly reduce filing times and improve speed-to-market. Improvements in workflow, document management, and communication tools will hopefully lead to more accurate filings, faster approvals, and fewer administrative delays. The inclusion of built-in quality control checks and expanded AI capabilities is a welcome step forward for both filers and regulators.

However, while we recognize the complexity of modernizing such a widely used platform, we are concerned about the length of time it has taken to complete this project. In addition, despite offers to provide expert input from companies who use SERFF every day, the NAIC has not taken steps to engage these practitioners in a meaningful way. Input from all stakeholders in the SERFF system could strengthen both the design and functionality of the end product. As the platform continues to evolve, we encourage a more collaborative approach that includes end users in the development process.

Doing so will help ensure the modernized SERFF platform meets the real-world needs of those who depend on it.

Financial Data Repository (FDR) Modernization
A modernized financial data repository (FDR) is a well-placed investment given how critical FDR is for regulators in assisting their ability to monitor the financial health of insurers and detect early signs of financial distress. Upgrading this platform will significantly improve the accessibility and reliability of financial data, enabling regulators to make faster, more informed decisions. The improvements in automation, data validation, and usability will streamline regulatory workflows and enhance the oversight of both solvency and market conduct.

That said, the long-term cost of this project is significant. The initial investment of $6.5 million in 2026 is only the beginning of a projected ten-year cost nearing $40 million. With annual operating and maintenance expenses expected to reach $3.5 million per year after the initial build, it's essential that all stakeholders have a clear understanding of how these recurring costs will be managed and how value will be measured over time.

Furthermore, the centralization of sensitive insurer financial data, including filings that cover nearly the entire U.S. insurance market, raises concerns about data security and governance. While the NAIC plays a role in supporting the state-based system, it is still a private organization. Entrusting it with such critical and confidential information requires transparency and strong accountability mechanisms to ensure that the safekeeping of this data remains aligned with the public interest. These risks must be carefully weighed and mitigated as the system is designed and deployed.

SBS Implementations – 2026
The NAIC's 2026 fiscal to support additional State Based Systems (SBS) implementations offers meaningful benefits for state insurance departments. SBS serves as a centralized platform that streamlines licensing, enforcement, consumer services, and revenue management. It enables states to modernize operations while allowing for jurisdiction-specific customization. By expanding SBS to three more jurisdictions (two standard implementations and one with complex, tailored functionality) this initiative helps improve efficiency.

The fiscal carries a high upfront cost of $1.7 million in 2026, with most revenue not expected until the following year. Additionally, the NAIC will rely heavily on outside consultants to manage this expansion, which raises concerns about the project's long-term continuity and cost control. While SBS is designed to support state functions, we ask that any product that helps regulators with their core regulatory functions does not shift too much day-to-day authority away from the primary state regulators.

Closing

Thank you for the opportunity to review and comment on the NAIC's proposed 2026 budget and related fiscal initiatives. We appreciate the transparency of the process and the NAIC's continued engagement with stakeholders as it considers how best to support state insurance departments. While we have shared both support and concerns regarding specific proposals, our overarching goal remains the same: to ensure the long-term strength and credibility of the state-based regulatory system.

We look forward to continued collaboration and to working together in support of efficient, accountable, and effective insurance regulation. Thank you for your consideration of these comments on this matter of importance to NAMIC, its member companies, and their policyholders.

Sincerely,

Jonathan Rodgers, Policy Vice President – Solvency
National Association of Mutual Insurance Companies

Draft: 10/21/25
Adopted by the Executive (EX) Committee and Plenary, TBD
To be considered for adoption by the Executive (EX) Committee, Dec. 10, 2025

2026 Proposed Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Executive (EX) Committee** will:
   A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2026 Commissioners' Conference.
   B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2026 as necessary.
   C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
   D. Consider requests from NAIC members for friend-of-the-court briefs.
   E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
   F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
   G. Conduct strategic planning on an ongoing basis.
   H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
   I. Plan, implement and coordinate communications and activities with state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
   J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
   K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
   L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Committee Support: Kay Noonan/Sarah Heidenreich

CLIMATE AND RESILIENCY (EX) TASK FORCE

NOTE: Restructuring and revised charges for the Climate and Resiliency (EX) Task Force are being considered and will be discussed at the Fall National Meeting.

Draft: 10/29/25
Adopted by the Executive (EX) Committee and Plenary, TBD
To be considered for adoption by the Executive (EX) Committee, Dec. 10, 2025
Adopted by the Government Relations (EX) Leadership Council, Oct. 29, 2025

2026 Proposed Charges

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Committee Support: Shana Oppenheim/Brian R. Webb

Draft: 12/2/25
Adopted by the Executive (EX) Committee and Plenary, TBD
To be considered for adoption by the Executive (EX) Committee, Dec. 10, 2025
Adopted by the Risk-Based Capital Model Governance (EX) Task Force, Dec. 3, 2025

2026 Proposed Charges

RISK-BASED CAPITAL MODEL GOVERNANCE (EX) TASK FORCE

The mission of the Risk-Based Capital Model Governance (EX) Task Force is to develop guiding principles for updating the risk-based capital (RBC) formulas to: 1) address current investment trends with a focus on more RBC precision in the area of asset risk; and 2) ensure that insurance capital requirements maintain their current strength and continue to appropriately balance solvency with the availability of products to meet consumer needs.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Risk-Based Capital Model Governance (EX) Task Force** will:
   A. Develop a set of guiding principles for the RBC framework to ensure a consistent approach to future RBC adjustments. These principles will serve as a strategic foundation to ensure that all revisions to the RBC framework are enhancements that uphold its integrity, adaptability, and global competitiveness and further the principle of "equal capital for equal risk."
   B. Complete a comprehensive gap analysis and consistency assessment to identify and inventory gaps that exist and establish a plan for addressing identified gaps and potential inconsistencies that improve the framework.
   C. Oversee the development of an education and public messaging campaign to highlight the benefits and strengths of the RBC framework as an important part of the U.S. state-based insurance regulatory system.
   D. Facilitate and oversee coordination and alignment among all NAIC committees, task forces, etc., related to this initiative and implementation of the guiding principles, including the Life Actuarial (A) Task Force, the Capital Adequacy (E) Task Force, the Accounting Practices and Procedures (E) Task Force, and the Valuation of Securities (E) Task Force. The work of this Task Force will not result in the work of other RBC-related committees, task forces, etc., being paused or stopped.
   E. Create a process for analyzing both retrospective and future adjustments to RBC, incorporating regular reviews of RBC outcomes and ensuring future adjustments are made in alignment with guiding principles. This process will facilitate ongoing improvements to ensure the framework remains responsive to emerging risks and market trends, enabling the RBC framework to adapt proactively.

NAIC Committee Support: Dan Daveline

Draft: 8/26/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Internal Administration (EX1) Subcommittee, Aug. 28, 2025

2026 Proposed Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

NAIC Committee Support: Kay Noonan/Sarah Heidenreich

Draft: 11/21/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Life Insurance and Annuities (A) Committee, Nov. 21, 2025

2026 Proposed Charges

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

3. The **Annuity Buyer's Guide (A) Working Group** will:
   A. Review and revise the *NAIC Buyer's Guides for Deferred Annuities* in light of changes in the marketplace.

4. The **Life Insurance and Annuities Illustrations (A) Working Group** will:
   A. Evaluate concepts for improving life insurance and annuity illustrations and disclosures, and consider revisions to relevant NAIC models or develop other guidance where feasible and appropriate.

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

Draft: 10/23/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Life Insurance and Annuities (A) Committee, Nov. 21, 2025
Adopted by the Life Actuarial (A) Task Force, Oct. 23, 2025

2026 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

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

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

6. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Address topics designated as post-launch activities following the implementation of the VM-22 principle-based reserving (PBR) framework.
   B. Monitor the non-variable (fixed) annuities reserve framework and determine if revisions need to be made.
   C. Develop and recommend appropriate changes, including those that improve the accuracy and clarity of the VM-22 reserve requirements and reporting.

NAIC Committee Support: Scott O'Neal/Jennifer Frasier

Draft: 11/20/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 20, 2025

2026 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

2. The **Consumer Information (B) Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
   C. Identify communication goals, strategies, and tactics to reach communities that experience inequities in health insurance access, including through partnerships with community-based organizations.

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

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

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

Draft: 10/8/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 20, 2025
Adopted by the Health Actuarial (B) Task Force, Oct. 20, 2025

2026 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

NAIC Committee Support: Eric King

Draft: 10/15/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 20, 2025
Adopted by the Regulatory Framework (B) Task Force, Oct. 20, 2025

2026 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Examine regulatory factors contributing to disparities in coverage, and recommend appropriate steps to reduce those disparities.
   D. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to group coverage.
   F. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage, short-term, limited-duration (STLD) coverage, health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage.

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

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

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

4. The **Prescription Drug Coverage (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues related to prescription drug coverage regulation and stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to prescription drug coverage regulation, such as pharmaceutical drug pricing and transparency, formularies, pharmacy payments, pharmacy benefit managers (PBMs), and coverage options.
   C. Maintain a current listing of prescription drug coverage laws and regulations and case law that fall under the purview of state-based insurance.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding prescription drug coverage and PBMs.
   F. Provide assistance and input to the Market Regulation and Consumer Affairs (D) Committee and/or any of its groups, as necessary, on matters related to PBM enforcement.

NAIC Committee Support: Jolie H. Matthews/Jennifer Cook

Draft: 10/24/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. 20, 2025
Adopted by the Senior Issues (B) Task Force, Oct. 24, 2025

2026 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
H. Examine systemic inequities and discrimination on access, affordability, and outcomes for older insurance consumers.

NAIC Committee Support: David Torian

Draft: 11/21/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 21, 2025

2026 Proposed Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Property and Casualty Insurance (C) Committee** will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor the activities of the Homeowners Market Data Call (C) Task Force.
   D. Monitor the activities of the Surplus Lines (C) Task Force.
   E. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the *Quarterly Listing of Alien Insurers*. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   F. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
      i. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
      ii. Review law changes and court decisions, and, if warranted, make appropriate changes to the *Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators.*
      iii. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.
   G. Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   H. Provide a forum for discussing issues related to parametric insurance, and consider the development of a white paper or regulatory guidance.
   I. Study and report on the availability and affordability of liability and property coverage for non-profit organizations.
   J. Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues. Provide analysis of property insurance markets to states.
   K. Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.

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

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

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

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

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

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

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

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

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

8. The **Workers' Compensation (C) Working Group** will:
   A. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.
   B. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
   C. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
   D. Discuss issues affecting workers' compensation.
   E. Stay informed about workers' compensation issues by collaborating with various workers' compensation organizations, such as the International Association of Industrial Accident Boards and Commissions (IAIABC), the National Council on Compensation Insurance (NCCI), and state workers' compensation bureaus.

NAIC Committee Support: Aaron Brandenburg

Draft: 10/17/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 21, 2025
Adopted by the Casualty Actuarial and Statistical (C) Task Force, Oct. 23, 2025

2026 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

E. Monitor cyber liability insurance and discuss regulatory data needs.
F. Develop rate indices to track, over time and in detail, the cumulative magnitude of the rate changes that impact each state's P/C insurance markets. Collaborate with the SERFF modernization team to help guide the new platform in a direction to make these types of indices more granular, reliable, and useful.

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

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

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

Draft 10/28/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by Property and Casualty Insurance (C) Committee, Nov. 21, 2025
Adopted by Homeowners Market Data Call (C) Task Force, Oct. 28, 2025

2026 Proposed Charges

HOMEOWNERS MARKET DATA CALL (C) TASK FORCE

The mission of the Homeowners Market Data Call (C) Task Force is to develop and oversee homeowners market data call matters and communicate to NAIC membership any related issues.

1. The **Homeowners Market Data Call (C) Task Force** will:
   A. Oversee development and delivery of periodic communication to the NAIC membership on issues related to the Homeowners Market Data Call.
   B. Develop a framework for the Homeowners Market Data Call, including data collection authority, confidentiality protections, and data sharing between states and the NAIC.
   C. Consider recommendations from the regulator-only drafting group and interested party input and approve any changes to the current scope and content of the data call for 2026
   D. Oversee continued development of regulator tools and training related to the data call.
   E. Develop a national analysis report, for regulators only, with support from CIPR. Consider the nature and extent of such national analysis report that may be suitable for public release.

NAIC Committee Support: Aaron Brandenburg

Draft: 7/22/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Property and Casualty Insurance (C) Committee, Nov. 21, 2025
Adopted by the Surplus Lines (C) Task Force, July 31, 2025

2026 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

NAIC Committee Support: Andy Daleo

Draft: 11/13/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 21, 2025

2026 Proposed Charges

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

2. The **Advisory Organization (D) Working Group** will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive and efficient. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
   D. Monitor the Third-Party Data and Models (H) Working Group in development of a third-party data and model vendor regulatory framework. Coordinate when the regulatory framework for advisory organizations should be consistent.

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

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

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

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

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

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

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

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

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

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

9. The **Pharmacy Benefit Management (D) Working Group** will:
   A. Establish and promote uniform examination and data collection standards, while remaining sensitive to the variation in state approaches.
   B. Develop examination standards for pharmacy benefit managers (PBMs) and related regulated entities for inclusion in the NAIC *Market Regulation Handbook*, which will provide consistent guidance and ensure more predictable and fair market regulation.
   C. Develop licensing and registration standards for PBMs in alignment with state and federal requirements, providing states with criteria to support uniformity in the licensure process.
   D. Establish protocols for the collection and analysis of data related to PBM examinations and market practices.
   E. Monitor and address market conduct trends associated with PBMs and the regulatory efforts of the states.
   F. Serve as a forum to share best practices, examination findings, and compliance issues encountered with PBM regulation.
   G. Facilitate coordination with federal and state agencies to support compliance and enforcement of PBM regulations and ensure alignment with federal standards, where applicable, minimizing redundancy and promoting collaboration.

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

10. The **Speed to Market (D) Working Group** will:
    A. Consider proposed System for Electronic Rates & Forms Filing (SERFF) features or functionality presented to the Working Group by the Product Steering Committee (PSC). Review periodic reports from the PSC, as needed.
    B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
    C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed-to-market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
        i. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
        ii. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed-to-market modernization efforts, as measured by nationwide and individual state speed-to-market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
        iii. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with, and report on state implementation of any PCM changes.
        iv. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.
    D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Receive periodic reports from NAIC staff, as needed.
    E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
        i. Provide support to the Compact as the speed-to-market vehicle for asset-based insurance products, encouraging state participation in, and the industry's usage of, the Compact.
        ii. Receive periodic reports from the Compact, as needed.

NAIC Committee Support: Tim Mullen/Randy Helder

Draft: 10/21/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 21, 2025
Adopted by the Antifraud (D) Task Force, Oct. 29, 2025

2026 Proposed Charges

ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Antifraud (D) Task Force** will:
   A. Work with NAIC committees, task forces, and working groups (e.g., Title Insurance (C) Working Group Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
   B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
   C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
   D. Coordinate with state, federal, and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
   E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
   F. Coordinate activities and information from national antifraud organizations, and provide information to state insurance fraud bureaus.
   G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
   H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
   I. Evaluate and recommend methods to track national fraud trends.
   J. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2026 Fall National Meeting.

ANTIFRAUD (D) TASK FORCE (*Continued*)

2. The **Antifraud Technology (D) Working Group** will:
   A. Work with the NAIC to develop and maintain the NAIC Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Provide recommended updates to the Antifraud (D)Task Force by the 2026 Fall National Meeting.
   B. Evaluate sources of antifraud data, and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2026 Fall National Meeting.
   C. Work with NAIC and other vendors to enhance the effectiveness and usefulness of the NAIC Online Fraud Reporting System (OFRS).

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

NAIC Committee Support: Greg Welker/Tim Mullen

Draft: 10/21/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Market Regulation and Consumer Affairs (D) Committee, Nov. 21, 2025
Adopted by the Producer Licensing (D) Task Force, Oct. 31, 2025

2026 Proposed Charges

PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

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

NAIC Committee Support: Tim Mullen/Greg Welker

Draft: 11/5/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025

2026 Proposed Charges

FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

FINANCIAL CONDITION (E) COMMITTEE (*Continued*)

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

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

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

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

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

FINANCIAL CONDITION (E) COMMITTEE (*Continued*)

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

9. The **Reciprocal Exchanges (E) Working Group** will:
   A. Modify the NAIC *Insurance Holding Company System Regulatory Act* (Model #440) and/or the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) to clarify that regardless of definitions of control and affiliation, fees charged by insurers from the attorney in fact are subject to fair and reasonable standards and subject to approval by the Commissioner and under no circumstances should they exceed the cost of such services plus a reasonable profit.

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

FINANCIAL CONDITION (E) COMMITTEE (*Continued*)

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

12. The **Risk Retention Group (E) Working Group** will:
    A. Operate in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, and in open session when discussing public RRG topics and policy issues.
    B. Monitor and evaluate the work of other NAIC committees, task forces, and working groups that may affect the filing requirements or compliance of RRGs (e.g., actions that affect compliance with the NAIC Financial Regulation Standards and Accreditation Program).
    C. Provide a forum for discussion of current and emerging RRG issues and topics.
    D. Interact with domiciliary regulators and registered states to assist and advise on the most appropriate regulatory strategies, methods, and action(s).
    E. Support, encourage, and promote efforts to address solvency concerns, including identifying adverse industry trends.
    F. Review and analyze annual and quarterly financial results.
    G. Provide ongoing maintenance and enhancements to the *Risk Retention and Purchasing Group Handbook* and related resources.
    H. Develop best practice guides on licensing and registering RRGs.
    I. Monitor federal activities related to RRGs, including legislation related to the Liability Risk Retention Act of 1986 (LRRA), and ensure all interested parties are informed.
    J. Monitor the resources available to domiciliary and non-domiciliary state insurance regulators of RRGs including educational programs or enhancements or the development of new resources.
    K. Develop or amend relevant NAIC model laws, regulations, and guidelines.

FINANCIAL CONDITION (E) COMMITTEE (*Continued*)

13. The **Valuation Analysis (E) Working Group** will:
    A. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding principle-based reserves (PBR) and asset adequacy analysis, including actuarial guidelines or other requirements.
    B. Develop and implement a plan to coordinate PBR reviews/examinations for VM-20, VM-21, and VM-22.
    C. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LV—Application of the Valuation Manual for Testing the Adequacy of Reserves Related to Certain Life Reinsurance Treaties* (AG 55), and coordinate with states as appropriate.
    D. Review, on a targeted basis, asset adequacy analysis filings for *Actuarial Guideline LIII—Application of the Valuation Manual for Testing the Adequacy of Life Insurer Reserves* (AG 53), and coordinate with states as appropriate.
    E. Review, on a targeted basis, long-term care (LTC) reserve adequacy filings for *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), and coordinate with states as appropriate.
    F. Provide a confidential forum to address questions/issues regarding PBR and asset adequacy analysis, as well as related reinsurance risk transfer issues, and make referrals, as appropriate, to other NAIC regulator groups.
    G. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual* or related actuarial guidelines.
    H. Assist NAIC resources in the use of models and other analytical tools to support the review of PBR/asset adequacy analysis.
    I. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
    J. Coordinate with the Reinsurance (E) Task Force, the Invested Assets (E) Task Force, and other NAIC task forces and groups to address issues, as appropriate.
    K. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

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

Draft: 8/12/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Accounting Practices and Procedures (E) Task Force, Aug. 13, 2025

2026 Proposed Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

NAIC Committee Support: Robin Marcotte

Draft: 6/30/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Capital Adequacy (E) Task Force, June 30, 2025

2026 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

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

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

6. The **Risk-Based Capital Investment Risk and Evaluation (E) Working Group** will:
   A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
      i. Evaluating relevant historical data and applying defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to current asset risk structure and factors (e.g. C-1o and C1-cs).
      ii. Facilitating coordination and alignment among NAIC committees/task forces/working groups related to its work in reviewing current asset risk framework.
      iii. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action levels.

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

NAIC Committee Support: Eva Yeung

Draft: 9/29/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Examination Oversight (E) Task Force, Sept. 29, 2025

2026 Proposed Charges

EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

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

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

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

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

NAIC Committee Support: Elise Klebba/Bailey Henning

Draft: 10/17/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Financial Stability (E) Task Force, Oct. 17, 2025

2026 Proposed Charges

FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products, or Services

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

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

NAIC Committee Support: Tim Nauheimer

Draft: 7/30/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Receivership and Insolvency (E) Task Force, July 30, 2025

2026 Proposed Charges

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

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

NAIC Committee Support: Jane Koenigsman

Draft: 8/11/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025
Adopted by the Reinsurance (E) Task Force, Aug. 11, 2025

2026 Proposed Charges

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

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

REINSURANCE (E) TASK FORCE (*Continued*)

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

NAIC Committee Support: Jake Stultz/Dan Schelp

Draft: 7/28/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Condition (E) Committee, Nov. 5, 2025

2026 Proposed Charges

INVESTED ASSETS (E) TASK FORCE

The mission of the Invested Assets (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's analysis of insurer invested assets.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Invested Assets (E) Task Force** will:
   A. Oversee the work of the Credit Rating Provider (E) Working Group, the Investment Analysis (E) Working Group, and the Investment Designation Analysis (E) Working Group.
   B. Provide a forum for education from various parties to regulators on investment products, their performance, and the financial risks for regulatory policy purposes, as well as how regulators may address such risks.
   C. Understand new or evolving investment products that may possess characteristics that pose unique risks to insurers and the industry and coordinate with different NAIC groups of the Financial Condition (E) Committee or other NAIC groups, if necessary, to develop, implement, or advise on investment-related solvency policy changes (e.g., accounting, risk-based capital [RBC], etc.) or procedures within their analysis and examination of insurers subject to such risks.

2. The **Credit Rating Provider (E) Working Group** will:
   A. Identify potential improvements to the filing exempt (FE) process (i.e., using credit rating provider ratings to determine an NAIC designation) through ongoing implementation of the CRP due diligence framework to ensure greater consistency, uniformity, and appropriateness to achieve the NAIC's financial solvency objectives.
   B. Implement policies resulting from the CRP due diligence framework related to NAIC's staff administration of rating agency ratings used in NAIC processes, including staff discretion over the applicability of their use in its administration of FE.
   C. Coordinate with the Investment Designation Analysis (E) Working Group on issues identified from the maintenance of the CRP due diligence framework.

3. The **Investment Analysis (E) Working Group** will:
   A. Monitor the risks associated with all types of invested assets, including collateral loans, mortgage loans, real estate, and Schedule BA investments.
   B. Analyze the details of new or evolving investment products or new investment characteristics that could pose unique risks to insurers and provide recommendations to the Task Force on investment-related solvency policy changes to be made in conjunction with other NAIC groups of the Financial Condition (E) Committee.
   C. Analyze insurers and groups that hold new, evolving, or riskier investments and advise the state of domicile on applicable risks, either directly or through coordination with the Financial Analysis (E) Working Group or Valuation Analysis (E) Working Group. Where applicable, utilize NAIC staff from the Securities Valuation Office and Structured Securities Group and Capital Markets Bureau to assist the Working Group with these deliverables.
   D. Oversee a revised portfolio analysis product from NAIC staff, the CMB Research agenda, and analytical investment reports produced by NAIC for the public.

INVESTED ASSETS (E) TASK FORCE (*Continued*)

E. Oversee the NAIC's implementation of revised systems designed to improve the availability of various investment data points from existing NAIC databases while also identifying and providing NAIC staff who support this group with at least one investment software package that facilitates portfolio analysis and portfolio modeling.
F. Monitor information technology and data resource needs to ensure data can be retrieved efficiently and effectively.
G. Develop best practice examples of supervisory plans that monitor complex investments where the company and the regulator oversee company-designed risk dashboards on their riskier investment areas/or risk mitigation tracking.

4. The **Investment Designation Analysis (E) Working Group** will:
   A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
   B. Maintain and revise *the Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions for investment-related regulatory issues for existing or anticipated investments.
   C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual* (AP&P Manual), as well as financial statement blanks and instructions, to ensure that the P&P Manual reflects regulatory needs and objectives.
   D. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
   E. Identify potential improvements to the credit filing and designation processes, including formats and electronic system enhancements.
   F. Coordinate with the Invested Assets (E) Task Force, Investment Analysis (E) Working Group, and other NAIC working groups and task forces to formulate recommendations and make referrals to other NAIC regulator groups to ascertain that the purpose and objective of guidance in the P&P Manual is reflective in the guidance of other groups and that the expertise of other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual. Implement additional and alternative ways to measure and report investment risk.

NAIC Committee Support: Mark Sagat

Draft: 8/11/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Financial Regulation Standards and Accreditation (F) Committee, Aug. 11, 2025

2026 Proposed Charges

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

NAIC Committee Support: Bailey Henning/Sara Franson/Dan Schelp

Draft: 11/10/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the International Insurance Relations (G) Committee, Nov. 17, 2025

2026 Proposed Charges

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE (*Continued*)

2. The **Aggregation Method Implementation (G) Working Group** will:
   A. Review group capital regulation of U.S. groups and their potential for comparable implementation of the insurance capital standard (ICS), including:
      i. Sensitivity to changes in interest rates and their impact on the solvency of the U.S. life groups.
      ii. Supervisory intervention of U.S. groups on group capital grounds.
      iii. Use of scalars and choice of regulatory intervention points.
      iv. Reporting and disclosure requirements.
   B. Coordinate the U.S. implementation of the ICS via the Aggregation Method (AM) by recommending:
      i. Potential domestic refinement.
      ii. The final AM.
   C. Monitor any further development of ICS at the IAIS and what implications those may have for the implementation of the AM.
   D. Report to, and coordinate with, the International Insurance Relations (G) Committee and any relevant groups under the Financial Condition (E) Committee.

NAIC Committee Support: Ryan Workman/Nikhail Nigam

Draft: 11/10/25
Adopted by the Executive (EX) Committee and Plenary, TBD
Adopted by the Innovation, Cybersecurity, and Technology (H) Committee, Nov. 17, 2025

2026 Proposed Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

2. The **Big Data and Artificial Intelligence (H) Working Group** will:
   A. Research the use of big data and AI (including ML) in the business of insurance.
   B. Monitor state, federal, and international activities on AI, including updates to the regulatory framework for the oversight of AI, to: i) respond to such activities, where appropriate, ii) address potential impacts on existing state insurance laws or regulations, and iii) support adoption of the *Model Bulletin on the Use of AI Systems by Insurers*.
   C. Facilitate discussion on AI systems evaluation, including coordination across the NAIC, to identify and/or develop tools, resources, materials, training, and guidance to assist regulators in their review of AI systems used by licensees.
   D. Facilitate and coordinate foundational and contextual educational content for regulators on topics related to the use of big data and AI techniques, tools, and systems in the insurance industry.

3. The **Cybersecurity (H) Working Group** will:

   Cybersecurity Charges

   A. Monitor cybersecurity trends, such as vulnerabilities, risk management, governance practices, and breaches, that have the potential to affect the insurance industry.
   B. Facilitate communication across state insurance departments regarding cybersecurity risks and events.
   C. Develop and maintain regulatory cybersecurity response guidance to assist state insurance regulators in the investigation of national insurance cyber events.
   D. Monitor federal and international activities on cybersecurity, engaging in efforts to manage and evaluate cybersecurity risk.
   E. Coordinate NAIC committee cybersecurity work, including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology (IT) Examination (E) Working Group.
   F. Work with the Center for Insurance Policy and Research (CIPR) to receive updates on cybersecurity research efforts, by the CIPR and others, and to analyze publicly available cybersecurity-related information.
   G. Support the states with implementation efforts related to the adoption of Model #668, including supporting the research into and, if approved, the implementation of a cybersecurity event notification portal.
   H. Coordinate with committee support to support cybersecurity preparedness for state insurance regulators, including advising on training development and facilitating tabletop exercises.

   Cybersecurity Insurance Charges

   A. Monitor industry trends pertaining to cyber insurance, including meeting with subject matter experts (SMEs) and evaluating data needs of state insurance regulators. Considerations should include the availability and affordability/pricing of cyber insurance, disclosures, limits and sublimits, as well asd sublimits in policies, policy language and trends in requirements, underwriting practices, and the role of reinsurance in the cyber insurance market.
   B. Coordinate with NAIC work groups addressing cyber insurance related issues, such as the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor federal and international activities related to cyber insurance and financing mechanisms for cyber risk.
   D. Coordinate with committee support to conduct analysis pursuant to the NAIC's *Cyber Insurance Report*.

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

E. Review the NAIC's *Property & Casualty Annual Statement Cybersecurity Insurance Coverage Supplement* recommending changes and/or developing reports to supplement data development as necessary.
F. Consider and develop a guide for states on cyber insurance data analysis best practices.

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

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

6. The **Third-Party Data and Models (H) Working Group** will:
   A. Develop and propose a framework for the regulatory oversight of third-party data and predictive models.
   B. Monitor and report on state, federal, and international activities related to governmental oversight and regulation of third-party data and model vendors and their products and services.

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

Draft: 11/14/25
Reaffirmed by the Executive (EX) Committee and Plenary, TBD
Reaffirmed by the NAIC/Consumer Liaison Committee, Nov. 14, 2025

2026 Proposed Mission Statement

NAIC/CONSUMER LIAISON COMMITTEE

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2026 are closely aligned with the priorities of the NAIC/Consumer Participation Board of Trustees.

NAIC Committee Support: Tim Mullen

Draft: 11/26/25
Reaffirmed by the Executive (EX) Committee and Plenary, TBD
Reaffirmed by the NAIC/American Indian and Alaska Native Liaison Committee, Nov. 26, 2025

2026 Proposed Mission Statement

NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE

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

NAIC Committee Support: Tim Mullen

Draft: 8/1/25
Reaffirmed by the Executive (EX) Committee and Plenary, TBD
Reaffirmed by the Internal Administration (EX1) Subcommittee, Aug. 10, 2025
Reaffirmed by the Audit Committee, July 31, 2025

2026 Proposed Committee Charter

AUDIT COMMITTEE

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

AUDIT COMMITTEE *(Continued)*

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

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

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

NAIC Committee Support: Carol Thompson

Pending adoption by the Executive (EX) Committee and Plenary on Dec. 11, 2025
Adopted by the Life Insurance and Annuities (A) Committee on Nov.21, 2025
Adopted by the Life Actuarial (A) Task Force on Oct. 2, 2025

TABLE 1

PROPOSED 2026 GRET FACTORS, BASED ON AVERAGE OF 2022/2023 DATA

DESCRIPTION	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	$217	$1.20	54%	$65	150	2,666	223
Career	238	1.30	60%	72	95	2,854	215
Direct Marketing	263	1.40	65%	79	24	490	142
Niche Marketing	126	0.70	32%	38	25	996	15
Other*	175	1.00	44%	53	86	961	90
* Includes companies that did not respond to this or prior year surveys					380		

TABLE 2

CURRENT 2025 GRET FACTORS, BASED ON AVERAGE OF 2022/2023 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	$204	$1.10	51%	$61	147	3,008	241
Career	227	1.20	57%	68	86	2,739	218
Direct Marketing	239	1.30	59%	72	24	465	119
Niche Marketing	131	0.70	33%	39	27	649	12
Other*	159	0.90	40%	48	94	869	81
* Includes companies that did not respond to this or prior year surveys					378		

APPENDIX A -- DISTRIBUTION CHANNELS

The following is a description of distribution channels used in the development of recommended 2022 GRET values:

1. Independent – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. Career – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. Direct Marketing – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet, or other media. No direct field compensation is involved.

4. Niche Marketers – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. Other – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years' surveys confirmed an "other" categorization (see below), values for the "other" category are given in the tables in this memo. It was also included to

indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

APPENDIX B – UNIT EXPENSE SEEDS

The expense seeds used in the 2014 and prior GRETs were differentiated between branch office and all other categories, due to the results of a relatively old study that had indicated that branch office acquisition cost expressed on a per Face Amount basis was about double that of other distribution channels. Due to the elimination of the branch office category in the 2015 GRET, non-differentiated unit expense seeds have been used in the current and immediately prior studies.

The unit expense seeds used in the 2026 GRET and the 2025 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2020 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
Term				
Weighted Average	$149	$0.62	38%	$58
Unweighted Average	$237	$0.80	57%	$76
Median	$196	$0.59	38%	$64
Permanent				
Weighted Average	$167	$1.43	42%	$56
Unweighted Average	$303	$1.57	49%	$70
Median	$158	$1.30	41%	$67

CURRENT UNIT EXPENSE SEEDS:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
All distribution channels	$200	$1.10	50%	$60

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

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

Identification:
Rachel Hemphill, Texas Department of Insurance
Ben Slutsker, Minnesota Department of Commerce

Title of the Issue:
Clarify the requirements of AG49 Section 7.B and 7.C, to address the observed practice of including of historical averages exceeding the maximum illustrated rate and backcasted performance.

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

Section 7, Actuarial Guideline 49

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.)

3. Definitions

G. Historical Period: The Historical Period for an Index Account is the number of whole years between the most recent inception date of any Index whose published values are utilized directly in the calculation of Indexed Credits and the date of the illustration.

H. Inception Date: The Inception Date of an Index is the date on which the Index was launched and began tracking and reflecting market performance, and Index values were made publicly available. If the Index is comprised of multiple component indices, then the Inception Date is based on the Index itself rather than the component indices.

I. Index: An Index is a financial benchmark that tracks the performance of market instruments or investment strategies whose published values are used directly in the calculation of Indexed Credits for an Index Account.

Drafting Note: Renumber the remaining definitions accordingly.

7. Additional Standards

A. For policies sold prior to April 1, 2026, the basic illustration shall also include the following:

i. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

ii. A table showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

iii. For each Index Account illustrated, a table showing actual historical index changes and corresponding hypothetical Indexed Credits using current index parameters for the most recent 20-year period.

Drafting Note: The above language is the same as the current Section 7 wording in AG9 49-A, with the intention that illustrations for policies sold prior to April 1, 2026 will not need to comply with the requirements in Sections 7.B through 7.D but may choose to do so for policies sold as early as January 1, 2026.

B. For policies sold on or after April 1, 2026, the basic illustration shall also include the following:

i. A ledger using the Alternate Scale shall be shown alongside the ledger using the illustrated scale with equal prominence.

ii. A table for the Benchmark Index Account, which may be a hypothetical Benchmark Index Account as described in 4.A.ii, only showing the minimum and maximum of the geometric average annual credited rates calculated in 4 (A).

iii. For each Index Account illustrated, a table showing annualized actual historical Index changes and corresponding hypothetical annualized rates of Indexed Credits using current Index Account parameters for only the most recent 25-year period.

1. For each Index Account illustrated, if the Historical Period is less than 10 years, then no table for that Index or Index Account shall be shown.

2. For each Index Account illustrated, if the Historical Period is at least 10 years but less than 25 years, then the table shall be limited to the Historical Period. In any calendar year in which an index first has a historical period of 10 years, the insurer shall be allowed to delay adding historical values for that index up to three (3) months from the end of that calendar year.

The table should include the historical geometric average return for the period shown, both for the annualized actual historical Index changes and the corresponding hypothetical annualized rate of Indexed Credits using the current Index Account parameters.

C. For policies sold on or after April 1, 2026, neither the basic illustration nor the supplemental illustration may include the following:

i. Historical returns, including historical geometric average returns, other than the historical returns required by Section 7.A.ii and Section 7.A.iii in this guideline.

ii. Neither tables nor disclosures that either explicitly or implicitly compare historical returns and maximum illustrated rates, such as a side-by-side presentation.

Nothing in this section shall be construed to prohibit showing the rate calculated in Section 4.B.i in the basic or supplemental illustration.

D. For policies sold on or after April 1, 2026, the basic illustration shall include a statement which is substantially similar to the following, as applicable:

"Historical index changes shown in this illustration are not indicative of future returns-."

~~i. "If historical Index changes and corresponding hypothetical annualized rates of Indexed Credits using current Index Account parameters are not shown for any Index Account that is illustrated, it is because there are less than [5 or 10] years between the most recent Inception Date of any Index whose published values are utilized directly in the calculation of Indexed Credits and the date of this illustration."~~

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

In the AG49 section on additional standards, there is a requirement to show a **20-year history** of **actual** index changes, and hypothetical credits based on those changes. This disclosure can illustrate the **volatility** in performance that can occur over time, compared to illustrations using a fixed illustrated rate.

Also in the AG49 section on additional standards, there is a requirement to have a table showing the min and max of the 25-year geometric averages **for the BIA** that are used in calculating the max illustrated rates. Just as a reminder, there is a single BIA for each policy.

Reviewing illustrations from 13 companies:

- Only one company did not include any historical averages or backcasting.
- The majority of companies included both.
- Five of the 12 companies added an <u>additional</u> chart displaying various historical average rates vs. the maximum illustrated rate.
- Some companies clearly labeled backcasted performance, while for others it was necessary to look up the index itself to identify that it was only recently created.

Where companies included historical averages (sometimes based on backcasting), they often showed multiple historical averages (e.g., 10-year, 15-year, 20-year, etc.) and often showed them side-by-side with the maximum illustrated rate. The historical averages were often 2-4x the maximum illustrated rate.

When companies were questioned about these disclosures, they noted that there was no explicit prohibition on including this information, and thought it showed consumers how the index may perform over different time periods.

This created a concern for regulators that these disclosures limit the effectiveness of AG49's maximum illustrated rate requirements.

Reviewing illustrations also highlighted that the length of the historical period shown varied across companies, with some showing a 20-year history and some showing a longer history. To address perceived optionality in the number of historical years shown (where the index or indices have been in existence for more than the 20-year history, the standard table is increased to 25 years and the language is clarified with "only".

Some regulators expressed that the 20-year history disclosure should be removed entirely, replaced by disclosures that simply illustrate the mechanics of the hypothetical credits based on index movements up, down, and a level index scenario. Because it is difficult if not impossible to create such scenarios that effectively show the impact for all different caps, etc., I am proposing a narrower edit to address the specific issue of the inconsistent historical periods, historical averages and backcasted performance.

Dates: Received	Reviewed by Staff	Distributed	Considered
Notes:			

NAIC
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Long-Term Care Insurance Multistate Rate Review Framework

December 2025

NAIC Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

Accounting & Reporting
Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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

Financial Regulation
Useful handbooks, compliance guides and reports on financial analysis, company licensing, state audit requirements and receiverships.

Legal
Comprehensive collection of NAIC model laws, regulations and guidelines; state laws on insurance topics; and other regulatory guidance on taxation and consumer privacy.

Market Regulation
Regulatory and industry guidance on market-related issues, including antifraud, product filing requirements, producer licensing and market analysis.

NAIC Activities
NAIC member directories, in-depth reporting of state regulatory activities and official historical records of NAIC national meetings and other activities.

Special Studies
Studies, reports, handbooks and regulatory research conducted by NAIC members on a variety of insurance- related topics.

Statistical Reports
Valuable and in-demand insurance industry-wide statistical data for various lines of business, including auto, home, health and life insurance.

Supplementary Products
Guidance manuals, handbooks, surveys and research on a wide variety of issues.

Capital Markets & Investment Analysis
Information regarding portfolio values and procedures for complying with NAIC reporting requirements.

White Papers
Relevant studies, guidance and NAIC policy positions on a variety of insurance topics.

For more information about NAIC publications, view our online catalog at: https://content.naic.org/prod_serv_home.htm

ISBN: 978-1-64179-325-4
Printed in the United States of America

NAIC Executive Office
1101 K Street, N.W.
Suite 650
Washington, DC 20005
202.471.3990

NAIC Central Office
1100 Walnut Street
Suite 1000
Kansas City, MO 64106
816.842.3600

NAIC Capital Markets
& Investment Analysis Office
One New York Plaza, Suite 4210
New York, NY 10004
212.398.9000

PREFACE

Background

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

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on Dec. 12, 2021, and the NAIC Executive Committee and Plenary on April 8, 2022.

2025 Amendments

Amendments to the LTCI MSA Framework were adopted by the Long-Term Care Insurance (B) Task Force on December 18, 2024, the Health Actuarial (B) Task Force on July 14, 2025, the Health Insurance and Managed Care (B) Committee on Aug. 13, 2025, and the NAIC Executive Committee and Plenary on [date]. The key amendments are 1) a change from two actuarial rate review methodologies to a single rate review methodology; 2) a revised cost-sharing formula; and 3) moving the governance of the LTCI MSA Framework and related processes to the Health Actuarial (B) Task Force, and other related work such as reduced benefit options, to the Senior Issues (B) Task Force.

TABLE OF CONTENTS

I. INTRODUCTION

A. Purpose

In 2019, the NAIC charged the Long-Term Care Insurance (EX) Task Force with developing a consistent national approach for reviewing current long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the Task Force developed this framework for a multi-state actuarial (MSA) LTCI rate review process (MSA Review).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program's rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team's approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal[1] and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team's (MSA Team's) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.[2] Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

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

This document will be maintained by NAIC staff under the oversight of the Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee, or an appointed subgroup, and be revised as directed by the Health Actuarial (B) Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

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

[1] "Premium rate increase proposal(s)" or "rate proposal(s)" in this document refers only to an insurer's request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.
[2] The term "rate increase filing" or "rate filing(s)" in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer's in force LTCI premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

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

C. General Description of the MSA Review

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

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

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

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

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

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

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

described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

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

D. Benefits of Participating in the MSA Review

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

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

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

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

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

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state's laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state's regulatory authority, responsibility, and/or decision making. Each state remains ultimately

responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.

A Participating State's use of the MSA Advisory Report's recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer's obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

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

Information Sharing Between State Insurance Departments

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

Confidentiality of the Rate Proposal

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

Confidentiality of the MSA Reports

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

F. Governing Body and Role of the NAIC Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee

The Health Actuarial (B) Task Force of the Health Insurance and Managed Care (B) Committee will oversee the MSA Review process, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Health Actuarial (B) Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Health Actuarial (B) Task Force may create or appoint one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Health Actuarial (B) Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff

competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

II. MSA TEAM

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

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

A. Qualifications of an MSA Team Member

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

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participate as a member of the Long-Term Care Actuarial (B) Working Group (or an equivalent Subgroup).
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the Health Actuarial (B) Task Force or its appointed Subgroup, or the former Long-term Care insurance (B) Task Force

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

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

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

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month when rate reviews are in progress (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.

- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

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

D. MSA Associate Program

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

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

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

<u>Authority of the MSA Team</u>

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

<u>Disclosures and Confidentiality Obligations, as Applicable</u>

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

same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state's laws and regulations for rate filings.

Conflict of Interest Avoidance Procedures and Certifications

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

F. Required NAIC and Compact Resources

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

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

III. REQUESTING AN MSA REVIEW

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

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

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

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

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

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

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

B. Process for Requesting an MSA Review

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

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

C. Certification

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

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

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

IV. REVIEW OF A RATE PROPOSAL

A. Receipt of a Rate Proposal

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

The supporting NAIC and Compact staff will notify participating or impacted states via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

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

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

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

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

C. Preparation and Distribution of the MSA Advisory Report

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

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

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

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

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

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

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

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

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

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

E. Feedback to the MSA Team

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

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.

4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

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

V. ACTUARIAL REVIEW

A. MSA Team's Actuarial Review Considerations

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

The MSA approach ensures remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The MSA approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied.

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

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

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed. The recommendation may be the result of MSA approach or may also use professional judgement, where the MSA Team may recommend a rate increase outside of this approach. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high.

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

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

Consideration of Solvency Concerns

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

Follow-Up Proposals on the Same Block

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

B. Loss Ratio Approach

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

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

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

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

4. The loss ratio approach, one of the minimum standards in many states' statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.
    a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the MSA approach and other approaches.
    b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.

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

C. MSA Approach

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

1. Blended if-knew / makeup approach to address the shrinking block issue.
    a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
    b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
    c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019[3] are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.

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

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

4. Interest rate / investment return component
    a. The MSA approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
        i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
        ii. In the MSA approach, all factors impacting the business are considered.

[3] NAIC Proceedings including meeting minutes are available from the NAIC Library, https://naic.soutronglobal.net/portal/Public/en-US/Search/SimpleSearch.

1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
2. If interest rates fall, this would tend to lead to higher rate increase approvals.

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

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

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

5. Original Assumption Adjustment
   a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a "benchmark premium."
      i. This results in a lower rate increase.
      ii. This adjustment wears off over 20 years from policy issue.
         1. The rationale for the wearing off of this adjustment is the assumption that no insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
      iii. This adjustment is intended to prevent, for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

D. RBOs

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

RBOs in the MSA Advisory Report

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

Future RBOs

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

E. Non-Actuarial Considerations

The Health Actuarial (B) Task Force or its appointed Subgroup and/or the Senior Issues (B) Task Force, will continue to review and consider non-actuarial considerations affecting states' approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

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

Considerations in the MSA Advisory Report

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

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

Future Non-Actuarial Considerations

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

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

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

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

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

3. Background on the MSA Review.

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

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

6. Appendices.
   a. Summary of the drivers of the rate proposal.
   b. Details regarding the MSA approach as applied to the rate proposal.
   c. Summary of rate proposal correspondence.
   d. Examples of rate increases if an RBO is not selected.
   e. Potential cost–sharing formula for typical circumstances.

B. Appendix B – Information Checklist

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

This document contains aspects of the *NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation*[4] (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

Information Required for an MSA Review of a Rate Proposal

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the "Consolidated, Most Commonly Asked Questions – States' LTC Rate Increase Reviews"[5] as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

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

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
    a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
    b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

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

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

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
    a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
    b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder's own past premium deficiencies and/or subsidizes other policyholders' past claims.

[4] https://content.naic.org/sites/default/files/inline-files/committees_b_senior_issues_exposure_ltc_guide_manual.docx

[5] https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx

c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

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

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

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

9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
   a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
   b. A comparison of the population or industry study to the in force related to the rate proposal should be performed, if applicable.
   c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
   d. Provide the year of the most recent morbidity experience study.

10. Information from the Guidance Manual Question and Answer (Q&A): Morbidity, Lapse, Mortality, Interest.
    a. Comparison with asset adequacy testing reserve assumptions.
       i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
       ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and *LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) reserves.
    b. Assumptions Template in Appendix 6 of the Guidance Manual for policies issued after 2017, where applicable.
    c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

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

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

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

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

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

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

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

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

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

Supplemental Information

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

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

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

3. RBOs
    a. Provide the history of RBOs offered and accepted for the block.

b. Provide a reasonability analysis of the value of each significant type of offered RBO.

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

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

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

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

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

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

C. Appendix C—Actuarial Approach Detail

MSA Approach

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

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

2. If-knew premium and makeup premium aspects – aggregate application.
   a. Makeup percentage:
      i. {[PV (claims) / original LLR] - PV (past premium)} / PV (future premium) – 1.
      ii. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
      iii.
   b. If-knew percentage:
      i. [PV (claims) / PV (premiums)] / original LLR – 1.
      ii. Premiums in the formula are at the original rate level.
      iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   c. Definitions and explanations:

i. PV means present value.
ii. LLR means lifetime loss ratio.
iii. Interest rates underlying PVs and LLRs are based on:
    1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
    2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
v. Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification.
    a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
        i. Calculate an estimate of the original premium.
            1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
            2. Apply first principles.
                a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
                b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
                c. Divide by the sum of the PV of an annuity of 1 per year.
                d. Multiply {b / c] times (1 + originally assumed profit percentage) to attain the original premium.
                e. This premium provides the basis for comparison against the makeup and if-knew premium.
            3. Replace the original premium with a benchmark premium.
                a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
                b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
                c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.
        ii. Calculate an estimate of the makeup premium.
            1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
            2. Calculate an updated dollar PV of profits for the sample policy using:
                a. Actual history of premiums and claims.
                b. Expectations of future claims.
                c. “Backed into” makeup premium.
            3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
                a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.
        iii. Calculate an estimate of the if-knew premium.
            1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
                b. Verifying the impact on expectation changes on rates

i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
2. Experience
3. Impact on LLR of changes in expectations of morbidity.
4. Industry information and trends (for reasonableness checks).

c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).

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

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

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.

a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
   i. 5% haircut for the first 100%.
   ii. 35% for the portion of cumulative rate increase between 100% and 400%.
   iii. 70% for the portion of cumulative rate increase between 400% and 800%.
   iv. 85% for the portion of cumulative rate increase in excess of 800%.

   Reviewers note: The cost-sharing formula (Step 6) was revised in 2025to address specific public policy challenges, particularly around large increases for older-age policyholders, with longer durations.

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

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. The original premium is $1,000
      ii. Makeup premium is $30,000.
      iii. If-knew premium is $1,500.
      iv. 46% of policyholders remain.
      v. Past rate increases are 405%:
      vi. Blended amount is:
         1. $30,000 / $1,000 * 0.46 +
         2. $1,500 / $1,000 * 0.54
         3. – 1 =
         4. 1380% + 81% – 1 = 1461% – 1 = 1361%
      vii. Reduced cumulative approval after cost-sharing is:
         1. 95% * 1.00 +
         2. 65% * 3.00 +
         3. 30% * 4.00 +
         4. 15% * 5.61 =
         5. 494%, reflecting cost-sharing of (1-4.94/13.61) = 64%
      viii. Deduction for past rate increases results in:
         1. (1 + 4.94) / (1 + 4.05) – 1 =
         2. Approvable rate increase of 18%

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

In 2020, the former Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to *"Identify options to provide consumers with choices regarding*

modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases." In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

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

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

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

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

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

Widely Established RBOs in Lieu of Rate Increases

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

Less Common RBOs for Potential Discussion

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

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Senior Issues (B) Task Force, or its

appointed Subgroup and/or the Health Actuarial (B) Task Force, or an appropriate NAIC actuarial committee or group, will encourage collective consideration of new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

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

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

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

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

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

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

<u>Filing Rate Action Letters</u>

Insurers should consider:

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

<u>Readability and Accessibility</u>

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.

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

Identification

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

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

Communication Touch and Tone

Insurers should consider:

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

Consultation and Contact Information

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

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

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

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

Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history by:

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

Insurers should consider advising policyholders of their current benefits:

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

Insurers should consider personal needs decision-making by:

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

- The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - Daily/monthly benefit.
  - Benefit period.
  - Inflation option.
  - Maximum lifetime amount.
  - Premium increase percentage and/or new premium.
  - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  - Current premium.

- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
  - What will happen if they take no action?
  - What will happen if they make no payment before the policy anniversary date?
  - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
  - If they elect the cash buyout, there could be tax implications.
  - If they elect a paid-up NFO, how long will the reduced benefit last if they had a claim?
  - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
  - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

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

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

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT[6]

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

Executive Summary

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

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

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

Background

The MSA Team was formed to assist in developing and implementing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team's actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

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

Insurer's Proposal

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

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

Workstream-Related Review Aspects

[6] Information contained in this sample report is an example only and is not derived from any actual rate filing.

Actuarial Review

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. The MSA Team applied the MSA approach to calculate the recommended, approvable rate increases. Aspects of the MSA approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states' laws and rules include:

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

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

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

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

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

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

Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States' Rate Increase Approvals

According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

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

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

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

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

Non-actuarial & Valuation/Solvency Considerations

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

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

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

RBOs – Review for Reasonableness

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

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

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

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

Mix of Business

From the insurer's actuarial memorandum:

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

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

Appendix 1

Drivers of Rate Increase Proposal – Summary

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

Details Regarding MSA Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:

- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
  - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%.
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%.
  - = 0.62 * 177% + (1 - 0.62) * 36%, adjusted for rounding
- Insurer cost share based on MSA formula (see Appendix 3): 11%.
- Recommended cumulative rate increase since issue: 109%.
  - = (1 - 0.11) * 1.23, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%.
  - = (1 + 1.09) / (1 + 0.55) – 1, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%.
  - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%.

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

Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
  - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
  - Reasons for the rate increase, including which pricing assumptions were not realized and why.
  - Statement that policy design, underwriting, and claims handling practices were considered.
  - A demonstration that actual and projected costs exceed anticipated costs and the margin.
  - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
  - Information (from NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation, “Guidance Manual” Q&A): Morbidity, Lapse, Mortality, Interest.
    - Comparison with asset adequacy testing reserve assumptions.
    - Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.

  - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
  - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
  - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

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

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

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

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

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

ABC Company

Jurisdiction Example*	Past Cumulative Approved Increases	Increase to Catch Up	Recommended New	20xx Recommended Rate Increase
Example: State with average past approvals	55%	0%	35%	35%
Example: state with lower-than-average past approvals	27%	22%	35%	65%

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

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

- 5% haircut for the first 100%.
- 35% for the portion of cumulative rate increase between 100% and 400%.
- 70% for the portion of cumulative rate increase between 400% and 800%.
-
- 85% for the portion of cumulative rate increase in excess of 800%.

Justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer's solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit www.naic.org.

2025 Updated Template

COMPANY INFORMATION						**COMPOUNDING VARIABLES**				
NAIC Company Code	Company Name	Contact Name	Contact Title	Contact Phone Number	Contact Email Address	Reporting Year **(2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025)**	State Abbreviation	Zip Code	**(~~DF~~, DP1, DP2, DP3, HO1, HO2, HO3, HO4, HO5, HO6, HO7, HO8, Other)**	New or Renewed Policies for Reporting Year **(New, Renewed)**
						Collecting two additional years.			Additional policy types for 2025.	

2025 version: 112 proposed columns
2024 version: 82 columns

PART I: PREMIUM, COVERAGE, AND DEDUCTIBLE INFORMATION FOR POLICIES IN FORCE (PIF)

Written Premium In-Force	Count of PIF	Coverage A Aggregate Limits	Coverage B Aggregate Limits	Coverage C Aggregate Limits	Coverage D Aggregate Limits	Count of PIF Not Providing Wind Coverage	Count of PIF Not Providing Wildfire Coverage	Count of PIF Not Providing Earthquake Coverage	Count of PIF Not Providing Cosmetic Damage on Roof	Count of PIF Not Providing Cosmetic Damage on Siding	Count of PIF or Endorsements with Earthquake Coverage	Aggregate Premium for Earthquake Coverage
	Change from House Months in Prior Data Call											

Count of PIF with Wind Endorsement	Aggregate Premium for Wind Endorsement	Count of PIF with Standalone Wind Coverage	Aggregate Premium for Standalone Wind Coverage	Count of PIF with RC Coverage on Dwelling	Count of PIF with ACV Coverage on Dwelling	Count of PIF with RC Coverage on Roof	Count of PIF with ACV Coverage on Roof	Count of PIF with RC Coverage on Siding	Count of PIF with ACV Coverage on Siding

							For All Peril Policies					
Based on Coverage A Amount							For Policies Using Fixed-Dollar Deductibles			For Policies Using Percentage Deductibles		
Count of PIF with 100% RC	Count of PIF with Extended Replacement Cost greater than 100% but less than or equal to 125%	Count of PIF with Extended Replacement Cost Greater than 125%	Maximum % RC Written	Aggregate All Perils Policy Deductible	Aggregate Tropical Cyclone/Hurricane/Named Storm Deductible	Aggregate Wind/Hail Deductible	Count of PIF with $500 or Lower Deductible	Count of PIF with Deductible between $500 and $2,000	Count of PIF with $2,000 or Greater Deductible	Count of PIF with 2% or less Deductible	Count of PIF with Deductible between 2% and 5%	Count of PIF with 5% or Greater Deductible

For Tropical Cyclone/Hurricane/Named Storm Deductibles						For Wind/Hail Deductibles					
For Policies Using Fixed-Dollar Deductibles			For Policies Using Percentage Deductibles			For Policies Using Fixed-Dollar Deductibles			For Policies Using Percentage Deductibles		
Count of PIF with $500 or Lower Deductible	Count of PIF with Deductible between $500 and $2,000	Count of PIF with $2,000 or Greater Deductible	Count of PIF with 2% or less Deductible	Count of PIF with Deductible between 2% and 5%	Count of PIF with 5% or Greater Deductible	Count of PIF with $500 or Lower Deductible	Count of PIF with Deductible between $500 and $2,000	Count of PIF with $2,000 or Greater Deductible	Count of PIF with 2% or less Deductible	Count of PIF with Deductible between 2% and 5%	Count of PIF with 5% or Greater Deductible

For Earthquake Deductibles							DEDUCTIBLE INFORMATION			
For Policies Using Fixed-Dollar Deductibles	For Policies Using Percentage Deductibles									
Count of PIF with any Fixed $ Deductible	Count of PIF with Deductible less than 5%	Count of PIF with Deductible 5% or greater and less than 10%	Count of PIF with Deductible 10% or greater and less than 15%	Count of PIF with Deductible 15% or greater and less than 20%	Count of PIF with Deductible 20% or greater and less than 25%	Count of PIF with 25% or Greater Deductible	Minimum Deductible for Fixed Deductible	Maximum Deductible for Fixed Deductible	Minimum Deductible for Percentage Deductible	Maximum Deductible for Percentage Deductible

PART II: CLAIMS AND LOSSES

Count of Paid Claims in Reporting Year	Losses Paid in Reporting Year	Count of Paid Claims for Fire, Not Including Wildfire, in Reporting Year	Losses Paid for Fire, Not Including Wildfire, in Reporting Year	Count of Paid Claims for Wind and Hail in Reporting Year	Losses Paid for Wind and Hail in Reporting Year	Count of Paid Claims for Water Damage and Freezing in Reporting Year	Losses Paid for Water Damage and Freezing in Reporting Year	Count of Paid Claims for Wildfire in Reporting Year	Losses Paid for Wildfire in Reporting Year	Count of Paid Claims for All Other Perils in Reporting Year	Losses Paid for All Other Perils in Reporting Year
		New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.

PART III: CANCELLATIONS AND NONRENEWALS								PART IV: MITIGATION DISCOUNTS FOR POLICIES IN FORCE (PIF)						
Count of Nonpayment Cancellations in Reporting Year	Count of Company Initiated Cancellations for Other Than Non-payment of Premium	Number of Company-initiated Cancellations That Occur in the First 59 Days After Effective Date of Policy	Number of Company-initiated Cancellations That Occur 60 to 90 Days After Effective Date of Policy	Number of Company-initiated Cancellations That Occur Greater Than 90 Days After Effective Date of Policy	Written Premium for Cancelled Policies in Reporting Year	Returned Premium for Cancelled Policies in Reporting Year	Count of Nonrenewals in Reporting Year	Count of PIF with State Required Mitigation Discounts	Count of PIF with State Required Fortified Standard Discounts	Average Percentage of State Required Fortified Standard Discounts	Count of PIF with State Required Wind Discounts	Average Percentage of State Required Wind Discounts	Count of PIF with State Required Fire/Wildfire Discounts	Average Percentage of State Required Fire/Wildfire Discounts
		New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.		New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.

Count of PIF with State Required Impact/Hail Discounts	Average Percentage of State Required Impact/Hail Discounts	Count of PIF with State Required Water Discounts	Average Percentage of State Required Water Discounts	Count of PIF with Non-State Required Mitigation Discounts	Count of PIF with Non-State Required Fortified Standard Discounts	Average Percentage of Non-State Required Fortified Standard Discounts	Count of PIF with Non-State Required Wind Discounts	Average Percentage of Non-State Required Wind Discounts	Count of PIF with Non-State Required Fire/Wildfire Discounts	Average Percentage of Non-State Required Fire/Wildfire Discounts	Count of PIF with Non-State Required Impact/Hail Discounts	Average Percentage of Non-State Required Impact/Hail Discounts	Count of PIF with Non-State Required Water Discounts	Average Percentage of Non-State Required Water Discounts
New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.	New for 2025.

Adopted by the Executive (EX) Committee and Plenary, Dec. 11, 2025
Adopted by the Property and Casualty Insurance (C) Committee, Dec. 11, 2025
Adopted by the Homeowners Market Data Call (C) Task Force, Oct. 28, 2025

DEFINITIONS FOR STATE REGULATOR

HOMEOWNERS MARKET DATA CALL ~~July~~ October 14, 2025

Dwelling Fire Policies – Policies that provide coverage for dwellings, other detached structures, and contents, caused by specified perils. It may also provide liability coverage and additional living expenses, and is usually written when a residential property does not qualify according to the minimum requirements of a homeowner's policy, or because of a requirement for the insured to select several different kinds of coverage and limits on this protection.

Include:

- Dwelling Fire and Dwelling Liability policies ONLY IF the policies written under these programs are for owner-occupied residential dwellings, not policies written for tenant-occupied dwellings, written under a commercial program and/or on a commercial lines policy form.

Homeowners Policies – Policies that provide comprehensive coverage for personal liability, medical payments, dwelling and other structures property damage, contents/personal property damage, and additional living expenses.

Include:

- Mobile/Manufactured homes intended for use as a dwelling regardless of where [or what line] on the Statutory Annual Statement state page associated premium is reported.
- Policies covering log homes, land homes, and site-built homes.
- Policies written on the HO-1, HO-2, HO-3, HO-4 HO-5, HO-6, HO-7 and HO-8 policy forms.

Exclude:

- Farmowners policies, as coverage is considered to be Commercial Lines for purposes of this data call.
- Umbrella policies.
- Lender-placed or creditor-placed policies.

If policies are written on different forms, match to the following:

- DP-1 (Basic Form) – Covers the dwelling structure and attached structures against specific named perils like fire, lightning, and windstorm.
- DP-2 (Broad Form) – Covers the perils included in DP-1, plus additional named perils such as falling objects, weight of snow, and vandalism.
- DP-3 (Special Form) – Offers "all-risks" coverage for the dwelling and attached structures. Covers all perils except those explicitly excluded in the policy, such as floods or earthquakes.

Homeowners Policy Forms:

- HO-1 (Basic Form) – Covers named perils such as fire, lightning, windstorm, and theft.
- HO-2 (Broad Form) – Covers additional named perils than HO-1, including falling objects and water damage from specific causes.
- HO-3 (Special Form) – Covers all perils except those explicitly excluded, such as floods or earthquakes.
- HO-4 (Renter's Form) – Covers unscheduled personal property on a broad named perils basis
- HO-5 (Comprehensive Form) – Provides comprehensive coverage, including open perils for both dwelling and personal property.
- HO-6 (Condo Owner's Form) – Covers the real property interest and the personal property of insureds who own a unit in a condominium or share an ownership interest in a cooperative building. Earthquake Loss Assessment Condo policies should not be included in this count.
- HO-7 (Mobile home/Manufactured Home Form) – Covers mobile home and manufactured home structures on an open perils basis, personal property is covered on a named perils basis. Policies written on other forms that cover mobilehomes/manufactured homes should be reported as HO-7.
- HO-8 (Modified Coverage) – Provides limited coverage for older or high-risk homes.
- Other – Specially designed coverage forms, including wind only policies.

If data elements are not applicable to certain policies, such as renters or other, please leave those columns blank.

Coverage A – Dwelling: Provides coverage for damage to the dwelling and/or other attached structures caused by an insured peril.

Coverage B – Other Structures: Provides coverage for damage to other detached structures on the residence premises (1) separated from the dwelling by a clear space or (2) connect to the dwelling by a fence, wall, wire, or other form of connection but not otherwise attached caused by an insured peril.

Coverage C – Personal Property: Provides coverage for damage to dwelling contents or other covered personal property caused by an insured peril.

Coverage D – Loss of Use: Provides coverage for additional living expenses incurred by the insured or fair rental value when the insured dwelling becomes uninhabitable as the result of an insured loss or when access to the dwelling is barred by civil authority.

Fixed-Dollar Deductible – A maximum fixed dollar amount the insured must pay toward any claim against the homeowners insurance policy.

Percentage Deductible – A specified maximum percentage of the homeowners policy's total Coverage A amount the insured must pay toward any claim against the policy.

Data Element Definitions

COMPANY INFORMATION

NAIC Company Code – The five-digit code assigned by the NAIC to all U.S. domiciled companies which filed a Financial Annual Statement with the NAIC.

Company Name

Contact Name

Contact Title

Contact Phone Number

Contact Email Address

COMPOUNDING VARIABLES

Reporting Year – 4-digit year during which policy was written (2025, 2024, 2023, 2022, 2021, 2020, 2019, 2018).

State Abbreviation – Two-character state abbreviation for location of insured property

Zip Code – 5-digit numerical zip code for location of insured property. Zip Code should match to the reported state.

Policy Form – Dwelling or Homeowners policy forms (DP-1, DP-2, DP-3, HO-1, HO-2, HO-3, HO-4 HO-5, HO-6, HO-7 HO-8 or the equivalent form in states without standard policy forms. See individual policy form definitions above. Specially designed policies, including wind only policies should be reported as "Other")

New or Renewed Policies for Reporting Year – Report "New" if policy was written for the first time in reporting year for your company. Report "Renewed" if the policy is a renewal in the reporting year.

PART I: PREMIUM, COVERAGE, AND DEDUCTIBLE INFORMATION FOR POLICIES IN FORCE (PIF)

~~Direct Written Premium~~Written Premium In-Force~~–~~ Sum of direct written premium for all policies in force as of Dec. 31 of reporting year. Include premium for endorsements~~. and coverages added and deleted during the year.~~

Count of Policies in Force – Count of all policies in which coverage is in effect as of Dec. 31 of the reporting year.

Coverage A Aggregate Limits – Aggregate sum of Coverage A Limits for all policies in force as of Dec. 31 of reporting year.

Coverage B Aggregate Limits – Aggregate sum of Coverage B Limits for all policies in force as of Dec. 31 of reporting year. Coverage C Aggregate Limits – Aggregate sum of Coverage C Limits for all policies in force as of Dec. 31 of reporting year. Coverage D Aggregate Limits – Aggregate sum of Coverage D Limits

for all policies in force as of Dec. 31 of reporting year. Count of PIF Not Providing Wind Coverage –Count of policies in force as of Dec. 31 that do not provide coverage for claims relating to wind events.

Count of PIF Not Providing Wildfire Coverage– Count of all policies in force as of Dec. 31 that do not provide coverage for claims relating to wildfire events.

Count of PIF Not Providing Earthquake Coverage– Count of policies in force as of Dec. 31 that do not provide coverage for claims relating to earthquake events.

Count of PIF s Not Providing Cosmetic Damage on Roof– Count of policies in force as of Dec. 31 that do not provide coverage for damage to roof structures that affects only the appearance and not the function of the roof.

Count of PIF Not Providing Cosmetic Damage on Siding– Count of policies in force as of Dec. 31 that do not provide coverage for damage to siding that affects only the appearance and not the function of the siding.

Count of PIF or Endorsements with Earthquake Coverage – Total number of policies in force or endorsements as of Dec. 31 that provide coverage for claims relating to an earthquake event. Only include policies or endorsements where the earthquake premium is explicitly rated and priced. Earthquake Loss Assessment Condo policies should not be included in this count.

Aggregate Premium for Earthquake Coverage – Total sum of written premium for the earthquake coverage portion of a policy or endorsement.

Count of PIF with Wind Endorsement – Total numbers of policies in force as of Dec. 31 that include an endorsement for coverage for claims relating to a wind event.

Aggregate Premium for Wind Endorsement – Total sum of premium charged for endorsements that provide coverage for claims relating to a wind event.

Count of PIF with Standalone Wind Coverage – Total number of policies in force as of Dec. 31 that provide coverage for claims relating to a wind event, written separate from a homeowners policy.

Aggregate Premium for Standalone Wind Coverage – Total sum of premium charged for a policy providing coverage for claims relating to a wind event, written separate from a homeowners policy.

> Note: For Hawaii only, where the data call asks for **Wind** data in "Count of Policies Not Providing Wind Coverage" Column, and Columns asking for "Policies with Wind Endorsement, "Premium for Wind Endorsement," "Count of Policies with Standalone Wind Coverage," and "Premium for Standalone Wind Coverage," it means **Hurricane**.

If a policy dictates ACV based on the covered property~~peril~~, please report as ACV. *There are instances in which a policy is issued with replacement cost coverage, but apply ACV coverage to property when the loss is attributed to a specified peril. For example, roof damage due to a wind/hail loss would fall under ACV coverage, while roof damage due to all other losses would be replacement cost coverage. In these instances, the policy should be reported in the applicable ACV column.*

Count of PIF with RC Coverage on Dwelling– Count of policies in force as of Dec. 31 that provide replacement cost coverage on dwelling structures.

Count of PIF with ACV Coverage on Dwelling– Count of policies in force as of Dec. 31 that provide actual cash value coverage on dwelling structures. This includes policies with roof service policy schedules (RPS).

> "Count of PIF with RC Coverage on Dwelling" + "Count of PIF with ACV Coverage on Dwelling" = "Count of PIF."

Count of PIF with RC Coverage on Roof– Count of policies in force as of Dec. 31that provide replacement cost coverage on roof structures.

Count of PIF with ACV Coverage on Roof– Count of policies in force as of Dec. 31that provide actual cash value coverage on roof structures. This includes policies with roof service policy schedules (RPS).

> "PIF with RC Coverage on Roof" + "PIF with ACV Coverage on Roof" = "Count of PIF."

Count of PIF with RC Coverage on Siding– Count of -policies in force as of Dec. 31that provide replacement cost coverage on siding materials.

Count of PIF with ACV Coverage on Siding– Count of policies in force as of Dec. 31 that provide actual cash value coverage on siding materials.

> "Count of Policies with RC Coverage on Siding" + "Count of Policies with ACV Coverage on Siding" = "Count of Policies in Force."

Count of PIF Year with 100% RC– Count of -policies in force as of Dec. 31 where coverage is up to and equal to 100% of replacement cost for Coverage A.

Count of PIF Year with Extended Replacement Cost greater than 100% but less than or equal to 125%– Count of policies in force as of Dec. 31 where coverage is greater than 100% but less than or equal to 125% of replacement cost for Coverage A.

Count of PIF with Extended Replacement Cost Greater than 125%– Count of policies in force as of Dec. 31 where coverage is greater than 125% of replacement cost for Coverage A. Guaranteed Replacement Cost policies should be reported here.

Maximum % RC Written – The maximum percentage of extended replacement cost for Coverage A~~coverage~~ written on the reported Policy Form. Guaranteed Replacement Cost policies and any amount over 125% should be reported as 126%. Input as a whole number (10, 25, etc.)

Aggregate All Perils Policy Deductible - Total sum of deductibles in policies providing "all-perils" coverage or "all other perils" coverage. If the policy has a percentage deductible, convert to dollar amount based on policy coverage limits. In the case of "named perils" policies, report the total policy deductible for all covered perils.

Aggregate Tropical Cyclone/Hurricane/Named Storm Deductible – Total sum of deductibles relating to tropical cyclone, hurricane, or named storm events. If the policy has a percentage deductible, convert to dollar amount based on policy coverage limits.

Aggregate Wind/Hail Deductible - Total sum of deductibles relating to wind or hail events. If the policy has a percentage deductible, convert to dollar amount based on policy coverage limits.

For All Peril or All Other Perils Policies

- Policies should only be reported ONCE for the below

Count of PIF with $500 or Lower Deductible – Total number of policies where all deductible amounts equal $500 or less.

Count of PIF with Deductible between $500 and $2,000 – Total number of policies where all deductible amounts are greater than $500 and less than $2,000.

Count of PIF with $2,000 or Greater Deductible – Total number of policies where all deductible amounts equal $2,000 or greater.

Count of PIF with 2% or less Deductible – Total number of policies where the (non-wind/hail) deductible is stated as 2% or less than the Coverage A amount.

Count of PIF with Deductible between 2% and 5% - Total number of policies where the deductible is stated as a percentage between 2% and 5% of the Coverage A amount.

Count of PIF with 5% or Greater Deductible – Total number of policies where the deductible is stated as 5% or more of the Coverage A amount.

[*Add example]

For Policies Covering Specific Perils

For Hurricane/Named Storm Deductibles

- Policies should only be reported ONCE for the below

Count of PIF with $500 or Lower Deductible – Total number of policies where the deductible for claims relating to a hurricane or named storm event is stated as $500 or less.

Count of PIF with Deductible between $500 and $2,000 – Total number of policies where the deductible for claims relating to a hurricane or named storm event is stated greater than $500 and less than $2,000.

Count of PIF with $2,000 or Greater Deductible – Total number of policies where the deductible for claims relating to a hurricane or named storm event is equal or greater than $2,000.

Count of PIF with 2% or less Deductible - Total number of policies where the deductible for claims relating to a hurricane or named storm event is stated as 2% or less than the Coverage A amount.

Count of PIF with Deductible between 2% and 5% - Total number of policies where the deductible for claims relating to a hurricane or named storm event is stated as a percentage between 2% and 5% of the Coverage A amount.

Count of PIF with 5% or Greater Deductible – Total number of policies where the deductible for claims relating to a hurricane or named storm event is stated as 5% or more of the Coverage A amount.

For Wind-Hail Deductibles

- Policies should only be reported ONCE for the below

Count of PIF with $500 or Lower Deductible – Total number of policies where the deductible for claims relating to a wind or hail event is stated as $500 or less.

Count of PIF with Deductible between $500 and $2,000 – Total number of policies where the deductible for claims relating to a wind or hail event is stated as greater than $500 and less than $2,000.

Count of PIF with $2,000 or Greater Deductible – Total number of policies where the deductible for claims relating to a wind or hail event is equal or greater than $2,000.

Count of PIF with 2% or less Deductible - Total number of policies where the deductible for claims relating to a wind or hail event is stated as 2% or less than the Coverage A amount.

Count of PIF with Deductible between 2% and 5% - Total number of policies where the deductible for claims relating to a wind or hail event is stated as a percentage between 2% and 5% of the Coverage A amount.

Count of PIF with 5% or Greater Deductible – Total number of policies where the deductible for claims relating to a wind or hail event is stated as 5% or more of the Coverage A amount.

For Earthquake Deductibles

Count of Policies with any Fixed $ Deductible – Total number of policies where the deductible is a fixed dollar amount, rather than a percentage.

- Policies should only be reported ONCE for the below

Count of PIF with less than 5%Deductible - Total number of policies where the deductible for claims relating to an earthquake event is stated as less than 5% the Coverage A amount.

Count of PIF with Deductible 5% or greater and less than 10% - Total number of policies where the deductible for claims relating to an earthquake event is stated as a percentage equal to or greater than 5% and less than 10% of the Coverage A amount.

Count of PIF with Deductible 10% or greater and less than 15% - Total number of policies where the deductible for claims relating to an earthquake event is stated as a percentage equal to or greater than 10% and less than 15% of the Coverage A amount.

Count of PIF with Deductible 15% or greater and less than 20% - Total number of policies where the deductible for claims relating to an earthquake event is stated as a percentage equal to or greater than 15% and less than 20% of the Coverage A amount.

Count of PIF with Deductible 20% or greater and less than 25% - Total number of policies where the deductible for claims relating to an earthquake event is stated as a percentage equal to or greater than 20% and less than 25% of the Coverage A amount.

Count of PIF with 25% or Greater Deductible – Total number of policies where the deductible for claims relating to an earthquake event is stated as equal to 25% or greater of the Coverage A amount.

DEDUCTIBLE INFORMATION

Minimum Deductible for Fixed Deductible – Minimum fixed-dollar deductible selected by the policyholder, for the reported Policy Form.

Maximum Deductible for Fixed Deductible – Maximum fixed-dollar deductible selected by the policyholder, for the reported Policy Form. Do not aggregate deductibles for all policies within the record. Select only the highest deductible within the record.

Minimum Deductible for Percentage Deductible – Minimum percentage deductible selected by the policyholder, for the reported Policy Form.

Maximum Deductible for Percentage Deductible – Maximum percentage deductible selected by the policyholder, for the reported Policy Form. Do not aggregate deductibles for all policies within the record. Select only the highest deductible within the record.

PART II: CLAIMS AND LOSSES

For paid claims, include claims closed with payment where the claim was closed during the reporting year regardless of the date of loss or when the claim was reported. Does not include claims where the loss amount is zero (claims closed without payment). In the case of partial payments, only one paid claim is included --successive payments are included as paid losses but without adding to the paid claim count.

For losses paid, include the total sum of losses paid during the reporting year. Direct losses paid should include losses paid less salvage & subrogation, not including case loss reserves or unpaid claim amounts. Losses are not developed or adjusted for trend and exclude loss adjustment expenses.

Count of Paid Claims in Reporting Year – Total number of claims closed with payment where the claim was closed during the reporting year regardless of the date of loss or when the claim was reported. Does not include claims where the loss amount is zero (claims closed without payment). In the case of partial payments, only one paid claim is included --successive payments are included as paid losses but without adding to the paid claim count.

Losses Paid in Reporting Year – Total sum of losses paid during the reporting year. Direct losses paid should include losses paid less salvage & subrogation, not including case loss reserves or unpaid claim amounts. Losses are not developed or adjusted for trend and exclude loss adjustment expenses.

Count of Paid Claims for Fire ~~and Removal and Fire caused by Lightning~~, Not Including Wildfire, in Reporting Year – Total number of claims closed with payment for fire ~~and removal and fire caused by lightning~~ where the claim was closed during the reporting year regardless of the date of loss of when the claim was reported. Do not include claims for wildfire.

Losses Paid for Fire, Not Including Wildfire, ~~and Removal and Fire caused by Lightning~~ in Reporting Year - Total sum of losses paid during the reporting year for fire losses. Do not include losses for wildfire.~~and removal and fire caused by lightning.~~

Count of Paid Claims for Wind and Hail in Reporting Year – Total number of claims closed with payment for wind and hail where the claim was closed during the reporting year regardless of the date of loss of when the claim was reported.

Losses Paid for Wind and Hail in Reporting Year - Total sum of losses paid during the reporting year for wind and hail damage.

Count of Paid Claims for Water Damage and Freezing in Reporting Year – Total number of claims closed with payment for water damage and freezing where the claim was closed during the reporting year regardless of the date of loss of when the claim was reported.

Losses Paid for Water Damage and Freezing in Reporting Year - Total sum of losses paid during the reporting year for water damage and freezing.

Count of Paid Claims for Wildfire in Reporting Year – Total number of claims closed with payment for wildfire where the claim was closed during the reporting year regardless of the date of loss of when the claim was reported.

Losses Paid for Wildfire in Reporting Year - Total sum of losses paid during the reporting year for wildfire damage.

Count of Paid Claims for All Other Perils in Reporting Year – Total number of claims closed with payment for damage caused by all other perils where the claim was closed during the reporting year regardless of the date of loss of when the claim was reported.

Losses Paid for All Other Perils in Reporting Year - Total sum of losses paid during the reporting year for damage cause by all other perils.

PART III: CANCELLATIONS AND NONRENEWALS

Count of Nonpayment Cancellations in Reporting Year – Total number of cancellations due to nonpayment by the insured where the cancellation effective date is during the reporting year.

Count of Company Initiated Cancellations for Other than Non-payment of Premium – Total number of policy cancellations that were initiated by the reporting company for reasons other than non-payment of premium during the reporting year. (These would be separate from non-renewals, as cancellations occur at anytime during the policy period. Non-renewals allow for the policy to remain in-force through the end of the policy period, and then is not renewed for the next policy year.) Do not include policies rescinded or voided where there is no liability. Do not include "cancel rewrites" where an insurer merely rewrites an existing policy, such as to align policy due dates.

Number of Company-initiated Cancellations that Occur in the First 59 days After Effective Date of Policy - Company-initiated cancellations for new business where the notice of cancellation was issued within the first 59 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Number of Company-initiated Cancellations that Occur 60 to 90 days After Effective Date of Policy - Company-initiated cancellations where the notice of cancellation was issued 60 to 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.
- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Number of Company-initiated Cancellations That Occur Greater than 90 days After Effective Date of Policy - Cancellations greater than 90 days – Company-initiated cancellations where the notice of cancellation was issued more than 90 days after the original effective date of the policy.

- The calculation of the number of days is from the original inception date of the policy, not the renewal date.
- This time frame should be used regardless of individual state requirements related to the 'underwriting' period for new business.

- The notice of cancellation is the date the cancellation notice was mailed to the insured.

Written Premium for Cancelled Policies in Reporting Year – Total premium written for policies that were written during reporting year but cancelled before year end. Premium reported would not be included in 'Written Premium' reported in Part I. For multiple cancellations, the final cancellation should be reported.

Returned Premium for Policies Cancelled in Reporting Year – Total amount of premium returned to insureds after policy cancellation. Report return premium in the year the policy was cancelled even if the policy was written and reported in a previous year.

Count of Nonrenewals in Reporting Year– Total number of existing policies that the insurer elected not to renew the coverage for circumstances allowed under the "non-renewal" clause of the policy during the reporting year.

PART IV: MITIGATION DISCOUNTS FOR POLICIES IN FORCE

Count of PIF with State Required Mitigation Discount – Total number of policies that include discounts for efforts to mitigate potential loss from natural hazards in accordance with state established guidelines. State required means a program established through legislation or regulations where premium discounts are required if the covered property meets certain requirements.

Count of PIF with State Required Fortified Standard Discount – Total number of policies in 'Count of Policies with State Required Mitigation Discounts' with discounts for mitigation efforts related to a "Fortified Standard" program. (Ex. Strengthen Alabama Homes, Strengthen Oklahoma Homes, etc.)

Average Percentage of State Required Fortified Standard Discount– Average percentage of discounts given for efforts to mitigate potential loss from natural hazards in accordance with state established guidelines, based on the policies reported in 'Count of Policies with State Required Fortified Standard Discount'.

Count of PIF with State Required Wind Discount – Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to wind. (Ex. South Caroline Safe Home Program)

Average Percentage of State Required Wind Discount – Average percentage of discounts given for efforts to mitigate potential loss from natural hazards in accordance with state established guidelines, based on the policies reported in 'Count of Policies with State Required Wind Discount'.

Count of PIF with State Required Fire/Wildfire Discount – Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to fire/wildfire. (Ex. California Safer from Wildfires program)

Average Percentage of State Required Fire/Wildfire Discount – Average percentage of discounts given for efforts to mitigate potential loss from natural hazards in accordance with state established

guidelines, based on the policies reported in 'Count of Policies with State Required Fire/Wildfire Discount'.

Count of PIF with State Required Impact/Hail Discount– Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to impact/hail.

Average Percentage of State Required Impact/Hail Discount – Average percentage of discounts given for efforts to mitigate potential loss from natural hazards in accordance with state established guidelines, based on the policies reported in 'Count of Policies with State Required Impact/Hail Discount'.

Count of PIF with State Required Water Discount– Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to water damage.

Average Percentage of State Required Water Discount – Average percentage of discounts given for efforts to mitigate potential loss in accordance with state established guidelines, based on the policies reported in 'Count of Policies with State Required Water Discount'.

Count of PIF with Non-State Required Mitigation Discounts – Total number of policies that include voluntary, non-state required, discounts for efforts by the insured to mitigate potential loss to the dwelling structure (e.g. Roof strapping, installing impact resistant roofing material, installing storm shutters etc.). This should not include common discounts such as smoke alarms, security systems, etc. Non-state required means laws or regulations do not exist to require the insurer to offer premium discounts.

Count of PIF with Non-State Required Fortified Standard Discount – Total number of policies in 'Count of Policies with Non-State Required Discounts' with discounts for mitigation efforts related to a "Fortified Standard" program. These discounts are not required by law or regulation but do require fulfilling the requirements of the "Fortified Standard."

Average Percentage of Non-State Required Fortified Standard Discount– Average percentage of discounts given for efforts to mitigate potential loss based on the policies reported in 'Count of Policies with Non-State Required Fortified Standard Discount'.

Count of PIF with Non-State Required Wind Discount – Total number of policies in 'Count of Policies with Non-State Required Discounts' with discounts for mitigation efforts related to wind. Examples include Roof strapping, installing impact resistant roofing material, installing storm shutters.

Average Percentage of Non-State Required Wind Discount – Average percentage of discounts given for efforts to mitigate potential loss based on the policies reported in 'Count of Policies with Non-State Required Wind Discount'.

Count of PIF with Non-State Required Fire/Wildfire Discount – Total number of policies in 'Count of Policies with Non-State Required Discounts' with discounts for mitigation efforts related to fire/wildfire. Examples include fire rated roofs, noncombustible zones implemented around a property, ember resistant vents.

Average Percentage of Non-State Required Fire/Wildfire Discount – Average percentage of discounts given for efforts to mitigate potential loss based on the policies reported in 'Count of Policies with Non-State Required Fire/Wildfire Discount'.

Count of PIF with Non-State Required Impact/Hail Discount – Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to impact/hail. Examples include installing impact resistant shingles and siding.

Average Percentage of Non-State Required Impact/Hail Discount – Average percentage of discounts given for efforts to mitigate potential loss based on the policies reported in 'Count of Policies with Non-State Required Impact/Hail Discount'.

Count of PIF with Non-State Required Water Discount – Total number of policies in 'Count of Policies with State Required Discounts' with discounts for mitigation efforts related to water damage. Examples include water shut off and leak detection systems.

Average Percentage of Non-State Required Water Discount – Average percentage of discounts given for efforts to mitigate potential loss based on the policies reported in 'Count of Policies with Non-State Required Water Discount'.

2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts

Illustrated Revisions

The revisions adopted at the Summer National Meeting by Statutory Accounting Principles (E) Working Group and the Accounting Practices and Procedures (E) Task Force at the Summer National Meting from agenda item *2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts* are shown below along with a minor clarification proposed for the effective date.

- ***SSAP No. 61—Life, Deposit-Type and Accident and Health Reinsurance***

Effective Date - **For SSAP No. 61, the minor shaded clarification below is recommended to the effective date paragraph in SSAP No. 61**. The Working Group chose year-end 2026 to allow companies that may have existing contracts adequate time to allow for industry and regulator assessment. At the Summer Meeting, the Working Group did not support grandfathering of existing contracts due to concerns of market inconsistency, creating conflicts with current guidance or recent state actions. After the Summer Meeting, discussions with companies and certified public accountants, noted that it would be helpful to be explicit that the change for existing contracts is reflected as a **change in accounting principle**. This clarification, which is shown as shaded text below, does not change the scope of the affected contracts from what was unanimously adopted at the Working Group, and is helpful to be explicit to avoid prior year restatements. The wording is consistent with the Working Group's intended prospective treatment of existing contracts as of the Dec. 31, 2026 reporting date.

94. The disclosure for compliance with Model #787 or AG 48 shall be effective for reporting periods ending on or after December 31, 2015. The revisions adopted in November 2018 to expand liquidity disclosures are effective year-end 2019, concurrent with the inclusion of data-captured financial statement disclosures. The disclosures captured in paragraphs 78-84 which help to identify certain reinsurance contract features are effective for reporting periods ending on or after December 31, 2020. Clarifications of existing guidance adopted in August 2025 regarding risk transfer on interdependent reinsurance agreements in paragraphs 17 and 19 are effective immediately for new/ newly amended contracts. For existing contracts, the clarification shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*, on or before December 31, 2026.

- Below is remainder of the adopted language to SSAP No. 61:

17. **Transfer of Risk** Reinsurance agreements must transfer risk from the ceding entity to the reinsurer in order to receive the reinsurance accounting treatment discussed in this statement.

a. If the terms of the agreement violate the risk transfer criteria contained herein, (i.e., limits or diminishes the transfer of risk by the ceding entity to the reinsurer), the agreement shall follow the guidance for Deposit Accounting. In addition, any contractual feature that delays timely reimbursement violates the conditions of reinsurance accounting.

b. For purposes of evaluating whether a reinsurance agreement/contract (for this paragraph "contract") transfers risk under statutory accounting, the determination of what constitutes a contract is essentially a question of substance. It may be difficult in some

2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts

Illustrated Revisions

circumstances to determine the boundaries of a contract. Multiple contracts, whether on one or multiple blocks of policies, must be evaluated together for risk transfer purposes where considerations to be exchanged under one contract depend on the performance of the other contract(s) whether they are entered into together, or separately, directly or indirectly, that achieve one overall planned effect.

c. For contracts that contemplate reinsurance on both a YRT and coinsurance basis, where there are interdependent features such as a combined experience refund or an inability to independently recapture, each of the YRT and coinsurance reinsurance components satisfying risk transfer requirements on their respective bases is necessary but not sufficient for the contract as a whole to satisfy risk transfer. When evaluated in its entirety, such contract(s) cannot 1) potentially deprive the ceding insurer of surplus at the reinsurer's option or automatically upon the occurrence of some event; 2) potentially require payments to the reinsurer for amounts other than the income realized from the reinsured policies, nor; 3) contain any of the other conditions prohibited by Appendix A-791 related to risk transfer.

18. This paragraph applies to all life, deposit-type and accident and health reinsurance agreements except for yearly renewable term reinsurance agreements and non-proportional reinsurance agreements such as stop loss and catastrophe reinsurance. All reinsurance agreements covering products that transfer significant risk shall follow the guidance for reinsurance accounting contained in this statement. All reinsurance contracts covering products that do not provide for sufficient transfer of risk shall follow the guidance for Deposit Accounting.

19. Yearly renewable term (YRT) reinsurance agreements that transfer a proportionate share of mortality or morbidity risk inherent in the business being reinsured and do not contain any of the conditions described in Appendix A-791, paragraphs 2.b., 2.c., 2.d., 2.h., 2.i., 2.j. or 2.k., shall follow the guidance for reinsurance accounting, including paragraphs 55-57 of this statement that apply to indemnity reinsurance. Contracts that fail to meet the requirements for reinsurance accounting shall follow the guidance for Deposit Accounting. For all treaties entered into on or after January 1, 2003, the deferral guidance in paragraph 3 of A-791 shall also apply to YRT agreements. YRT agreements shall follow the requirements of A-791, paragraph 6, regarding the entire agreement and the effective date of agreements. Since YRT agreements only transfer the mortality or morbidity risks to the reinsurer, the recognition of income shall be reflected on a net of tax basis, as gains emerge based on the mortality or morbidity experience. See paragraph 17.b. for additional requirements if a YRT agreement has interdependent contract features with reinsurance on a different basis (such as coinsurance).

- Appendix *A-791, Life and Health Reinsurance Agreements* **adopted revisions** to the first Q&A

Q – Aside from assumption reinsurance, what other types of reinsurance are exempt from the accounting requirements?

A – Yearly renewable term (YRT) and certain nonproportional reinsurance arrangements, such as stop loss and catastrophe reinsurance are exempt because these do not normally provide

2024-06 Risk Transfer Analysis of Combination Reinsurance Contracts

Illustrated Revisions

significant surplus relief and therefore are outside the scope of this Appendix. If a catastrophe arrangement takes a reserve credit for actual losses beyond the attachment point or the unearned premium reserve (UPR) of the current year's premium, there will most likely be no regulatory concern.

Similarly, if a YRT treaty provides incidental reserve credits for the ceding insurer's net amount at risk for the year with no other allowance to enhance surplus, there will most likely be no regulatory concern. For purposes of this exemption, a treaty labeled as YRT does not meet the intended definition of YRT if the surplus relief in the first year is greater than that provided by a YRT treaty with zero first year reinsurance premium and no additional allowance from the reinsurer.

For contracts that contemplate reinsurance on both a YRT and coinsurance basis, where there are interdependent features such as a combined experience refund or an inability to independently recapture, risk transfer can only occur if there is no potential for payments out of surplus at the reinsurer's option or automatically upon the occurrence of some event, meaning that in all cases there would be an established liability to absorb any possible payments. The YRT premium simply being at or below the valuation net premium does not ensure that payments from surplus are not possible.

Additional pertinent information applicable to all YRT treaties and to non-proportional reinsurance arrangements is contained in paragraphs 19 and 20 of SSAP No. 61.

Attachment Eight
Executive (EX) Committee and Plenary
12/11/25

State Implementation Report of NAIC-Adopted Model Laws and Regulations
As of 11/17/2025

Life Insurance and Annuities (A) Committee

- Amendments to the ***Annuity Disclosure Model Regulation*** **(#245)** (participating income annuities)—Adopted at the 2021 Summer National Meeting. 5 jurisdictions have adopted these revisions.

- Amendments to the ***Standard Nonforfeiture Law for Individual Deferred Annuities*** **(#805)** (contingent deferred annuities)—Adopted at the 2020 Fall National Meeting. 33 jurisdictions have adopted these revisions.

Health Insurance and Managed Care (B) Committee

- Amendments to the ***Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act*** **(#171)** (STLD plans and title change)—Adopted at the 2024 Fall National Meeting. No adoption activity.

- Amendments to the ***Health Maintenance Organization Model Act*** **(#430)** (consistency with Model #520)—Adopted at the 2020 Fall National Meeting. 2 jurisdictions have adopted these revisions.

Property and Casualty Insurance (C) Committee

- Adoption of the ***Real Property Lender-Placed Insurance Model Act*** **(#631)**—Adopted at the 2021 Spring National Meeting. 3 jurisdictions have adopted this model.

- Adoption of the ***Pet Insurance Model Act*** **(#633)**—Adopted at the 2022 Summer National Meeting. 16 jurisdictions have adopted this model.

Market Regulation and Consumer Affairs (D) Committee

- Amendments to the ***Public Adjuster Licensing Model Act*** **(#228)**—Adopted at the 2025 Spring National Meeting. No state adoption activity.

- Amendments to the ***Unfair Trade Practices Act*** **(#880)** (lead generator)—Adopted at the 2024 Spring National Meeting. 2 jurisdictions have adopted this model.

- Amendments to the ***Unfair Trade Practices Act*** **(#880)** (rebates)—Adopted at the 2021 Spring National Meeting. 16 jurisdictions have adopted these revisions.

Attachment Eight
Executive (EX) Committee and Plenary
12/11/25

Financial Condition (E) Committee

- Amendments to the ***Insurance Holding Company System Regulatory Act*** **(#440)** (GCC and LST)—Adopted at the 2020 Fall National Meeting. 48 jurisdictions have adopted these revisions.

- Amendments to the ***Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*** **(#450)** (GCC and LST)—Adopted at the 2020 Fall National Meeting. 26 jurisdictions have adopted these revisions.

- Amendments to the ***Insurance Holding Company System Regulatory Act*** **(#440)** (receivership)—Adopted at the 2021 Summer National Meeting. 27 jurisdictions have adopted these revisions.

- Amendments to the ***Insurance Holding Company System Model Regulation with Reporting Forms and Instructions*** **(#450)** (receivership)—Adopted at the 2021 Summer National Meeting. 25 jurisdictions have adopted these revisions.

- Amendments to the ***Property and Casualty Insurance Guaranty Association Model Act*** **(#540)** (insurance business transfers, corporate divisions, cybersecurity insurance)—Adopted at the 2023 Fall National Meeting. 9 jurisdictions have adopted these revisions.

- Amendments to the ***Mortgage Guaranty Insurance Model Act*** **(#630)** (capital and reserve requirements)—Adopted at the 2023 Summer National Meeting. No adoption activity.

Innovation, Cybersecurity, and Technology (H) Committee

- Adoption of the ***Insurance Data Security Model Law*** **(#668)**—Apoproved at the 2017 Fall National Meeting. 28 jurisdictions have adopted this model.

- Adoption of the ***Artificial Intelligence Bulletin***—Adopted at 2023 Fall National Meeting. 24 jurisdictions have adopted this bulletin.