Draft date: 8/4/26

2026 Summer National Meeting
Columbus, Ohio

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE
Wednesday, August 12, 2026
3:45 – 5:00 p.m.
Hilton Tower 401—Bellows Ballroom A-D—Lower Level

ROLL CALL

Angela L. Nelson, Chair	Julie Lederer, Chair	Missouri
Timothy N. Schott, Vice Chair	Sandra Darby, Vice Chair	Maine
Mark Fowler	Charles Hale	Alabama
Heather Carpenter	Heather Carpenter	Alaska
Ricardo Lara	Tina Shaw	California
Joshua Hershman	Wanchin Chou	Connecticut
Karima M. Woods	David A. Christhilf	District of Columbia
Michael Yaworsky	Richie Federick	Florida
Holly W. Lambert	Lawrence Steinert	Indiana
Doug Ommen	Travis Grassel	Iowa
Vicki Schmidt	Nicole Boyd	Kansas
Timothy J. Temple	Nichole Torblaa	Louisiana
Marie Grant	Aaron Levine	Maryland
Anita G. Fox	Kevin Dyke	Michigan
Grace Arnold	Phil Vigliaturo	Minnesota
Eric Dunning	Nguyen Thai	Nebraska
Ned Gaines	Gennady Stolyarov	Nevada
D.J. Bettencourt	Sean Rosene	New Hampshire
Susan Ochs	Susan Ochs	New Jersey
Remedio C. Mafnas	Maryann Borja-Arriola	N. Mariana Islands
Judith L. French	Tom Botsko	Ohio
Glen Mulready	Andy Schallhorn	Oklahoma
TK Keen	Eric Bredeson	Oregon
Michael Humphreys	Michael McKenney	Pennsylvania
Michael Wise	Will Davis	South Carolina
Amanda Crawford	Nicole Elliott	Texas
Kaj Samsom	Rosemary Raszka	Vermont
Patty Kuderer	William Wilder	Washington

Erin K. Hunter	Ellen Potter	West Virginia

NAIC Support Staff: Kris DeFrain/Roberto Perez/Sam Kloese

AGENDA

1. Consider Adoption of its August 7, July 14, June 26, June 10, June 9, May 12, April 14, and Spring National Meeting Minutes—*Julie Lederer (MO)*	Attachments One–Eight
2. Consider Adoption of the Reports of its Working Groups A. Actuarial Opinion (C) Working Group—*Julie Lederer (MO)* B. Statistical Data (C) Working Group—*Sandra Darby (ME)*	Attachment Nine
3. Consider Adoption of the Title Schedule P Instructions Proposal —*Julie Lederer (MO)*	Attachment Ten
4. Discuss Comments Received on the Draft Homeowners Regulation White Paper—*Julie Lederer (MO)*	Attachment Eleven
5. Hear Updates on Activities and Research from Professional Actuarial Associations—*Julie Lederer (MO)*	Attachment Twelve
6. Discuss Any Other Matters Brought Before the Task Force —*Julie Lederer (MO)*	
7. Adjournment	

1. Consider Adoption of its August 6, July 14, June 26, June 10, June 9, May 12, April 14, and Spring National Meeting Minutes

Attachments One-Eight

Julie Lederer (MO)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Draft 8/7/26

Casualty Actuarial and Statistical (C) Task Force
E-Vote
August 7, 2026

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Aug. 7, 2026. The following Task Force members participated: Heather Carpenter represented by Chad Bennett (AK); Joshua Herman represented by Wanchin Chou (CT); Karima M. Woods represented by David A. Christhilf (DC); Doug Ommen represented by Travis Grassel (IA); Lawrence Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa (LA); Marie Grant (MD); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); TK Keen represented by David Dahl (OR); Michael Humphreys represented by Michael McKenney (PA); Amanda Crawford represented by Nicole Elliott (TX); and Kaj Samsom represented by Rosemary Raszka (VT).

1. Adopted the Competition Report

The Task Force conducted an e-vote to consider adoption of the *2024 Competition Database Report* (Competition Report) (Attachment xx). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft: 7/27/26

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
July 14, 2026

The Casualty Actuarial and Statistical (C) Task Force met July 14, 2026. The following Task Force members participated: Angela L. Nelson, Chair, represented by Julie Lederer (MO); Timothy N. Schott, Vice Chair, represented by Sandra Darby (ME); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Tina Shaw (CA); Joshua Hershman represented by Wanchin Chou and Christian Citarella (CT); Michael Yaworsky represented by Richie Frederick (FL); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Lawrence Steinert (IN); Timothy J. Temple represented by Nichole Torblaa (LA); Marie Grant represented by Walter Dabrowski (MD); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); D.J. Bettencourt represented by Sean Rosene (NH); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); TK Keen represented by Eric Bredeson (OR); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Amanda Crawford represented by Nicole Elliott and Miriam Fisk (TX); Kaj Samsom represented by Zoie Y. Swaim (VT); and Erin K. Hunter represented by Ellen Potter (WV).

1. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk reported that the Actuarial Opinion (C) Working Group held a regulator-only meeting on June 10 to discuss recent actuarial opinions and an open meeting on June 24, taking the following action: 1) discussed initial potential changes to the 2026 regulatory guidance document, including language and qualification documentation changes. Fisk said the Working Group plans to meet next July 15 to discuss an alternative set of edits to the regulatory guidance document, specifically about qualification documentation.

Fisk made a motion, seconded by Vigliaturo, to adopt the report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

2. Adopted the Report of the Statistical Data (C) Working Group

Darby reported that the Statistical Data (C) Working Group met June 17 to continue discussing updates to the *Statistical Handbook of Data Available to Insurance Regulators*. The Working Group will continue this discussion in monthly meetings with the goal of adopting an updated handbook by year-end, which will include a completed personal lines section. She said they will begin working on the commercial lines sections in 2027. The Working Group will meet on July 29.

Darby reported that the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) and the *Report on Profitability by Line by State* (Profitability Report) have been adopted and will be embargoed with the commissioners before a public release. The Working Group is reviewing the *Auto Insurance Average Premium Supplement* and will consider a vote for adoption when the review period ends on July 17.

Darby made a motion, seconded by Botsko, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

3. Received an Update on the Rate Regulation White Paper and Cross-Subsidization

Lederer said at the Spring National Meeting, the Property and Casualty Insurance (C) Committee adopted this charge for the Task Force: "Draft a white paper that explains how homeowners' insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses." On June 26, the Task Force exposed a white paper to seek feedback from all parties. The paper was exposed with a 40-day public comment period ending Aug. 5. Written comments were directed to be sent to Kris DeFrain (NAIC). She said the Task Force will then offer opportunities for oral presentations of written comments and discussion at the Summer National Meeting. Lederer thanked the white paper oversight group and NAIC committee support for producing a thorough draft in only two and a half months.

Members of the white paper oversight group, including Citarella, Vigliaturo, Chou, Torblaa, Darby, and McKenney, presented an overview of the paper (Attachment ___).

Discussion among Task Force members centered on the framing of the cross-subsidization question and noted that it would be interesting to delve into issues in which an individual company might have varying levels of rate adequacy across states. McKenney noted that would be a different issue from what the Task Force was charged to do. Stolyarov said some insurers have intentionally sought to reduce growth by increasing rates and cited Nevada's rate review experience, in which regulators reduced proposed increases and estimated substantial consumer savings. He suggested that a more comprehensive empirical study across multiple states and over longer time periods would be needed to fully evaluate that issue. Huntington said he would be concerned if consumers in one state paid higher rates because rates elsewhere are inadequate, but questioned that regulators would be permitting persistent inadequacy in another state. Steinert agreed that individual exceptions exist but viewed the paper as accurately describing the general operation of insurance markets and regulation. Chou acknowledged that insurers may attempt aggressive or unreasonable actions and stressed that effective regulatory review and professional actuarial oversight help prevent inappropriate rates.

Additional feedback included notice that the American Academy of Actuaries' (Academy's) Homeowners Insurance Task Force would be submitting comments on the paper and appreciation from participants, including a positive comment from Birny Birnbaum, regarding the quality and thoughtfulness of the draft paper.

4. Received Liaison Reports

Vigliaturo reported that the Natural Catastrophe Risk and Resilience (EX) Task Force met June 15, and the Severe Peril (EX) Working Group met July 13 to hear a presentation from Verisk on severe peril trends, including hail, roof, and market impacts.

Chou reported that the Cybersecurity (H) Working Group has exposed the cybersecurity event response coordination framework and extended the public comment period to July 24.

Darby reported that the Third-Party Data and Models (H) Working Group exposed the third-party framework for property/casualty (P/C) pricing and underwriting for a public comment period ending Aug. 5.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft 6/17/26

Casualty Actuarial and Statistical (C) Task Force
E-Vote
June 26, 2026

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded June 26, 2026. The following Task Force members participated: Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Larry Steinert (IN); Marie Grant represented by Aaron Levine (MD); Robert L. Carey represented by Sandra Darby (ME); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Judith L. French represented by Thomas Botsko (OH); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Amanda Crawford represented by Nicole Elliott (TX); Taj Samsom represented by Rosemary Raszka (VT); Patty Kuderer represented by William Wilder (WA); and Allan L. McVey (WV).

1. Adopted the 2023 Homeowners Report

The Task Force conducted an e-vote to consider adoption of the *2023 Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft: 6/12/26

Casualty Actuarial and Statistical (C) Task Force
E-Vote
June 10, 2026

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded June 10, 2026. The following Task Force members participated: Joshua Hershman represented by Wanchin Chou (CT); Karima M. Woods represented by David A. Christhilf (DC); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Judith L. French represented by Tom Botsko (OH); Michael Wise represented by Will Davis (SC); Amanda Crawford represented by Nicole Elliott (TX); Kaj Samsom represented by Rosemary Raszka (VT) and Allan L. McVey (WV).

1. Adopted the 2024 Profitability Report

The Task Force conducted an e-vote to consider adoption of the *Report on Profitability by Line by State* (Profitability Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft: 7/7/26

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
June 9, 2026

The Casualty Actuarial and Statistical (C) Task Force met June 9, 2026. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Christian Citarella (NH); Angela L. Nelson, Vice Chair, represented by Julie Lederer (MO); Heather Carpenter represented by Chad Bennett (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Tina Shaw (CA); Joshua Hershman represented by Kristin Fabian (CT); Michael Yaworsky represented by Richie Frederick (FL); Doug Ommen represented by Travis Grassel (IA); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa (LA); Marie Grant represented by Walter Dabrowski (MD); Timothy N. Schott represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Ned Gaines represented by Gennady Stolyarov (NV); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Amanda Crawford represented by Nicole Elliott and Miriam Fisk (TX); Kaj Samsom represented by Rosemary Raszka (VT); Patty Kuderer represented by William Wilder (WA); and Allan L. McVey represented by Juanita Wimmer (WV).

1. Adopted the Report of the Actuarial Opinion (C) Working Group

Fisk reported that the Actuarial Opinion (C) Working Group plans to meet June 10 in regulator-to-regulator session. Additionally, the Working Group plans to meet June 24 to discuss observations and issues regarding the Property/Casualty (P/C) Statement of Actuarial Opinion Instructions and Regulatory Guidance documents.

Fisk made a motion, seconded by Lederer, to adopt the report of the Actuarial Opinion (C) Working Group. The motion passed unanimously.

2. Adopted the Report of the Statistical Data (C) Working Group

Darby reported that the Statistical Data (C) Working Group is updating the *Statistical Handbook of Data Available to Insurance Regulators* (Handbook). The Working Group met May 20 and will continue discussions in monthly meetings, with its next meeting on June 17. The goal is to have the Handbook adopted by year-end.

The *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) is being considered for adoption. The *Competition Database Report* (Competition Report) and the *Auto Insurance Database Average Premium Supplement* will be distributed for review this week.

Darby made a motion, seconded by Dyke, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

3. Discussed Schedule P Next Steps

Lederer said the Task Force's proposal to modify instructions for P/C Schedule P is exposed at the Blanks (E) Working Group. The Title Insurance (C) Working Group asked if the Task Force could propose similar changes to the Title Schedule P instructions. Lederer presented a proposal and identified specific areas where feedback is needed. One question is that the title instructions provide little guidance on what should be in the prior year's row, and the practice of reporting appears to be different from P/C companies.

The Title Schedule P instructions were exposed for 45 days with comments due July 24. The Title Insurance (C) Working Group will receive the announcement of the exposure too.

4. Discussed Homeowners Rate Regulation and Potential Rate Cross-Subsidization Across States

Citarella said the Task Force was charged at the Spring National Meeting to draft a white paper that explains how homeowners insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses.

The Task Force discussed the definition of cross-state subsidization. Torblaa proposed a definition for the white paper that would focus on structural, market-wide distortions, in which policyholders in one state pay inadequate rates while policyholders in another state pay more than expected costs to offset it. Actions by large individual insurers that may materially affect a market would also be considered. State insurance regulators discussed concerns such as single-company behavior, profit provisions, capital allocation, differences in actuarial soundness across states, profit provisions, and capital allocation.

Citarella said the white paper draft should be exposed later in June. He said the Oversight Group and NAIC committee support are removing extraneous regulatory background that does not directly help explain whether cross-state subsidization exists.

5. Received Liaison Reports

The Catastrophe Risk (E) Subgroup has conducted a few meetings to review severe convective storm model updates and evaluate impact analyses. The Cybersecurity (H) Working Group has focused on the implementation of the cybersecurity event response coordination framework.

6. Discussed Other Matters

Citarella announced he is leaving the New Hampshire Insurance Department to work at the Connecticut Insurance Department.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft: 5/22/26

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
May 12, 2026

The Casualty Actuarial and Statistical (C) Task Force met May 12, 2026. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Sean Rosene (NH); Angela L. Nelson, Vice Chair, represented by Julie Lederer (MO); Ricardo Lara represented by Tina Shaw (CA); Joshua Hershman represented by Wanchin Chou (CT); Karima M. Woods represented by David A. Christhilf (DC); Michael Yaworsky represented by Richie Frederick (FL); Doug Ommen represented by Travis Grassel (IA); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa (LA); Marie Grant represented by Walter Dabrowski and Arthur Schwartz (MD); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); TK Keen represented by Raven Collins (OR); Amanda Crawford represented by Nicole Elliott (TX); and Kaj Samsom represented by Rosemary Raszka (VT).

1. Adopted the Report of the Statistical Data (C) Working Group

Darby reported that the Statistical Data (C) Working Group will meet May 20 to discuss the *Statistical Handbook of Data Available to Insurance Regulators*. NAIC committee support is making edits to the *Report on Profitability by Line by State in 2024* (Profitability Report) based on comments received. The *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) is under regulatory review until May 22.

Darby made a motion, seconded by Dyke, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

2. Discussed Schedule P Next Steps

Lederer said the Schedule P instructions adopted during the April 14 meeting were sent to the Blanks (E) Working Group for consideration for year-end 2027 instructions. She said there were a few remaining issues that could be considered in Phase 3 of this project, but given competing priorities and efficient use of time, she recommended ending this project and letting anyone start a new project if they wish to propose additional changes to Schedule P blanks or instructions.

3. Heard Presentations about Homeowners Rate Regulation and Potential Rate Cross-Subsidization Across States

Answering the Task Force's open invitation to speak about the Task Force's new charge to "[d]raft a white paper that explains how homeowners' insurance rates are regulated across states with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses," three speakers gave presentations (Attachment ___).

Norman Niami (American Property Casualty Insurance Association—APCIA) said a lot of references have been made to homeowners issues over the last few years, which, based on his knowledge of actuarial work and actuarial professional obligations, are not true. In particular, for property, because of extreme weather, inflation, population moving, and construction in riskier areas, homeowners insurance prices are going up. Therefore, several claims have been made that companies may be shifting losses from one jurisdiction to another to recover

those costs. However, based on regulatory requirements and professional obligations, that is generally not the case. He said that if the claim is correct, small companies would have a problem passing losses to other states because they would face competitive issues.

If losses were transferred from one state to another, there would be flatter loss ratios across states. Niami said a focus on risk-based pricing is critical because, without it, many market challenges arise. Some states have tried to impact regulation in a particular area or in general, but then the residual market grows, resulting in one segment of the market subsidizing the others. He said the APCIA has some case studies in California, Florida, Massachusetts, New Jersey, and South Carolina.

Niami said in 2023 that prior-approval states had average rate increases about 1% lower than those in use-and-file states. In terms of actuarial principles and standards, he said, passing on losses from one jurisdiction to another is pretty much impossible in terms of losses and claims. He said a rate is considered reasonable if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer, plus the actuary must determine the extent to which historical data are available and appropriate for estimating future costs. He said New York law states the "Superintendent shall further determine whether any component of such rates represents an effort on the part of the insurer to recover losses incurred in another state."

Niami said there is a possibility of a $100 billion loss in New York, which would be a large multiple of the average annual loss. He said if that occurred, it would take companies almost 70 years to collect enough premium to cover those losses in terms of return on net worth.

Mike Goldman (Perr & Knight) said each state has its own statutes, filing requirements, regulatory culture, political pressures, and tolerance for rate changes. He said catastrophe risk does not respect state regulatory boundaries. He said catastrophes are concentrated geographically: wildfire risk in the West, hurricane risk along the Gulf Coast and the Atlantic, and severe convective storms (SCS) across the Plains and central U.S.

Goldman said there are many considerations when it comes to rates being too low or too high. If rates are not adequate, there are solvency and availability issues. Low rates may seem consumer-friendly, but there could be capacity issues down the line, and if carriers cannot get rate increases when they need, the insurers may take actions such as restricting new business, changing coverage, non-renewing, or exiting the market.

Goldman says cross-subsidization arises when one of the objectives of "not excessive, not inadequate, or not unfairly discriminatory" is emphasized in a way that shifts costs from one place to another. For example, if affordability concerns lead to suppressed rates in a high-risk area, those unrecovered costs are likely to show up elsewhere, whether through a residual market mechanism, higher rates elsewhere, or federal support.

Goldman identified three distinct claims of cross-subsidization, the first being residual markets, such as the Fair Access to Insurance Requirements (FAIR) plan and the Texas Windstorm Insurance Association. Costs are spread within the same state. Residual market growth is often associated with rate friction, reinsurance costs, catastrophe (CAT) model results, litigation environment, capital availability and capacity, inflation, and the market's risk appetites. Second, cross-state subsidization occurs with national carrier portfolios. He said this is difficult to observe directly, but the argument is that an insurer may need to alleviate financial pressure somewhere else, where rate increases are easier to implement. He said it is debatable. He said the rate pressure might be relieved by lowering returns to shareholders, tightening underwriting standards, changing the insurer's market, or leaving the market. Third, there is federal cross-subsidization through the National Flood Insurance Program (NFIP) and disaster aid, which can be analyzed with NFIP subsidies.

Erica Weyhenmeyer (NAMIC) said the educational purpose of the charge is valuable. She said cross-subsidization is not how homeowners insurance markets work. A rate indicator for one state is simply not loaded to pay for catastrophe losses in another state. The actuarial process is prospective and risk-based. Insurers estimate expected losses, including CAT losses, where relevant, using exposure, geography, construction, coverage terms, reinsurance costs, expenses, and other actuarially supported inputs. The actuarial and regulatory framework is designed to reflect catastrophe costs in the state's rate level, not transfer them invisibly to policyholders elsewhere.

Weyhenmeyer said it is important to distinguish pooling from cross-subsidy. Insurance necessarily pools similar risks and spreads volatility over time across policyholders and through capital and reinsurance, but that is not the same as charging homeowners in one state to subsidize inadequate rates in another. Risk pooling supports solvency and claim paying.

Capacity cross-subsidization implies a rate structure disconnected from expected costs. State regulation, actuarial standards, competitive market constraints, and company-level financial oversight all work against that result.

Weyhenmeyer said the white paper should avoid implying that cross-subsidization is occurring in the absence of evidence in filed rates and actual support. The ideal framing is to explain how state-based regulation, actual indications, catastrophe modeling reinsurance, and insurer capital interact to produce homeowners rates. That explanation will help regulators respond to public concerns while preserving the core principle that rates should remain risk-based, actuarially sound, and state-specific.

Chou said the Task Force should focus on state cross-subsidization. State regulators do not control the other types of potential cross-subsidization presented. He said the long-term care rate cross-subsidization issues from a few years ago are political, not actuarially based. He said the Task Force should focus on actuarial ratemaking principles and making sure carriers provide evidence to support their rate changes, including the catastrophe model. Niami said that in California, where companies previously could not charge the price of risk, they had to decide whether to stay in business. They did not charge 12 other states for what it was losing in California.

Stolyarov said a recent catastrophe model showed large increases in wildfire rates were needed in Nevada, even though the most destructive wildfire in Nevada history affected 29 homes. He said Nevada's wildfire risk is two to three orders of magnitude lower than in California, yet some large insurers are initially proposing larger rate increases on double-digit profitable books of business than they are proposing in California. He added that competition has an important role and agrees that if an insurer tried to pass on losses from one state to another, it would face a competitive disadvantage from other insurers. He said it is not done overtly but could be much subtler, such as being more conservative in assumptions than in other states (e.g., use a 7% trend instead of 3%). He said there is a range of reasonable trend assumptions. Another approach would be credibility, where if a state has few claims, the complement of credibility can be given to experience in another state. He said these examples would not run afoul of actuarial standards, but regulators need to evaluate those proposals. He would like to see the subtler pressures and mechanisms addressed.

Niami disagreed, noting that if an actuary is doing that, it should be pursued. He said the academic discussions are often theoretical and rely on complex mathematical models. He said the central question is whether there is evidence of cross-subsidization actually occurring in practice. Stolyarov said there may not be an explicit motive to cross-subsidize, but catastrophe risk may serve as a de facto cross-subsidy. He said regulators have a responsibility to question unreasonable assumptions, but there is also a broader misalignment between how risk is distributed across states and how it is perceived to be distributed at higher decision-making levels, which perhaps, as an industry, needs to be challenged.

4. Heard Liaison Reports

Botsko said the risk-based capital (RBC) preamble is being revised, and actuaries could provide feedback.

Vigliaturo said the Natural Catastrophe Risk and Reliance (EX) Task Force heard presentations from Aon on the future of insurability in the face of catastrophe risks, from the Center for Risk and Insurance Research on regulator/university partnerships, and about a natural catastrophe risk dashboard. Two working groups were formed regarding pre-disaster mitigation and risk modeling and severe perils.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft: 4/15/26

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
April 14, 2026

The Casualty Actuarial and Statistical (C) Task Force met April 14, 2026. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Christian Citarella (NH); Angela L. Nelson, Vice Chair, represented by Julie Lederer (MO); Heather Carpenter represented by Austin Childs (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Sarah Ye (CA); Joshua Hershman represented by Wanchin Chou (CT); Michael Yaworsky represented by Peshala Disanayaka (FL); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa (LA); Marie Grant represented by Arthur Schwartz (MD); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); Michael Humphreys represented by Michael McKenney and James DiSanto (PA); Amanda Crawford represented by Nicole Elliott (TX); Kaj Samsom represented by Rosemary Raszka (VT); Patty Kuderer represented by William Wilder (WA); and Allan L. McVey represented by Heather Mihallik (WV).

1. Adopted the Report of the Statistical Data (C) Working Group

Darby reported that the Statistical Data (C) Working Group is updating the *Statistical Handbook of Data Available to Insurance Regulators*. The Working Group met April 8 to walk through the homeowners and mobile home section of the report, focusing on proposed changes that need further consideration. The Working Group is working closely with statistical agents to refine the data elements and align definitions. The Working Group plans to meet April 29 and May 20.

The *Report on Profitability by Line by State in 2024* (Profitability Report) was distributed to the Working Group and this Task Force for review during this meeting. This will be followed closely by reviews of the *Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report* (Homeowners Report) and *Competition Database Report* (Competition Report). Last year's statistical reports will be sent to the Task Force for adoption soon.

Darby made a motion, seconded by Elliott, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

2. Received an Update on its 2026 Charges

Citarella said that the Property and Casualty Insurance (C) Committee adopted the following charge for the Task Force: "Draft a white paper that explains how homeowners' insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses."

He appointed members from New Hampshire, California, Connecticut, Iowa, Louisiana, Maine, Minnesota, and Pennsylvania to serve as a drafting group for this white paper. He said the Task Force will work in coordination with NAIC staff and the Center for Insurance Policy and Research (CIPR) to develop the white paper . Regulators and interested parties will be asked to provide comments and questions during the process, during typical NAIC exposures, and throughout. He said the paper will be developed in a collaborative manner.

Citarella said one of the first steps in this process is to collect information. He asked for speakers to present about states' rate regulation in the homeowners market during the Task Force's May 12 meeting. Kris DeFrain (NAIC) said that some papers on rate regulation were recently released, and those authors are welcome to speak.

3. Discussed Schedule P Proposed Changes ("Phase Two") and Comments Received

Lederer said the proposed Schedule P instructions were exposed for a 45-day public comment period that ended March 26. Several comments were received (Attachment __). Lederer said she revised the proposal based on comments received and documented her response to each comment (Attachment __).

Lederer provided the background that a couple of years ago, Schedule P was changed to require 10 years of data for all lines of business, whereas some had previously only required two years. During the exposure of that proposal at the Blanks (E) Working Group, comment letters were received proposing additional changes to the Schedule P instructions unrelated to the current proposal. One comment said that the Schedule P instructions for the prior years can be quite vague and are sometimes not provided. The Task Force decided to start a project to look at the Schedule P instructions with that in mind. She said the project has had two phases so far. DeFrain took the lead on phase one to make the wording of instructions consistent, add instructions about prior year rows, and eliminate outdated, unnecessary information (e.g., instructions for prior to 2000). On a Task Force call in October 2024, volunteers for the project were requested. Lederer and Miriam Fisk (TX) volunteered. The phase one changes were adopted and implemented in the year-end 2025 instructions.

Phase two was started this year to further develop instructions for prior year rows. At the Task Force's Feb. 10 meeting, Lederer described the proposed phase two changes. She said that just like in phase one, the goal was to improve the instructions, not change reporting or the blanks. Phase two includes proposed changes to correct information, reorganize the content, make minor improvements, increase clarity without changing the meaning, correct information that is no longer true, and add more examples for prior years.

Lederer said there are unresolved comments, especially regarding the claim counts and why they are required for only some lines of business. Potential future changes could be grouped into two different categories. Some focus on instructions, which could be included in a third phase of the current project, and others are more in-depth and could require changes to the blank. Lederer said she has questions about Schedule P, Parts Six and Seven.

Interested parties and members discussed phase two and agreed with the proposal. Lederer said that phase two accomplishes the goals. There are some remaining issues that could be easily handled in a third phase, and others that likely belong in a separate project, if there is interest.

Lederer made a motion, seconded by DiSanto, to adopt the Schedule P instructions proposal and forward it to the Blanks (E) Working Group for consideration. The motion passed unanimously.

4. Discussed Rate Filing Review Training

Citarella, Darby, and Kelsey McElroy (MN) conducted a basic rate-filing training session for regulators that covered topics such as indications, trends, and credibility at the Spring National Meeting. There was significant participation, with more than 140 attendees. Citarella said the purpose of the training was to assist regulators with few to no actuarial exams. The plan is to address the main lines of business (e.g., homeowners, auto, personal umbrella) but not expand into areas of expertise, such as predictive modeling. He said pet insurance might be a good topic. Volunteers to assist with training are encouraged. Darby added that experts who can ad lib or provide advice during the event were helpful in the first presentation and do not have to volunteer for duties such as creating slides.

5. Received Liaison Reports

Citarella added some NAIC groups to the list of NAIC groups the Task Force should follow, including those that focus on catastrophe, pre-disaster, and resilience issues. He said that Minnesota is implementing a home risk mitigation project that involves actuaries in determining a discount. He asked for volunteers to serve as 2026 liaisons to report to the Task Force about activities in other NAIC groups. An updated liaison list was created (Attachment __).

Chou stated that work is underway on supplemental cybersecurity reporting.

Darby said the Homeowners Market Data Call (C) Task Force released its data call. She stated that she and Eric Lowe (VA) recorded a presentation that can be viewed on the Task Force's web page and helps answer industry questions.

6. Discussed Other Matters

Citarella said the Task Force is charged with overseeing the Rate Model Review Team and updating the adopted Model Review Manual. He said the charge is to evaluate the queue of filings on a quarterly basis and oversee the rate model review for staffing and resources. He asked for three to five volunteers to lead this effort.

He said the Task Force might consider creating a working group for its predictive model work. DeFrain said some of the work is now in the maintenance stage, but there are opportunities to build on it. She said that the Book Club can bring in different speakers and topics. DeFrain suggested that there could be oversight of the Rate Model Review Team's work, and there is a need to update the Model Review Manual with information on different types of models to keep it useful. She said that something more formal could be established to allow a forum for rate model reviewers to explain their models to a large regulatory audience. Citarella said it would be helpful to set up such a forum rather than consider each case and emphasized that there would be no approval process, but that discussions would be helpful.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

Draft Pending Adoption

Draft: 4/1/26

Casualty Actuarial and Statistical (C) Task Force
San Diego, California
March 23, 2026

The Casualty Actuarial and Statistical (C) Task Force met in San Diego, CA, March 23, 2026. The following Task Force members participated: D.J. Bettencourt, Chair, represented by Christian Citarella (NH); Angela L. Nelson, Vice Chair, represented by Julie Lederer and Brad Gerling (MO); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Tina Shaw (CA); Joshua Hershman represented by Wanchin Chou (CT); Michael Yaworsky represented by Richie Frederick (FL); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Lawrence Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa (LA); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Eric Dunning represented by Nguyen Thai (NE); Susan Ochs represented by John Swierczyna (NJ); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Amanda Crawford represented by Nicole Elliott and Mark Worman (TX); Kaj Samsom represented by Zoie Y. Swaim (VT); Patty Kuderer represented by William Wilder (WA); and Allan L. McVey represented by Justin Parr (WV).

1. Adopted its Feb. 10, 2026; Dec. 19, 2025; and 2025 Fall National Meeting Minutes

Citarella said the Task Force met Feb. 10, 2026; Dec. 19, 2025; and Dec. 9, 2025. During its Feb. 10, 2026, meeting, the Task Force took the following action: 1) exposed Schedule P ("Phase 2") for a 45-day public comment period ending March 26. During its Dec. 19, 2025, meeting, the Task Force took the following action: 1) adopted the *2022/2023 Auto Insurance Database Report* (Auto Report).

The Task Force also met March 17 and Feb. 3 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

Additionally, the Task Force held Predictive Analytics Book Club meetings on Jan. 27 and Feb. 24. The meetings included a presentation from Dorothy Andrews (NAIC) and Roberto Perez (NAIC) on large language models (LLMs) and a presentation from Raymond Sheh (Johns Hopkins University) on Shapley values.

Botsko made a motion, seconded by Dyke, to adopt the Task Force's Feb. 10, 2026 (Attachment One); Dec. 19, 2025 (Attachment Two); and Dec. 9, 2025 (*see NAIC Proceedings – Fall 2025, Casualty Actuarial and Statistical (C) Task Force*) minutes. The motion passed unanimously.

2. Adopted the Report of the Statistical Data (C) Working Group

Darby said the Statistical Data (C) Working Group met March 12, 2026, and Dec. 17, 2025. During these meetings, the Working Group discussed edits to the *Statistical Handbook of Data Available to Insurance Regulators.*

Darby made a motion, seconded by Chou, to adopt the report of the Statistical Data (C) Working Group, including its March 12, 2026 (Attachment Three) and Dec. 17, 2025 (Attachment Three-A) minutes. The motion passed unanimously.

3. Received a Report on a Homeowners Rate Regulation White Paper Charge

Citarella said that the Property and Casualty Insurance (C) Committee is considering the following charge for the Task Force: "Draft a white paper that explains how homeowners' insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses."

Shana Oppenheim (NAIC) outlined the need for a rate regulation white paper as a new charge for the Task Force through the federal and media lens. Oppenheim stated that federal policymakers are increasingly framing insurance affordability as a systemic economic risk rather than a state-only issue. Sen. Sheldon Whitehouse (D-NY) has repeatedly warned that rising homeowners' insurance costs and non-renewals threaten mortgage availability, housing values, and broader financial stability—explicitly analogizing the risk to a pre-2008 style economic shock if left unaddressed. This framing elevates insurance rate regulation from a technical state matter to a macro prudential concern, drawing in the U.S. Department of the Treasury (Treasury Department), Financial Stability Oversight Council (FSOC), and congressional committees with jurisdiction beyond insurance. An implication for the NAIC is that, absent a clear, evidence-based explanation of how state rate regulation works—and its tradeoffs—federal actors will fill the gap with their own narratives.

Congressional proposals, such as Sen. Adam Schiff's (D-CA) Incorporating National Support for Unprecedented Risks and Emergencies (INSURE) Act, assume that rate regulation is part of the problem but lack a shared factual baseline. The INSURE Act responds to insurer exits and premium increases by proposing a federal reinsurance backstop premised on the view that markets are failing under climate pressure. While the bill does not directly preempt state rate regulation, it implicitly questions whether existing state frameworks can accommodate rapidly rising catastrophe risk without federal intervention. Oppenheim said a white paper would allow the NAIC to clarify what rate regulation can and cannot do, and where federal tools may complement—rather than substitute for—state authority.

Academic literature is now being cited to argue that rate regulation distorts risk signals. The Harvard Business School and Federal Reserve working paper finds that in more heavily regulated states, rates adjust less frequently and by smaller amounts after losses, leading insurers to cross-subsidize by raising rates in less regulated states. The authors explicitly question whether insurance pricing can still function as a signal for climate adaptation under current regulatory frictions. Oppenheim said that without a regulator-authored response, this research risks being treated as a definitive indictment of rate regulation rather than one input into a more nuanced policy discussion.

Oppenheim said that media narratives increasingly portray rate regulation as opaque and politically constrained. For example, New York Times coverage consistently highlights consumer confusion, affordability pressures, and perceived inconsistencies in how insurance prices are set, often without explaining the regulatory standards or consumer protections involved. The absence of a clear, accessible explanation from regulators allows a simplified storyline: rates are either "suppressed" for political reasons or "spiking" without accountability. Oppenheim said a white paper can serve as a media-ready explainer, improving baseline understanding before misinformation hardens.

Federal oversight bodies are already asking the NAIC to justify its approach. Members of Congress, including Sen. Whitehouse, have formally pressed the NAIC for updates on how state regulation is responding to climate-related insurance risk, citing Treasury/Federal Insurance Office (FIO) findings on regulatory gaps. Rate regulation sits at the center of these concerns, even when not explicitly named. Oppenheim said proactively articulating the rationale, limits, and evolution of rate regulation positions the NAIC as a policy leader rather than a respondent.

Oppenheim summarized that a white paper would allow the NAIC to reframe the debate around tradeoffs instead of ideology. The current federal and media conversation often treats rate regulation as either consumer protection or market distortion. The evidence, including the Harvard paper, shows that the reality is more complex: balancing affordability, availability, solvency, and risk signaling under accelerating catastrophe losses. She said a white paper can credibly re-center the discussion on regulatory tradeoffs, state diversity, and data-driven oversight—areas in which the NAIC has unique authority.

4. Received a Report on the AI Systems Evaluation Tool and Pilot

Scott Sobel (NAIC) gave an update on the Big Data and Artificial Intelligence (H) Working Group's artificial intelligence (AI) systems evaluation tool and pilot process. The Working Group finalized the initial draft of the tool, which is a document consisting of four exhibit questionnaires. The tool represents the NAIC's latest step to adopt examination and related processes for the regulation of insurance companies' use of AI. The tool gives regulators an optional resource to assist in evaluating a company's use of AI systems and assessing potential risks.

Sobel said state insurance regulators are currently piloting the tool to test it prior to adoption. The pilot officially started earlier this month, meaning all regulators are cleared to send inquiries related to the tool. The pilot group of regulators is meeting weekly to coordinate the selection of companies and to share insights on anticipated responses to the tool.

Sobel stated that the decision of when to use the tool is a domestic regulatory decision. Regulators are generally engaging their domestic companies to ensure the use of the tool is explained and understood. Where a company is part of a group, regulators are coordinating among pilot group members or reaching out to non-pilot states to ensure everyone is aware of the inclusion of the company in the pilot. Most of the pilot states have selected one to 10 insurance companies, with two states sending inquiries to more than 10 companies.

Regulators have also been tasked with using the tool in support of a mix of regulatory processes, including to support a market conduct exam, financial exam, financial analysis, and as part of a more general regulatory inquiry. Communication throughout the pilot process is important, so the pilot states' regulators are collaborating and sharing information to create a feedback loop and learn from each other.

5. Received Liaison Reports

Botsko reported that the Property and Casualty Risk-Based Capital (E) Working Group adopted wildfire to the risk-based capital (RBC) catastrophe risk charge (Rcat) calculation as part of a four-year project to include the solvency concerns that catastrophes bring to companies. Additionally, the Risk-Based Capital Investment Risk and Evaluation (E) Working Group continued its discussion on collateralized loan obligation (CLO) structured investments and the charges associated with that. While it primarily affects life insurance companies, it will have some residual effect on property/casualty (P/C) companies in the RBC calculation.

Citarella reported that the Third-Party Data and Models (H) Working Group is continuing discussions on its third-party framework document.

6. Heard Updates on Activities and Research from Professional Actuarial Associations

The American Academy of Actuaries (Academy), Actuarial Standards Board (ASB), Actuarial Board for Counseling and Discipline (ABCD), Casualty Actuarial Society (CAS), and Society of Actuaries (SOA) provided reports on current activities and research.

Draft Pending Adoption

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2026_Spring/CASTF/032326 Minutes CASTF SpNM

2. Consider Adoption of the Reports of its Working Groups

A. Actuarial Opinion (C) Working Group
   –Julie Lederer (MO)
B. Statistical Data (C) Working Group
   –Sandra Darby (ME)

Attachment Nine

Draft: 7/29/26

Actuarial Opinion (C) Working Group
Virtual Meeting
July 15, 2026

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met July 15, 2026. The following Working Group members participated: Miriam Fisk, Chair (TX); Julie Lederer, Vice Chair (MO); Susan Gozzo Andrews (CT); David A. Christhilf (DC); Chantel Long (IL); Sandra Darby (ME); Tom Botsko (OH); and Andy Schallhorn (OK). Also participating was: Arthur Schwartz (MD).

1. Discussed Changes to 2026 P/C Regulatory Guidance

Fisk reviewed proposed revisions to the *2026 Property/Casualty (P/C) Regulatory Guidance*, including edits Lederer proposed to the qualification documentation section. The revisions added sample language and illustrative examples addressing basic education, experience, continuing education (CE), accepted actuarial designation, and professional actuarial association membership. Michelle Iarkowski (American Academy of Actuaries [Academy] Committee on Property and Liability Financial Reporting [COPLFR]) said the examples, in addition to the sample language, would be helpful to appointed actuaries.

Iarkowski said an Academy committee was considering potential revisions to Section 3 of the U.S. Qualification Standards (USQS), including whether "responsible work" should be defined for purposes of the alternative basic education requirement, and welcomed regulator feedback.

Schwartz commented on the guidance for Exhibit B, Item 11. He said the phrase "at no additional charge" could be misleading because the cost of extended reporting coverage may be incorporated into rates. Fisk noted that the phrase was consistent with *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts* and the 2026 instructions and, therefore, it should remain in the exposure draft. Schwartz proposed separate wording clarifying that coverage arising from death, disability, or retirement may apply to professional liability lines other than medical professional liability. Fisk agreed to incorporate that clarification.

Lederer made a motion, seconded by Christhilf, to expose the draft *2026 P/C Regulatory Guidance*, incorporating Schwartz's clarification, for a 37-day public comment period ending Aug. 21. The motion passed.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

Draft: 7/7/26

Actuarial Opinion (C) Working Group
Virtual Meeting
June 24, 2026

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met June 24, 2026. The following Working Group members participated: Miriam Fisk, Chair (TX); Julie Lederer, Vice Chair (MO); Susan Gozzo Andrews (CT); Chantel Long (IL); Sandra Darby (ME); Tom Botsko (OH); Andy Schallhorn (OK); and James Di Santo (PA).

1. Discussed Changes to 2026 P/C Regulatory Guidance

Fisk said the Working Group was beginning its review of possible 2027 instruction changes and the year-end 2026 regulatory guidance document. Fisk noted that the Working Group adopted several changes to the Property/Casualty (P/C) Statement of Actuarial Opinion (SAO) instructions the prior year, but those changes apply to year-end 2026 opinions and have not yet been used in practice. As a result, the Working Group does not anticipate making many additional instruction changes for 2027 until 2026 opinions are evaluated.

Fisk reviewed proposed edits to the 2026 Regulatory Guidance document. The proposed edits included updating the introduction to focus on 2026 instruction changes; revising language on making use of another's work to reflect new requirements in the 2026 instructions; retaining guidance and example language regarding P/C long-duration unearned premium reserves; and updating Exhibit B references to reflect the removal and renumbering of certain items. Fisk also discussed proposed revisions to the guidance on Exhibit B, Item 11, regarding extended reporting endorsement policy reserve associated contracts.

Fisk also reviewed proposed edits to the qualification documentation section. Michelle Iwarkowski (American Academy of Actuaries—COPLFR) said the existing examples remain valuable because appointed actuaries continue to have questions about how to prepare qualification documentation. The Working Group discussed retaining and improving sample language.

Fisk then asked state insurance regulators to share examples of qualification documentation they have found useful. She said revised edits would be prepared for review before the next meeting, where the Working Group could discuss additional changes and consider exposing the Regulatory Guidance for public comment.

2. Discussed Observations Regarding P/C SAO, P/C AOS, and Title SAO Instructions

Fisk said the Working Group did not currently expect to make major changes to the P/C SAO, P/C Actuarial Opinion Summary (AOS), or Title SAO instructions for 2027. No substantive proposed instruction edits were raised.

Lederer provided an update on her review of the *Financial Analysis Handbook* worksheet for actuarial opinions. Lederer said the current worksheet applies to both P/C and title and includes parenthetical comments where title differs from P/C. Lederer said she had identified places where additional title-related parentheticals may be needed and asked Working Group members to consider whether separate P/C and title worksheets would be more useful than a combined worksheet. Fisk suggested that the Working Group review actuarial references in the *Financial Condition Examiners Handbook* during a future meeting.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

Draft: 8/5/26

Statistical Data (C) Working Group
Virtual Meeting
July 29, 2026

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met July 29, 2026. The following Working Group members participated: Sandra Darby, Chair, (ME); Brad Gerling, Vice Chair (MO); Kyle Ogden and Ken Williamson (AL); Lori Dreaver Munn (AZ); Ross Gjede, George Bradner, and Christian Citarella (CT); Sean Rosene (NH); Tom Botsko (OH); Andy Schallhorn (OK); and David Dahl (OR).

1. Adopted its June 17 and May 20 Minutes

The Working Group met June 17 and May 20 to continue discussion on updates to the *Statistical Handbook of Data Available to Regulators* (Handbook).

Botsko made a motion, seconded by Gerling, to adopt the Working Group's June 17 (Attachment XX) and May 20 (Attachment XX) minutes. The motion passed unanimously.

2. Discussed Comments on Handbook Sections 1, 2, 3, 5, 7, and 8

Darby said the Working Group would return to the claim count note in the homeowners section before moving into the private passenger auto section. She said the American Association of Insurance Services (AAIS) had previously raised concerns about the difficulty of reporting claim counts because the note allows claims to be counted on either a per-accident basis or a per-claimant basis.

Darby reviewed information provided by AAIS regarding its statistical plan. The information stated that the claim count field captures the number of new claims and that the first loss record reported for a claim must have a claim count of one, regardless of whether it is a paid or outstanding loss record. It also stated that paid and outstanding loss adjustment expenses are not reported with a claim count, and that certain salvage and subrogation recovery records may carry a zero or negative claim count depending on whether the recovery is full or partial.

Mary Annese (Insurance Services Office—ISO) said the ISO's process is similar. She said the ISO receives claim counts when a loss payment is made, or a reserve is established, but not when the record is only for loss adjustment expense. She said when a payment is made, and reserves remain outstanding, the claim count may be carried on either the payment or the outstanding loss, but the claim is not counted twice. Al Burton (Independent Statistical Services—ISS) said the ISS' process is essentially the same.

Susan Chudwick (Travelers) asked whether the potential confusion relates to the phrase "per claimant." She said a single accident could involve multiple claimants and asked whether any statistical agent counts each claimant separately rather than counting one accident as one claim. Bradner said homeowners generally involve a one-to-one relationship, but rare liability examples could involve multiple claimants from a single occurrence. Annese said the ISO uses a claim ID field to identify multiple claimants while keeping the claim count per accident.

Mike Puchner (AAIS) said the AAIS also uses an accident-based claim count with claim IDs for claimants. He said the current note could be removed or revised because it suggests that insurers notify statistical agents of the reporting basis, while statistical agents actually instruct insurers how to report.

Gerling said he wanted to ensure that claim counts are collected consistently. He said that if one statistical agent collected data on a per-claimant basis while others collected on a per-accident basis, aggregation would be inappropriate. Darby suggested revising the language to state that claim counts should be reported on a per-accident basis and that, where multiple claimants are involved, claim IDs or similar identifiers should be used without increasing the claim count. Botsko said the approach was acceptable.

Becky Konkle (National Independent Statistical Service—NISS) said similar language appears in the private passenger auto section, and for auto, the NISS has companies report on a claimant basis because the current language states that claimant-based reporting is preferable. Puchner said the AAIS reports auto claim counts on an accident basis, with claim IDs for each claimant. Darby said the issue should be placed on the next agenda because it may result in different statistical agents collecting different data. She said the Working Group should consider how to revise the language without losing information needed for excess loss reporting. Konkle agreed to send information from the NISS statistical plan for review.

The Working Group reviewed proposed changes to the private passenger auto section. Darby reviewed Section 5.2, which included removing "station wagons" and adding "SUV." No concerns were raised.

The Working Group reviewed Section 5.6 and related class group changes. Darby said territory references were being removed because the Working Group had decided to use ZIP codes. The Working Group discussed revised class group variables, including gender, age, business use, farm use, annual mileage, marital status, and principal operator. Darby clarified that the data would be split by variables such as gender and age, rather than reported only through combined legacy class descriptions. Gerling said the proposed changes to the class group were good.

The Working Group discussed annual mileage buckets. Puchner said the AAIS currently has more granular ranges within the proposed buckets but uses 25,000-plus as its maximum bucket. Darby asked whether the proposed 20,000-to-50,000 and 50,000-plus mileage buckets were necessary. Gerling and Munn said the highest-mileage buckets were likely unnecessary because those records would be rare. The Working Group discussed revising the mileage buckets to 20,000-to-25,000 and 25,000-plus.

Citarella said the method used to obtain mileage could be relevant, such as whether the mileage is operator-reported or obtained through a third party. Darby said that would likely require additional information from carriers and statistical agents and should be considered further.

The Working Group reviewed changes to the loss amount, including the addition of salvage and subrogation. No concerns were raised. The Working Group also reviewed claim count changes, including the addition of closed without payment and total loss. Gerling confirmed that closed without payment had been added.

The Working Group reviewed type-of-loss changes. Gerling asked how the data would be broken down by type of loss and said that a template would help visualize it. Darby said statistical agents had been assigned sections and were expected to bring dummy data templates to the September meeting. Gerling also asked about language that would allow statistical agents to collect no-fault outstanding losses either in total of all types or in detail. He said he preferred detail if available and suggested that the Working Group revise the language if statistical agents already collect detailed information consistently. Darby asked statistical agents to review what they currently collect for no-fault outstanding losses before the next meeting.

Darby said the Working Group had time to begin reviewing Section 1. The Working Group questioned whether the reference to page 15 of the annual statement remains accurate. Gerling said the relevant page may now be page 19. Darby asked NAIC committee support to highlight the reference and determine what it currently references.

Darby said Section 1.2 did not appear to need changes. She asked whether references to certain NAIC materials, including the Annual Statement Instructions and the *Accounting Practices and Procedures Manual* (AP&P Manual), remain accurate. Gerling confirmed that "Accounting Practices and Procedures Manual" remains the title.

Darby noted that Section 1.6 refers to the Statistical Information Task Force, which no longer exists. She asked NAIC committee support to update the reference to the appropriate current group. Darby asked that a similar update be made in Section 1.7.

Darby and Munn discussed two paragraphs regarding the NAIC model regulation and states that have not adopted it. Munn said the paragraphs appear to conflict. Darby said the language should be highlighted for future editorial changes. Darby asked whether statistical agents collect data for all states in which reporting companies write business, regardless of the state's adoption of the model regulation. Puchner said the AAIS has data in every state except Texas. Munn noted that Texas has its own approach. Chudwick indicated that personal auto and commercial auto in Massachusetts are also exceptions. Darby said the group should revise the paragraphs because they appear contradictory.

3. Discussed Other Matters

Darby said the Working Group will not meet in August because of the Summer National Meeting. She said the next meeting is scheduled for Sept. 23.

Having no further business, the Statistical Data (C) Working Group adjourned.

Draft: 7/30/26

Statistical Data (C) Working Group
Virtual Meeting
June 17, 2026

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met June 17, 2026. The following Working Group members participated: Sandra Darby, Chair (ME); Charles Hale and Kyle Ogden (AL); Lori Dreaver Munn (AZ); Ross Gjede and George Bradner (CT); Colton Schulz (ND); Sean Rosene (NH); Alexander Vajda (NY); Andy Schallhorn and Landon Hubbart (OK); David Dahl (OR); and Nicole Elliott (TX). Also participating were: Daniel Zhong (FL); John Sobhanian (LA); Phillip Glasovatz (MI); Kelsey McElroy (MN); Ashely Perez (MT); and Eric Scott and Kaleb Short (TN).

1. Discussed Comments on Handbook Sections 1, 2, 3, 5, 7, and 8

The Working Group revisited whether farmowners policies should be classified as commercial lines or personal lines. Andy Regis (American Association of Insurance Services—AAIS) said AAIS differentiates between farm personal liability and commercial liability. Bradner said Connecticut does not allow farmowners policies to be submitted on personal lines. Elliott said the same is true for Texas. The Working Group agreed not to make any changes to the farmowners section of the *Statistical Handbook of Data Available to Regulators* (Handbook).

Darby asked the participating statistical agents, AAIS, Insurance Services Office (ISO), Independent Statistical Service (ISS), and National Independent Statistical Service (NISS) to each provide dummy data for one of the personal lines sections. She asked for them to provide data based on the current version of the Handbook and another data set based on the suggested changes to the Handbook.

Darby said the Working Group has aligned many of the changes in the dwelling fire and allied lines section of the Handbook with those in the homeowners section, including replacing experience period with loss date, removing territory reporting, and adding property mitigation designations. Bradner said it makes sense to mirror the changes made in the homeowners section.

Darby said the Working Group made edits to the property mitigation elements in the homeowners section to clarify that mitigation designations similar to the Insurance Institute for Business & Home Safety (IBHS) designation should also be reported. She asked if that same edit should be made in the dwelling fire and allied lines section. The Working Group agreed that the edit should be implemented.

Darby said the Working Group will discuss the private passenger auto (PPA) section during its next meeting.

Having no further business, the Statistical Data (C) Working Group adjourned.

Draft: 7/30/26

Statistical Data (C) Working Group
Virtual Meeting
May 20, 2026

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met May 20, 2026. The following Working Group members participated: Sandra Darby, Chair (ME); Brad Gerling, Vice Chair (MO); Charles Hale and Kyle Ogden (AL); Lori Dreaver Munn (AZ); George Bradner (CT); David A. Christhilf (DC); Colton Schulz (ND); Christian Citarella (NH); Alexander Vajda (NY); Landon Hubbart (OK); David Dahl (OR); and Ken Burton (TX). Also participating were: Luciano Gobbo (CA); Daniel Zhong (FL); Julie Rachford (IL); John Sobhanian, Nichole Torblaa, and Niles Watson (LA); Phillip Glasovatz (MI); Kelsey McElroy (MN); Mari Kindberg (MT); Eric Scott and Kaleb Short (TN); Kelly Christensen (UT); William Wilder (WA); and Jeff Grothman (WI).

1. Adopted its April 8 Minutes

The Statistical Data (C) Working Group met April 8 to discuss comments on the *Statistical Handbook of Data Available to Regulators* (Handbook).

Schulz made a motion, seconded by Gerling, to adopt the Working Group's April 8 minutes (Attachment --). The motion passed unanimously.

2. Discussed Comments on Handbook Sections 1, 2, 3, 5, 7, and 8

Darby said questions that were outstanding from the Working Group's April 8 meeting were sent to statistical agents. She said statistical agents were asked how they collect protection codes and how carriers that do not use protection codes in rating are handled for homeowners policies. The National Independent Statistical Service (NISS) said it recently made changes to its statistical plan for homeowners and now uses the same protection codes as the Insurance Services Office (ISO). NISS also said it added a code for companies that do not use protection codes in rating. Independent Statistical Service (ISS) said it assigns a code for companies that do not use protection codes in rating. The American Association of Insurance Services (AAIS) said it collects fire protection rating codes based on AAIS classification plans, and it can also collect fire loss assignments. Laura Panesso (ISO) said ISO collects the actual Public Protection Classification (PPC), and if a carrier does not utilize the PPC, the ISO can grant it permission to report a default code.

Darby asked the Working Group whether protection codes should be collected as is, broken out and collected individually, or the Handbook should add a code to indicate companies that do not use protection codes. Bradner agreed that the Handbook should at least collect a code for companies that do not use protection codes. He said there are companies that are creating new protection classes, and the Handbook should allow for that flexibility. Schulz suggested breaking out the protection codes and using an additional code for companies that do not use the PPC. The Working Group agreed to break out each individual protection code, add a code for companies that do not use the PPC, and insert language that companies should match to the closest equivalent code if using a different type of code.

Darby said statistical agents were asked if collect the data outlined in the transaction identifiers section for endorsements. NISS responded that it collects written premium and written exposures for endorsements. ISS responded that it collects written premium, paid losses, and outstanding losses but not allocated losses. AAIS and ISO responded that they do collect the transaction identifier elements for endorsements. The Working Group agreed to collect written premium and paid loss amounts for endorsements.

Darby said statistical agents were asked if they had suggestions for catastrophe codes. NISS responded that some larger companies collect Property Claim Services (PCS) catastrophe codes, and some companies have their own internal catastrophe codes. NISS said it would be important for the Handbook to clearly define "catastrophe" as this will not be reported the same by all companies. ISS responded that companies have different internal thresholds for catastrophes. AAIS responded that it does not directly collect catastrophe codes. Panesso said ISO does not collect the PCS codes for this data, and it would not be a one-size-fits-all approach in terms of defining catastrophes. Schulz said the PCS codes could be backed into with the date of loss. The Working Group agreed with this approach and did not implement catastrophe codes.

Darby said statistical agents were asked if they had suggested changes to the type of loss section. NISS responded that it recently made changes to its cause of loss field due to mandates in North Carolina. ISS responded that any changes to type of loss need to be consistent across all statistical agents. AAIS and ISO responded that they collect more granular loss codes. Panesso said the Handbook should not collect anything too granular, especially across the different types of fire losses. The Working Group agreed to combine fire and fire caused by lightning, and to separately collect lightning damage with no fire. It also agreed to collect wildfire as its own type of loss.

Darby said statistical agents were asked to verify if their farmowners programs were classified as personal lines or commercial lines. NISS and ISS said they do not distinguish between personal lines and commercial lines for farmowners. AAIS said it has a data field that distinguishes personal lines from commercial lines. ISO said farmowners is collected under their commercial statistical plan. Bradner said smaller farming operations should be collected as personal lines and distinguished from large commercial farming operations. Darby asked the statistical agents to look into the eligibility requirements for farmowners being reported as a commercial line.

The Working Group discussed the current instructions in the Handbook that specify reporting either the all other perils deductible or the wind and hail deductible if it is different from the all other perils deductible. The Working Group agreed that the Handbook should be changed to specify reporting the deductible applying to all other perils and the highest deductible amount of any peril-specific deductible.

Darby asked statistical agents to look into how they are reporting out claim counts when they collect claim counts on both a per-accident and per-claimant basis.

Having no further business, the Statistical Data (C) Working Group adjourned.

Draft: 4/17/26

Statistical Data (C) Working Group
Virtual Meeting
April 8, 2026

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met April 8, 2026. The following Working Group members participated: Sandra Darby, Chair, (ME); Brad Gerling, Vice Chair (MO); Charles Hale and Kyle Ogden (AL); Lori Dreaver Munn (AZ); George Bradner (CT); David A. Christhilf (DC); Colton Schulz (ND); Christian Citarella (NH); Alexander Vajda (NY); Landon Hubbart (OK); David Dahl (OR); and Ken Burton (TX). Also participating were: Luciano Gobbo (CA); Daniel Zhong (FL); Julie Rachford (IL); John Sobhanian, Nichole Torblaa, and Niles Watson (LA); Phillip Glasovatz (MI); Kelsey McElroy (MN); Mari Kindberg (MT); Eric Scott and Kalen Short (TN); Kelly Christensen (UT); William Wilder (WA); and Jeff Grothman (WI).

1. Discussed Comments on Handbook Sections 1, 2, 3, 5, 7, and 8

Darby said the Working Group plans to wrap up discussion of the personal lines and introductory sections of the handbook by the end of 2026. She said that finalizing these sections will allow statistical agents to start implementing changes into their systems without having to wait for the rest of the commercial lines sections to be finished.

Regarding the Homeowners section of the Statistical Handbook of Data Available to Regulators (Statistical Handbook) Darby asked if any additional coverages should be added to the coverages list in the Homeowners section which currently includes credit card and debris removal. Jenny Tornquist (American Association of Insurance Services—AAIS) asked why credit card is included. Bradner said homeowners policy may cover a certain amount for credit card theft. Tornquist clarified that this is just a list of what would be included in the coverage and not a separate collection of this specific data element. Bradner said the Linux Foundation is building out a platform on homeowners and auto data that might be useful to the Working Group. Mike Puchner (AAIS) said the Linux Foundation group would like to align with the Working Group and the Statistical Handbook on the technical specifications of the data. Darby said the current wording in the Statistical Handbook makes these additional coverages seem limiting to what is listed. She asked NAIC to reword the sentence to be inclusive of any additional coverages provided by a homeowners policy.

Darby said based on previous discussion the Working Group removed the data element called Dates and Amounts of Premium because premium is now included in a new element called Transaction Identifier. Tornquist asked if this change clarifies that only written premium will be reported because earned premium can be calculated from the dates provided. Darby agreed that it does.

Darby said there was no issues raised in the previous discussion on changes to Calendar Year and Loss Date for Claims and Losses.

Darby asked if any statistical agents have an issue with removing territory and only reporting zip code data. There were no issues raised. She asked if everyone was in agreement on the additional policy forms and construction type. There was no disagreement.

Darby and Bradner said the Property Mitigation section should be expanded to not be exclusive to Insurance Institute for Business and Home Safety (IBHS) designations. Darby suggested talking with regulators in Florida about their standards.

Darby said the Working Group should look further into the use of specific protection codes versus grouping protection codes into buckets. Schulz suggested using generic codes that could allow for easy mapping.

Darby said the Statistical Handbook should clarify if endorsement data is only collecting the counts of endorsements or if it is being broken out by the Transaction Identifiers. Darby asked statistical agents to provide information on what kind of data they have for endorsements.

Darby said the Working Group has previously discussed collecting both all-peril and wind/hail deductibles instead of only one. Schulz said to future proof the Statistical Handbook the Working Group should think about allowing for per peril deductible collection.

Darby said there are additional data elements the group has discussed adding to this section but are in need of definitions. Laura Panesso (Insurance Services Office—ISO) said they can help provide definitions for some of the elements as a starting point.

Puchner asked about the intention of separating Fire and Fire Caused by Lightning. He said AAIS does not currently capture these as separate elements. He asked if the intention is to find what caused the loss or what caused the fire. Munn said Arizona regulators would like to see the cause of the fire. Schulz said that makes sense because carriers would be interested in the cause of the fire for underwriting purposes. Darby said she would like to know the cause of fire and it might not be limited to lightning. Wilder said some type of catastrophe code associated with wildfire and other catastrophes could help identify wildfire losses. Nancy Clark (ISO) said the dates of claims and losses, which was added as a new element, could help identify whether a loss was due to a catastrophic event.

Darby said the Working Group will continue discussion during the next meeting on April 29.

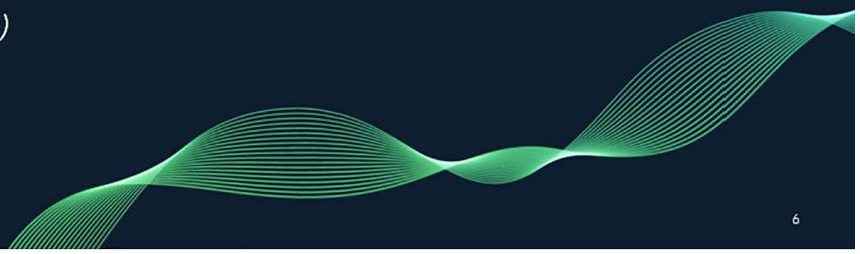
Having no further business, the Statistical Data (C) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2026_Summer/CASTF/SDWG/StatDataWGmin_0408

3. Consider Adoption of the Title Schedule P Instructions Proposal

Attachment Ten

Julie Lederer (MO)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

	DATE: 8/4/2026	**FOR NAIC USE ONLY**
CONTACT PERSON:	Kris DeFrain	Agenda Item # 2026-xxBWG
TELEPHONE:	816-783-8229	Year 2027
EMAIL ADDRESS:	kdefrain@naic.org	Changes to Existing Reporting [X]
ON BEHALF OF:	Casualty Actuarial and Statistical (C) Task Force	New Reporting Requirement [ ]
NAME:	Julie Lederer	**REVIEWED FOR ACCOUNTING PRACTICES AND PROCEDURES IMPACT**
TITLE:	Chair of CASTF	No Impact [X] Modifies Required Disclosure [ ]
AFFILIATION:	Missouri Dept. of Commerce and Insurance	Is there data being requested in this proposal which is available elsewhere in the Annual/Quarterly Statement? [NO] ****If Yes, complete question below****
ADDRESS:		**DISPOSITION**
		[ ] Rejected For Public Comment [ ] Referred To Another NAIC Group [ ] Received For Public Comment [ ] Adopted Date [ ] Rejected Date [ ] Deferred Date [ ] Other (Specify)

BLANK(S) TO WHICH PROPOSAL APPLIES

[X] **ANNUAL STATEMENT**	[X] **INSTRUCTIONS**	[ ] **CROSSCHECKS**
[ ] **QUARTERLY STATEMENT**	[ ] **BLANK**	
[ ] Life, Accident & Health/Fraternal	[ ] Separate Accounts	[X] Title
[ ] Property/Casualty	[ ] Protected Cell	[ ] Other
[ ] Health	[ ] Health (Life Supplement)	[ ] Life (Health Supplement)

Anticipated Effective Date: Annual 2027

IDENTIFICATION OF ITEM(S) TO CHANGE

Upon request from the Title Insurance (C) Working Group, the Casualty Actuarial and Statistical (C) Task Force is proposing updates to the Title Schedule P instructions to be consistent with revisions to the Property/Casualty Schedule P instructions.

REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to clarify the instructions by making minor improvements. These changes are consistent with the updates to the Property/Casualty Schedule P instruction updates.

*****IF THE DATA IS AVAILABLE ELSEWHERE IN THE ANNUAL/QUARTERLY STATEMENT, PLEASE NOTE WHY IT IS REQUIRED FOR THIS PROPOSAL*****

NAIC STAFF COMMENTS

Comment on Effective Reporting Date:

Other Comments:

** **This section must be completed on all forms.** **Revised 11/17/2022**

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SCHEDULE P

There are five parts and the interrogatories within Schedule P. Part 1 provides detailed information on losses and loss adjustment expenses. Part 2 provides a history of incurred losses and allocated loss adjustment expenses (ALAE) on a policy year basis. Part 3 provides a history of incurred losses and allocated loss adjustment expenses on a report year basis. Part 4 provides a history of claim counts on a policy year basis. Part 5 provides a history of claim counts on a report year basis. Schedule P Interrogatories provides for additional calculation and explanation of various amounts. If the company is unable to provide any part of the data required in Schedule P for years prior to 1994, the company must obtain a letter of waiver from its domiciliary commissioner. A copy of this letter must be included with the company's annual statement. Data for 1994 and subsequent should be provided in complete detail except for unallocated loss adjustment expenses (ULAE) that should be in complete detail for 1996 and subsequent.

Schedule P includes only the data for the insurer identified on the Jurat Page of the annual statement. Do not include consolidated data for affiliated companies. If the insurer participates in an intercompany pooling agreement, it should report only its share of the business, not the total of all participants.

In those instances where an insurer files an amended annual statement as a result of a restatement of previous year written premium, losses or loss adjustment expenses, Schedule P must be restated and included in the amended annual statement. In those instances where one title insurer is merged into another title insurer, Schedule P must be prepared so it includes the entire combined history of both companies.

Title insurance losses should include all losses on any transaction for which a title insurance premium, rate or charge was made or contemplated. Escrow losses for which the company is contractually obligated should be included. Losses arising from defalcations for which the company is contractually obligated should be included.

Allocated loss adjustment expenses are those that can be related to specific claims and include fees, salaries, overhead, and expenses of lawyers for legal services in defense, trial or appeal of suit, other legal services rendered in connection with title claims, and general court costs and fees together with appeal costs and expenses. Allocated loss adjustment expenses should include all costs associated with attorneys involved in litigation of specific claims whether such attorneys are engaged as outside counsel or salaried employees of a reporting entity. Allocated loss adjustment expenses also include any fee or expense, other than claim adjuster services, which is directly attributable to the defense of a particular claim.

Allocated loss adjustment expenses for reinsurance assumed and ceded should be reported in accordance with the terms of the applicable reinsurance contracts. In addition, an assuming reinsurer that incurs allocated loss adjustment expenses in its adjustment of reinsured losses should report ALAE in the manner described above for direct losses.

Unallocated loss adjustment expenses are those expenses, other than allocated loss adjustment expenses, that are assigned to the expense group "Loss Adjustment Expenses." As an example, the costs related to salaried employees of the insurer involved in the management of claims are included in this category.

Loss and loss adjustment expense reserves are to be presented on a non-discounted basis. Discounting of loss and loss adjustment expense reserves is allowed only if expressly permitted by the state insurance department to which this annual statement is being filed. Work papers relating to any discount amounts must be available for examination upon request.

Salvage and subrogation should be determined in accordance with *SSAP No. 57—Title Insurance* using the following rules:

1. Paid losses shall be reported net of realized, but not anticipated, salvage and subrogation. Case basis loss and loss adjustment expense reserves shall not be reduced for anticipated salvage and subrogation, nor shall an asset be established.

2. Paid salvage and subrogation is not realized until a salvage asset or an actual payment pursuant to a subrogation right is in the direct control of the insurer and admissible as an asset for statutory reporting purposes in its own right.

3. Salvage assets and payments pursuant to a subrogation right shall be recorded at current fair value. Current fair value of real estate shall be established through an appraisal conducted by a qualified independent appraiser.

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Moved down [2]: Schedule P, Part 1 is organized so that written premiums and other income for a year are matched with corresponding losses and allocated loss adjustment expenses (ALAE) and unallocated loss adjustment expenses for policies issued during that year. Experience is shown for direct business, reinsurance assumed, reinsurance ceded and net of reinsurance.¶
¶
Written premium and other income is on a calendar year basis, and should reconcile with the totals on Schedule T.¶
¶
Policy year loss and loss adjustment expense payments and reserves should be assigned to the year in which the policy was written under which coverage is triggered. Payments and reserves for escrow and defalcation loss and loss adjustment expenses should be assigned to the year of the associated title insurance order or, if the year is unknown, to the year the defalcation or escrow loss was first known by the company

Deleted: Part 2 displays 20-year loss development triangles on a policy year basis. Part 3 displays 10-year loss development triangle on a report year basis. In Parts 2 and 3, losses are combined with ALAE and are net of reinsurance. Loss and ALAE development is shown for total incurred, payments, case basis reserves, bulk reserves and incurred but not reported (IBNR) reserves (policy year basis only). Part 4 displays 20-year claim count development triangles on a policy year basis.

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4. If a salvage asset is sold or revalued by the insurer within twelve months of realization for an amount less than the value at which it was originally placed on the books of the insurer, then the loss on disposition shall be treated as a decrease in paid salvage (same effect as an addition to the paid loss) on the corresponding claim. After twelve months, such salvage revaluation will be treated as a loss on disposition or change in value of an asset, and shall not be deducted from the salvage on the corresponding claim.

5. If a salvage asset is sold or revalued by the insurer within twelve months of realization for an amount greater than the value at which it was originally placed on the books of the insurer, then the gain on disposition is to be treated as an increase in paid salvage (same effect as a deduction to the paid loss) on the corresponding claim. After twelve months, such salvage revaluation shall be treated as a gain on disposition or change in value of an asset and shall not to be added to the salvage on the corresponding claim.

6. IBNR reserves may make an actuarially determined provision for the expected value of future salvage and subrogation on open claims and IBNR claims.

Report all dollar amounts in Schedule P in thousands of dollars ($000 omitted), either by rounding or truncating. All claim counts are to be shown in whole numbers.

For reporting entities reporting on a pooling basis, the intercompany pooling percentage should be applied to claim count as well as dollar amounts.

If the company changes its method of counting claims, the new method should be disclosed in the Notes to Financial Statements and in the Schedule P - Interrogatories.

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SCHEDULE P – PART 1

Part 1 – Summary provides detailed information on losses, loss adjustment expenses, written premium, and claim counts. Part 1 – Summary should be equal to the sum of Part 1A and Part 1B. Columnar headings provide instructions necessary for completion.

Part 1 is organized so that written premiums and other income for a year are matched with corresponding losses and allocated loss adjustment expenses and unallocated loss adjustment expenses for policies issued during that year. Experience is shown for direct business, reinsurance assumed, reinsurance ceded and net of reinsurance.

Written premium and other income is on a calendar year basis, and should reconcile with the totals on Schedule T.

Policy year loss and loss adjustment expense payments and reserves should be assigned to the year in which the policy was written under which coverage is triggered. Payments and reserves for escrow and defalcation loss and loss adjustment expenses should be assigned to the year of the associated title insurance order or, if the year is unknown, to the year the defalcation or escrow loss was first known by the company.

The "Prior Years" category can be completed using one of the following methods:

1. "Prior Years" consists of all policies issued by the company from inception of the company forward, with the exception of policies that are presented elsewhere on the exhibit.

2. "Prior Years" consists of all policies issued by the company from 1970 forward, with the exception of policies that are presented elsewhere on the exhibit.

3. The company can pick a year earlier than 1970 but later than the inception of the company.

Once a method is established, the company should not alter that method at a later date.

The amount of liability to be reported in Column 1 is the policy amount (net of reinsurance) in those cases not involving a simultaneous issue of multiple policies. In determining the amount of liability to be reported in case of simultaneous issue of an owners policy and a mortgage policy, include the higher liability policy only. This amount is reported in millions of dollars ($000,000 omitted).

The net reserve shown in Schedule P, Part 1, Line 12, Column 24 should make a sufficient provision for ultimate loss and LAE for all reported and unreported title insurance claims (including escrow and defalcation claims) for which the company is obligated net of reinsurance. The gross reserves shown in Schedule P, Part 1, Line 12, Column 24 plus Column 19 plus Column 22 should make a sufficient provision for ultimate loss and LAE for all reported and unreported title insurance claims (including escrow and defalcation claims) for which the company is obligated gross of reinsurance ceded.

The work papers showing a reconciliation explaining reinsurance, discounting and salvage and subrogation adjustments should be available for examination on request.

"Assumed" means reinsurance assumed, including from affiliated intercompany pooling agreements.

"Direct" means as directly written. Do not include coverages written as part of an affiliated intercompany pooling agreement.

"Ceded" means reinsurance ceded on business so reported as direct or assumed.

Direct, Assumed, and Ceded experience should be provided for Written Premium and Other Income, Loss Payments, Allocated LAE Payments, Known Claim Reserves and IBNR Reserves.

Loss and ALAE Payments should be reported net of realized salvage and subrogation. Salvage and Subrogation Received represents the cumulative salvage and subrogation realized, as defined in *SSAP No. 57—Title Insurance*. It is shown for reference only and should not be included in the Total Net Paid.

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Inception to-date ULAE Payments by policy year should be provided with the allocation of payments to policy year described in the Schedule P Interrogatories.

The known claim reserve includes case basis reserves and "bulk" reserves. "Bulk" reserves are a provision for subsequent development on known claims.

IBNR reserves are a provision for unreported or unknown title insurance claims on all policies issued by the company as of the accounting date.

Unallocated loss expenses unpaid are a provision for ULAE yet to be paid related to claims that are either open or unreported as of the accounting date.

Losses and ALAE Incurred is the addition of the corresponding Direct, Assumed, and Ceded columns for payments, Known Claim Reserves and IBNR Reserves.

Column 2 – Direct Written Premium

Line 11 should equal Schedule T, Line 59, Column 3 plus Column 4 plus Column 5.

Column 4 – Other Income

Line 11 should equal Schedule T, Line 59, Column 6.

Column 17 – Direct Known Claim Reserve

Line 12 should equal Schedule T, Line 59, Column 10.

Column 23 – Unallocated loss Adjustment Expense Unpaid

Line 12 should equal Operations and Investment Exhibit, Part 3, Line 25, Column 5.

Column 32 – Net Loss & LAE Per $1000 of Coverage

Amounts used in this calculation should be in whole dollars.

Line 12 – Total

Column 17 plus Column 18 minus Column 19 (net known claim reserve) should equal Line 1 of the Liabilities, Surplus, and Other Funds page.

Columns 1 through 29 and Columns 33 and 34 should equal Part 1A plus Part 1B.

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SCHEDULE P – PART 1A – POLICIES WRITTEN DIRECTLY

Part 1A provides a summary of loss and Loss adjustment expense experience for policies written directly.

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Policies written directly are those written by the home office and owned and operated branch offices of the title insurer.

Refer to Part 1 for instructions to complete this part.

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Column 2 – Direct Written Premium

Line 11 should equal Schedule T, Line 59, Column 3.

SCHEDULE P – PART 1B – POLICIES WRITTEN THROUGH AGENTS

Part 1B provides a summary of loss and Loss adjustment expense experience for policies written through agents.

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Policies written through agents are those written by both affiliated and non-affiliated agency operations.

Refer to Part 1 for instructions to complete this part.

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Column 2 – Direct Written Premium

Line 11 should equal Schedule T, Line 59, Column 4 plus Column 5.

SCHEDULE P – PART 2

Part 2 provides a historical summary of incurred loss and ALAE development by policy year on a net of reinsurance basis. Columnar headings provide instructions necessary for completion. Column 11 equals Column 10 minus Column 9 for common years (Rows 1 through 20). Column 12 equals Column 10 minus Column 8 for common years (Rows 1 through 19).

The definition of "prior years" should be the same as that used by the company in Part 1.

Columns 1 to 10 should equal the sum of Parts 2A, 2B, 2C, and 2D.

SCHEDULE P – PART 2A

Part 2A shows cumulative net loss and ALAE payments by year the policy was written as of December 31 of each year shown in Columns 1 to 10. Payments should reflect subrogation, salvage and escrow and defalcation claims according to the rules contained in *SSAP No. 57—Title Insurance*.

Part 2A, Column 10, should equal Part 1, Column 15 minus Column 14.

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SCHEDULE P – PART 2B

Part 2B shows case basis loss and ALAE reserves by year the policy was written on claims that are open as of December 31 of each year shown in Columns 1 to 10.

Part 2B, Column 10 plus Part 2C, Column 10, should equal Part 1, Columns 17 plus Column 18 minus Column 19.

SCHEDULE P – PART 2C

Part 2C shows bulk reserves on known claims by year the policy was written for claims that are open as of December 31 of each year shown in Columns 1 to 10.

SCHEDULE P – PART 2D

Part 2D shows Incurred But Not Reported (IBNR) reserves as of December 31 of each year shown in Columns 1 to 10. IBNR reserves make a provision for claims not yet reported to the company but can also include other amounts needed to result in an adequate total reserve.

For years prior to 1994, some companies did not compute an IBNR reserve. In such cases, the company should display zero IBNR, and make an appropriate disclosure in the Notes to Financial Statements. Some companies compute IBNR in their U.S. GAAP annual statements. In such cases, the company should provide IBNR for policy years prior to 1994. The IBNR reserve should not be discounted for investment income.

Part 2D, Column 10 should equal Part 1, Column 20 plus Column 21 minus Column 22.

SCHEDULE P – PART 3

Part 3 provides a historical summary of incurred loss and ALAE development by report year on a net of reinsurance basis. Claims should be grouped by the year in which the claim was first reported. Columnar headings provide instructions necessary for completion. Column 11 equals Column 10 minus Column 9 for common years (Rows 1 through 10). Column 12 equals Column 10 minus Column 8 for common years (Rows 1 through 9).

The "Prior Years" category for report year need not be the same as for policy year. Several methods are acceptable, but once established, the company should not alter its method at a later time. The following methods are acceptable:

1. "Prior Years" consists of all claims reported by the company from inception of the company forward, with the exception of reported claims that are presented elsewhere on the exhibit.
2. "Prior Years" consists of all claims reported by the company from 1980 forward, with the exception of reported claims that are presented elsewhere on the exhibit..
3. The company can pick a year earlier than 1980, but later than the inception of the company.

The treatment of salvage and subrogation should be the same as in Parts 1 and 2.

The totals in Part 3 may not reconcile with the totals in Part 1 - Summary due to differences in the meaning of "prior years."

Part 3, Columns 1 to 10 should equal the sum of Parts 3A, 3B, and 3C.

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SCHEDULE P – PART 3A

Part 3A shows cumulative net loss and ALAE payments by year the claim was reported as of December 31 of each year shown in Columns 1 to 10. Payments should reflect subrogation, salvage and escrow and defalcation claims according to the rules contained in *SSAP No. 57—Title Insurance*.

Part 3A total of Column 10 should equal Part 1, Line 12, Column 15 minus Column 14. However, Part 3A may not reconcile with Part 1 – Summary due to differences in the meaning of "prior years" resulting in a validation error. Differences in the meaning of "prior years" would be an acceptable explanation of the error for the Validation Error Explanation Text File submitted as part of the statement filing.

SCHEDULE P – PART 3B

Part 3B shows case basis loss and ALAE reserves by year the claim was reported on claims that are open as of December 31 of each year shown in Columns 1 to 10.

Part 3B total of Column 10 plus Part 3C total of Column 10, should equal Part 1, Line 12, Columns 17 plus Column 18 minus Column 19.

SCHEDULE P – PART 3C

Part 3C shows bulk reserves on known claims by year the claim was reported for claims that are open as of December 31 of each year shown in Columns 1 to 10. Bulk reserves provide for subsequent development on known claims and do not make a provision for claims not yet reported to the company. A company is not required to carry bulk reserves.

SCHEDULE P – PART 4

Part 4 provides a historical summary of direct claim count development by policy year. Columnar headings provide instructions necessary for completion.

The definition of "prior years" should be the same as that used by the company in Part 1.

Part 4 is gross of reinsurance.

SCHEDULE P – PART 4A

Part 4A shows cumulative reported claim counts on a direct basis by year the policy was written as of December 31 of each year shown in Columns 1 to 10. The number of claims reported is to be cumulative by policy year. The number of claims reported for each policy year is equal to the number of open claims at the end of the current year plus cumulative claims closed with or without payment for the current and prior calendar years.

Part 4A, Column 10 should equal Part 1, Column 16.

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SCHEDULE P – PART 4B

Part 4B shows cumulative claims closed with loss payment on a direct basis by year the policy was written as of December 31 of each year shown in Columns 1 to 10.

Part 4B, Column 10 should equal Part 2A, Column 11.

SCHEDULE P – PART 4C

Part 4C shows cumulative claims closed without loss payment on a direct basis by year the policy was written as of December 31 of each year shown in Columns 1 to 10.

Part 4C, Column 10 should equal Part 2A, Column 12.

SCHEDULE P – PART 5

Part 5 provides a historical summary of direct claim count development by report year. Columnar headings provide instructions necessary for completion.

The definition of "prior years" should be the same as that used by the company in Part 3.

Part 5 is gross of reinsurance.

SCHEDULE P – PART 5A

Part 5A shows cumulative reported claim counts on a direct basis by year the claim was reported as of December 31 of each year shown in Columns 1 to 10.

SCHEDULE P – PART 5B

Part 5B shows cumulative claims closed with loss payment on a direct basis by year the claim was reported as of December 31 of each year shown in Columns 1 to 10.

Part 5B, Column 10, should equal Part 3A, Column 11.

SCHEDULE P – PART 5C

Part 5C shows cumulative claims closed without loss payment on a direct basis by year the claim was reported as of December 31 of each year shown in Columns 1 to 10.

Deleted: DRAFT 549_Title_2026_Schedule_P updated jlDRAFT 549_Title_2026_Schedule_P updated.docx

Part 5C, Column 10, should equal Part 3A, Column 12.

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Responses to comments received on title Schedule P instructions exposure draft

Rebecca Armon, Texas Department of Insurance
Comments sent by email on June 8, 2026

JL response to Rebecca's comment #1:

I changed the quoted text in the "Schedule P – Part 1" section to read (text added to the current language is shown in bold red font):

> *The "Prior Years" category can be completed using one of the following methods:*
>
> *1. "Prior Years" consists of all policies issued by the company from inception of the company forward**, with the exception of policies that are presented elsewhere on the exhibit**.*
>
> *2. "Prior Years" consists of all policies issued by the company from 1970 forward**, with the exception of policies that are presented elsewhere on the exhibit**.*

Part 1 shows ten individual years of policy year data. Parts 2 and 4, which are supposed to use the same "prior years" definition as in Part 1, show twenty individual years of policy year data.

I changed the quoted text in the "Schedule P – Part 3" section to read (text added to the current language is shown in bold red font):

> *The "Prior Years" category for report year need not be the same as for policy year. Several methods are acceptable, but once established, the company should not alter its method at a later time. The following methods are acceptable:*
>
> *1. "Prior Years" consists of all claims reported by the company from inception of the company forward**, with the exception of reported claims that are presented elsewhere on the exhibit**.*
>
> *2. "Prior Years" consists of all claims reported by the company from 1980 forward**, with the exception of reported claims that are presented elsewhere on the exhibit**.*

Parts 3 and 5 both show ten individual years of report year data, and Part 5 is supposed to use the same "prior years" definition as in Part 3. Other wording would be acceptable here, such as "with the exception of claims reported in the most recent ten years," but I used the proposed wording for consistency with the proposed wording in the Part 1 section.

JL response to Rebecca's comment #2:

I changed the first sentence in the “Schedule P – Part 1” section to “Part 1 – Summary provides detailed information on losses, loss adjustment expenses, written premium, and claim counts.”

Ronald Blitenthal, Old Republic National Title Insurance Company
Comments sent by email on June 26, 2026

JL response: This comment provides helpful confirmation. If the title insurance industry or regulators who work with title insurance would like more detailed instructions in the title Schedule P instructions on what should be in the “prior years” rows, I recommend that they form a working group (in consultation with the NAIC’s Title Insurance (C) Working Group) to codify what should be in those rows.

COPLFR
Comments sent by email on July 24, 2026

JL response: COPLFR’s proposal would entail a change to the Schedule P blanks. The scope of this project only encompasses the Schedule P instructions.

July 23, 2026

Angela L. Nelson, Chair
Timothy N. Schnott, Vice Chair
Casualty Actuarial and Statistical (C) Task Force
National Association of Insurance Commissioners (NAIC)

Re: Schedule P Title Exposure

Dear Chair Bettencourt and Vice Chair Nelson:

On behalf of the Casualty Practice Council's Committee on Property and Liability Financial Reporting (Committee) of the American Academy of Actuaries,[1] we appreciate the opportunity to comment on the updated Schedule P Title instructions, issued for comment on June 9, by the Casualty Actuarial and Statistical (C) Task Force. The Committee has reviewed the exposure and offers the following comments. We would be happy to discuss any questions you may have regarding our suggestions.

We suggest updating Schedule P to display 20 years instead of 10 years in all parts. To do so, we recommend the following edits to Schedule P – Part 1:

> "Part 1 – Summary provides a 20~~10~~-year summary of loss and loss adjustment expense experience for the company. Part 1 – Summary should be equal to the sum of Part 1A and Part 1B. Columnar headings provide instructions necessary for completion."
>
> The "Prior Years" category can be completed using one of the following methods:
>
> 1. "Prior Years" consists of all policies issued by the company from inception of the company forward, with the exception of policies issued in the most recent ~~ten~~ twenty years.
>
> 2. "Prior Years" consists of all policies issued by the company from 1970 forward, with the exception of policies issued in the most recent ~~ten~~ twenty years.

The Committee looks forward to the continued collaborative dialogue with the NAIC as it continues its work on this project. If you have any questions or would like to discuss these comments further, please contact Rob Fischer, policy project manager, casualty (fischer@actuary.org, 202-785-7865).

Sincerely,

Michelle L. Iarkowski, MAAA, FCAS
Chairperson, Committee on Property and Liability Financial Reporting

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

From: Blitenthal, Ronald <RBlitenthal@OldRepublicTitle.com>
Sent: Friday, June 26, 2026 10:28 AM
To: Beydler, Nancy <nbeydler@naic.org>; DeFrain, Kris <kdefrain@naic.org>
Cc: Ikegami, Jane <JIkegami@OldRepublicTitle.com>
Subject: RE: Exposure: Title Schedule P Instructions Proposal

Dear Kris and Nancy:

We appreciate the opportunity to comment on the proposed Schedule P changes regarding title insurance. We concur with Julie Lederer's comment #1 in the second attachment. There is a difference in the P&C and Title instructions on defining "Prior Year" rows. We agree with Ms. Lederer that the Title instruction indicating cumulative data is correct for us and title insurers should not follow the P&C instructions. We don't know what the P&C rational is for only using the current calendar year payments and incurred versus the cumulative data. But for Title, using cumulative information fully and correctly matches all of the policy year losses (not just the current calendar year losses for those policy years) with the policy year premiums.

Please let us know if you have any questions.

Take care,

Ron

Ronald Blitenthal
SVP | Old Republic National Title Insurance Company
Chief Regulatory Counsel | Corporate Legal Department

Old Republic Title
1408 N. Westshore Blvd., Suite 900 | Tampa | Florida | 33607

O: 612-371-3812 | M: 612-747-8099

rblitenthal@oldrepublictitle.com

From: Lederer, Julie <Julie.Lederer@insurance.mo.gov>
Sent: Tuesday, June 9, 2026 1:17 PM
To: DeFrain, Kris <kdefrain@naic.org>; Perez Santiago, Roberto <rperez1@naic.org>
Subject: FW: Title Insurance Schedule P Instructions suggestions

Here is the email correspondence between me and Rebecca that I recommend sending with the exposure draft. Thanks!

From: Rebecca Armon <Rebecca.Armon@tdi.texas.gov>
Sent: Monday, June 8, 2026 2:07 PM
To: Lederer, Julie <Julie.Lederer@insurance.mo.gov>
Subject: RE: Title Insurance Schedule P Instructions suggestions

👍 **Rebecca Armon** reacted to your message:

From: Lederer, Julie <Julie.Lederer@insurance.mo.gov>
Sent: Monday, 08 June 2026 19:05:06
To: Rebecca Armon <Rebecca.Armon@tdi.texas.gov>
Subject: RE: Title Insurance Schedule P Instructions suggestions

Hi Rebecca,

Thank you so much for the careful review! I appreciate the time you took to go through this.

Good point on #1.

On #2, I agree. That's not a good description of Part 1. I checked the P/C instructions, which say, "Part 1 provides detailed information on losses and loss adjustment expenses." That's also not a good description. If we want to keep something and retain some harmony with the P/C instructions, maybe we could change the description to something like, "Part 1 – Summary provides detailed information on losses, loss adjustment expenses, written premium, and claim Julie Lederer, FCAS, MAAA

Property and Casualty Actuary

Missouri Department of Commerce & Insurance

816-889-2219

Julie.Lederer@insurance.mo.gov

- counts." I'd also be okay deleting the sentence entirely.

See you (virtually) tomorrow. Thanks again.

Julie

From: Rebecca Armon <Rebecca.Armon@tdi.texas.gov>
Sent: Monday, June 8, 2026 1:43 PM
To: Lederer, Julie <Julie.Lederer@insurance.mo.gov>
Subject: Title Insurance Schedule P Instructions suggestions

Hi Julie,

You have done a great job, I just thought of two notes before tomorrow's meeting.

1. Changing the definition of "prior years" in part 1 impacts other sections, I recommend a different change.

"Prior Years" consists of all claims reported by the company from inception of the company forward, with the exception of claims reported in the most recent ten years.[JL1]

- Any change impacts part 2 & 4, which say: *The definition of "prior years" should be the same as that used by the company in Part 1.*
- Part 1 shows 10 years where part 2 & 4 show 20 years. So maybe some non-numerical way to say excluding those years show on exhibits

- "*Prior Years" consists of all claims reported by the company from inception of the company forward, that are not presented elsewhere on the exhibit*.

2. Also, the first sentence of Schedule P – Part 1, could it just be deleted from the instructions?

Part 1 – Summary provides a 10-year summary of loss and ALAE experience for the company.

- You corrected by changing ALAE to loss adjustment expenses.
- That sentence may be helpful on part 2, 3, etc. but It is not fully descriptive of part 1, which also has premiums, claims counts, ratios, etc.
- Also saying 10 years when there are cumulative amounts on the "prior" rows seems a little confusing

Rebecca Armon, FCAS, MAAA (She/Her)

Property & Casualty Actuary

Financial Regulation Division – Actuarial

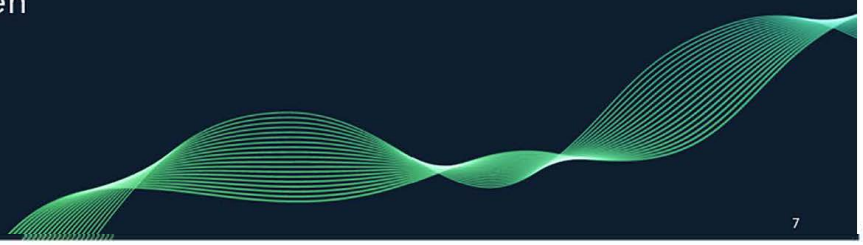
Texas Department of Insurance

512-676-6820

4. Discuss Comments Received on the Draft Homeowners Regulation White Paper

Attachment Eleven

Julie Lederer (MO)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Nevada DOI Comments on the NAIC Draft White Paper on Home Insurance Rate Regulation

August 5, 2026

Thank you for the opportunity to comment on the NAIC's draft white paper addressing home insurance rate regulation and the question of potential cross-state subsidization. I appreciate the significant effort invested in assembling the draft paper's overview of regulatory frameworks, actuarial standards, catastrophe modeling, and market dynamics. However, after reviewing the draft in detail, I offer the following substantive critiques and recommendations aimed at strengthening the paper's analytical rigor, empirical grounding, and clarity.

1. The Paper Frequently Assumes Its Central Conclusion Without Empirical Support.
Throughout the draft, assertions are made that cross-subsidization "often stems from misunderstanding" or "is not occurring," yet these conclusions are reached *prior* to any systematic, multi-state empirical study. Much of the current argumentation relies on theoretical descriptions of how the regulatory system is *intended* to function rather than how it *does* function in practice. A rigorous paper should not presume its conclusion but instead evaluate evidence for how often insurers ***attempt*** cross-subsidization and how often regulators ***successfully block*** such attempts.

2. Insufficient Attention to the Frequency and Nature of Attempted Cross-Subsidization
Even if regulatory systems constrain cross-subsidization, that does not address how frequently insurers attempt it, especially following well-publicized disasters. The paper repeatedly describes mechanisms intended to prevent cost-shifting but does not acknowledge that insurers may still try to engage in such behavior, sometimes in subtle ways, through actuarial assumptions, model configurations, or expense allocations. Empirical research is needed to assess the frequency with which regulators detect and mitigate such attempts.

3. Overly Restrictive Definition of "Structural Cross-Subsidization"
The paper defines cross-subsidization as requiring both inadequate rates in one state and excessive rates in another. This definition is too narrow and excludes practical, real-world avenues through which cross-subsidization may occur even when all rates are technically adequate. Insurers may seek above-market returns on their national portfolios by targeting certain states for rate increases masked within actuarial assumptions, even if rates are not strictly inadequate elsewhere. The definition should be broadened to include attempts to redistribute losses or build surplus differentially across states.

4. Competitive Market Pressures Are Not Uniformly Effective.
While competition is cited as a counteracting force against excessive pricing, the paper does not sufficiently consider insurers that may *prefer* to limit growth in certain states or follow "market leaders" toward greater rate increases, even when their own data do not justify such increases. Some insurers explicitly seek to raise rates to match competitors rather than compete on price or service. This behavior undermines the notion that market pressures always discipline insurer pricing.

5. Credibility Procedures Can Import Catastrophe Experience from Other States.
Credibility weighting is presented as neutral, but it can unintentionally "smuggle" catastrophe

experience from high-risk states into low-risk states—particularly when statewide data are deemed not credible due to low claim volumes. The paper should explicitly address how complements of credibility or countrywide loss trends may embed cross-state catastrophe effects unless safeguards are implemented.

6. Catastrophe Models Can Be Misapplied or Miscalibrated Across States.
The paper presumes that catastrophe models, and especially updated models, necessarily reflect an "improved scientific understanding." This assumption is unwarranted. Models can contain inadvertent biases, rely heavily on data from catastrophe-prone states, or be configured by insurer users in ways that inflate risk in other, less catastrophe-prone jurisdictions. Regulators must scrutinize these models rather than assume that newer equals better. The paper should explicitly acknowledge model uncertainty and the possibility that misapplication may lead to *de facto* cross-subsidization.

7. Reinsurance Cost Allocation Can Be Overly Simplified and Lead to Cross-State Burdens.
Although the paper asserts that reinsurance costs are allocated by risk contribution, in practice many reinsurance treaties cover "all other states" except a few outliers (e.g., California, Florida, New York). This creates potential for simplistic or inaccurate allocation of reinsurance loads, disproportionately burdening lower-risk states. Empirical evidence—not theoretical assertions—is needed to demonstrate that insurers are allocating reinsurance costs appropriately by state.

8. Claims of "No Effect" in Limited Case Studies Are Not Generalizable.
The two case studies cited (Minnesota/Iowa hail, Virginia filings after California wildfires and Hurricanes Harvey/Irma) cover a small number of filings in just a handful of states, and only for disaster events in 2017–2018. They do not meaningfully represent "industry-level evidence." A more relevant analysis would examine insurer rate proposals *in all states* following major disasters such as the 2025 Los Angeles wildfires. Broader, multi-year, multi-insurer studies are necessary to substantiate the paper's conclusions.

9. Greater Emphasis Is Needed on Real-World Regulatory Constraints.
The paper asserts that cross-state subsidization "would not survive regulatory scrutiny." A more realistic statement is that it *should not* survive scrutiny. Regulators in some states lack full prior-approval authority, may face resource constraints, or may experience political pressure. These vulnerabilities should be acknowledged. Market-conduct oversight or competition also only discipline insurers that care about retaining business in a given state in the first place.

10. The Paper Should Highlight Regulators' Protective Work Rather Than Presume No Problem Exists.
A more constructive approach would be to document the specific ways regulators have prevented excessive or unfairly discriminatory rate increases—rather than assuming cross-subsidization does not occur. Demonstrating how regulators protect consumers, including examples where they have moderated excessive proposals, would confer credibility and practical value to the paper.

11. "Homeowners Insurance" Is Not a Grammatically Correct Term and Should Be Replaced.
Potential grammatically correct replacements would be "Homeowners' Insurance", "Homeowner

Insurance", or "Home Insurance". The term "Homeowners Insurance" is both grammatically incorrect (plural possessive nouns need to end with an apostrophe) and also incorrect in substance (as, without the apostrophe at the end, the implication is that homeowners are the peril being insured against, rather than the policyholders and beneficiaries of the insurance).

I use "home insurance" in place of "homeowners insurance" in my markup. The reasons why I prefer this term among the three are that **(i)** its use could bypass the differences between the NAIC publication conventions and long-established English grammar in regard to the use of the apostrophe; and **(ii)** not all products to which this paper is relevant provide insurance to *owners*. For instance, tenants' or renters' insurance could also potentially be subject to cross-subsidization concerns in certain parts of certain states.

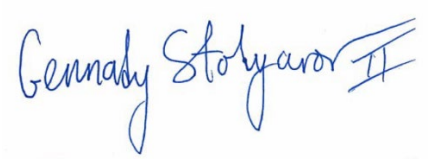
Conclusion

The NAIC draft would be significantly strengthened by incorporating empirical research, expanding the definition of cross-subsidization to reflect some actual observed insurer behavior of concern, acknowledging the vulnerabilities present in catastrophe modeling and credibility-weighting approaches, and more fully recognizing regulatory constraints that may permit attempted cross-subsidization to surface.

The purpose of rate regulation is to ensure that rates are not excessive, inadequate, or unfairly discriminatory. Achieving this requires vigilance—not assumptions—regarding how "additional information" and actuarial flexibility can be used in ways that unintentionally or deliberately shift costs across states. A more empirical and less presumptive treatment of these issues will offer greater value to regulators, policymakers, and consumers.

I appreciate the opportunity to contribute these comments and welcome further discussion on how the paper might evolve to address these concerns.

Respectfully submitted,



Mr. Gennady Stolyarov II, FSA, ACAS, MAAA, CPCU, ARe, ARC, API, AIS, AIE, AIAF
Lead Actuary, Property and Casualty Insurance
Nevada Division of Insurance

6/26/2026

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

U.S. Homeowners Insurance Rate Regulation–A Regulatory Perspective

Regulation, Consumer Protection, and Market Dynamics in the Modern Era

Casualty Actuarial and Statistical (C) Task Force

2026

Executive Summary

Imagine a hypothetical where a multi-state insurer tries to charge more premium to homeowners in a state with lower risk of natural disasters to make up for heavy losses in a state with higher risk. This paper addresses this scenario, commonly referred to as "cross-subsidization" and concludes that, under the state-based system of insurance regulation, home insurance rates are designed and reviewed to reflect the expected future cost of risk in the state where the policy is written, not to shift costs from one state's policyholders to another's.

State insurance regulators protect consumers by requiring insurers to justify rates with state-specific data and actuarial analysis. Although the regulatory framework varies by state, insurance rates are generally subject to standards requiring that they not be excessive, inadequate, or unfairly discriminatory. Actuaries evaluate data, assumptions, and methods used to estimate future losses, including inflation, catastrophe risk, and reinsurance costs to ensure alignment with actuarial standards. Regulators also oversee how insurers classify risk, ensuring that differences in price are tied to real differences in risk and are not arbitrary or unfair.

Under existing regulatory frameworks in the United States, cross-subsidization is constrained by laws, actuarial standards, and markets.

So how would those legal, actuarial, and market challenges play out in the real world for our hypothetical multi-state insurer attempting cross subsidization?

Commented [GS1]: This should be "Homeowners' Insurance", "Homeowner Insurance", or "Home Insurance". The term "Homeowners Insurance" is both grammatically incorrect (plural possessive nouns need to end with an apostrophe) and also incorrect in substance (without the apostrophe at the end, the implication is that homeowners are the peril being insured against, rather than the policyholders and beneficiaries of the insurance).

I will use "home insurance" in place of "homeowners insurance" in my markup. The reasons why I prefer this term among the three are that (i) its use could bypass the differences between the NAIC publication conventions and long-established English grammar in regard to the use of the apostrophe, and (ii) not all products to which this paper is relevant provide insurance to owners. For instance, tenants' or renters' insurance could also potentially be subject to cross-subsidization concerns in certain parts of certain states.

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Commented [GS2]: Whether cross-subsidization is constrained by these influences (and good arguments can be made that it indeed could be) does not address the question of whether such cross-subsidization is *attempted* by insurers on a widespread basis. If certain insurers attempt cross-subsidization after natural disasters but are stopped from fully realizing their plans by a combination of regulatory and market forces, then this is a phenomenon worthy of study, and considering it more explicitly could highlight the value that regulators provide in protecting homeowners and other insureds against excessive premium increases.

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First, insurers must support their home insurance rates with state-specific data and actuarial analysis showing that the rates reflect the expected future cost to cover insured homes in that state.

Regulators review rate filings to identify anything unsupported or inconsistent with the state's actual risk and can challenge the rate, require revisions, or reject the filing altogether. Depending on the state, this process can happen before and/or after the rates go into effect. If an insurer inflates rates to account for losses in another state, it will show up in this review in inflated loss projections, excessive catastrophe loadings, or unsupported expenses.

Regulators look for mismatches between the risk in the state and the costs built into the rate. For example, if an insurer tried to hide cross-state subsidization by charging certain groups more without a risk-based reason, that would likely be deemed excessive or unfairly discriminatory and disallowed.

Second, oversight continues after rates take effect. Follow-up spot checks by regulators to verify insurers are treating their customers fairly and help ensure insurers are actually charging the filed rates, not deviating from what was approved. Even if a rate filing is approved, companies could misapply rating factors, overcharge specific consumers, or use unfiled surcharges. Market conduct exams can catch those real-world deviations and protect consumers by, for example, requiring refunds to consumers, imposing fines or penalties, or requiring changes to rating practices. When a state takes regulatory action against an insurer as a result of a market conduct exam, it notifies regulators in other states where that insurer does business.

Third, competitive market pressures act as a backstop. Insurers that price above the risk of the market *in that state* will lose business to competitors *in that state*, making it difficult to sustain rates that are artificially high.

These safeguards help explain why claims of cross-subsidization often stem from a misunderstanding of how the regulatory system operates. Premiums are forward-looking estimates of future costs, not a way to recover past losses, and differences across states can reflect local risks, timing, data limitations, or broader economic factors like inflation and reinsurance, not cross-state cost shifting. While major disasters *can* affect costs nationwide indirectly by raising rebuilding costs due to higher costs of materials and labor, or reinsurance prices, those are market-wide effects, not insurers shifting losses from one state to another.

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Commented [GS3]: This is quite correct. I think that one intent of many of the authors of this paper is to highlight the ways in which effective rate regulation can serve as a safeguard against cross-subsidization, and indeed I would agree that it does. However, observing that this is the case does not speak to concerns that could arise based on (i) how frequently cross-subsidization may be initially *attempted* by some insurers; and (ii) how frequently a degree of cross-subsidization may be implemented by insurers *despite* the best efforts by regulators to prevent it (for instance, due to insufficient resources, insufficient statutory authority to disapprove rates, political pressure, and/or concealed assumptions that could subtly lead to cross-subsidization without being readily discernible at first glance). Both of the above are empirical questions and should be studied instead of the assumption being made that the current regulatory system will always prevent such scenarios from even being possible.

Commented [GS4]: These competitive market pressures are also real. However, their efficacy depends on whether an insurer *cares* about retaining or gaining business in a particular state in the first place. I have encountered a surprising number of instances in which highly profitable insurers with rates below those of their competitors expressed worries about growing "too quickly" and instead stated a preference for raising their rates to match those of competitors. Unfortunately, instead of seeking to compare favorably to their competitors through a combination of lower prices and superior service, some insurers will seek to match the more restrictive, less consumer-friendly changes that their competitors may have implemented. At times, this may be due to the mindset of, "Our competitors are market leaders. What unfavorable ...

Commented [GS5]: The conclusion that such claims "often stem from a misunderstanding" seems to antecede any empirical study of the subject and not be based on any systematic analysis of whether any cross-subsidization is occurring or where. It seems that, in putting forth such an assertion, this paper is ...

Commented [GS6]: This is true, but many insurers may be tempted to see future premiums as a way to offset extreme catastrophe losses from the recent past and thus soften those losses' bottom-line impacts. Whether or not this is theoretically the role that premiums are supposed to serve, the incentive to use ...

Commented [GS7]: Higher reinsurance prices could redistribute the impact of catastrophe losses from one state to another if the same reinsurance treaty covers both more catastrophe-prone states and less catastrophe-prone states, but the less catastrophe-prone states are charged reinsurance loads that are ...

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In short, the regulatory system is designed so that if an insurer tried to make one state pay for another, multiple layers of regulatory review would catch it.

Overall, this paper concludes that state-based rate regulation is a holistic core consumer protection system; it ties rates to risk, subjects them to rigorous review, and helps ensure insurance remains both available and financially sound.

Commented [GS8]: It is designed in that way, but how often does that design hold up in practice? This is where empirical data are needed.

Commented [GS9]: I agree with this conclusion. It would be more effectively demonstrated if concerns about cross-subsidization were not defined away, but rather evidence were presented about how the good work that regulators do has saved consumers large amounts of money relative to some insurers' attempted excessive rate increases for home insurance.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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6/26/2026

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Introduction

Regulators have been asked by legislators, researchers, media, and consumer advocates whether home insurance policyholders in relatively low-risk states are financially subsidizing policyholders in states with high catastrophe exposure. The question is whether insurers spread catastrophic losses across their entire book of business, causing premiums in less disaster-prone states to rise to offset losses sustained in states with recent natural catastrophes.

At the 2026 Spring National Meeting, the NAIC Property and Casualty Insurance (C) Committee adopted the following charge for the Casualty Actuarial and Statistical (C) Task Force:

> ***Draft a white paper that explains how homeowners' insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses.***

I. What Is Home Insurance Rate Regulation?

Home insurance rate regulation is the framework through which insurance regulators oversee the rates charged for home insurance. It governs the filing and review of proposed rates, the actuarial support insurers must provide, the timing of rate implementation, and the regulator's assessment of whether rates are legal and not excessive, not inadequate, and not unfairly discriminatory. Although many insurers operate across multiple states, home insurance rates are regulated on a state-specific basis.

This section first describes the legal foundations of state-based insurance regulation, explains the core rate regulatory standards, and describes how market forces also impact home insurance rates.

A. State Rating Statutes and Market Regulation

Insurance regulation in the United States is conducted at the state level rather than the federal level. This decentralized structure traces its legal origin to the Supreme Court's 1944 decision in United States v. South-Eastern Underwriters Association, which held that insurance transactions crossing state lines constituted interstate commerce subject to federal regulation. Congress responded with the McCarran-Ferguson Act of 1945, which explicitly preserved the primacy of

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state regulation by providing that the continued regulation and taxation of the business of insurance by the several states is in the public interest, and that no act of Congress shall invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance.

Within each state, the legislature delegates primary regulatory authority over insurance to the Insurance Commissioner, Superintendent, or Director (collectively, the "commissioner"). That official, whether appointed by the governor or elected by the public, exercises broad authority over market entry and behavior, financial solvency, policy forms, and rates.

The cornerstone of rate regulation in nearly every American jurisdiction is a three-part standard derived from the All-Industry Bills and later the *NAIC Model Rating Law*, which is adopted, with variations, across most states. Under this standard, insurance rates must be: (1) not excessive, meaning they do not result in unreasonably high profits or financial gains to the insurer; (2) not inadequate, meaning they are sufficient to cover expected losses and expenses and maintain insurer solvency; and (3) not unfairly discriminatory, meaning they do not differentiate among similarly situated risks without actuarial or otherwise justifiable basis.[1]

Each state legislature also defines the rate regulatory filing frameworks which reflect different calibrations of regulatory oversight of the rate filing process itself. These are broadly categorized as prior approval, modified prior approval, flex rating, file and use, use and file, and no file. See "Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title"[2] for definitions. This filing framework varies by lines of business within the state. Included in the architecture of rate regulation are the filing requirements, support of rates (actuarial justification), and review authority.

Rate regulation, as conventionally understood, involves the review of prospective rates that insurers propose to charge. Market conduct regulation addresses a different but complementary set of concerns: whether insurers are, in practice, treating consumers fairly in their claims handling, underwriting, marketing, and billing practices. Market conduct regulation ensures that consumers are being charged premiums in accordance with filed rates and, in coordination or

[1] See state laws for definitions that apply in each state. For example, some state insurance laws do not allow risk classification based upon race, religion, etc.
[2] https://content.naic.org/sites/default/files/model-law-chart-pa-10-rate-filing-methods-for-property-casualty-insurance-workers-comp-title.pdf

Commented [GS10]: The footnote states that "some" state insurance laws do not allow risk classification based upon race, religion, etc. I think the number of states that prohibit such discrimination is greater than "some". In fact, I am not aware of any state that does not prohibit such unfair discrimination. I would recommend replacing "some" with "essentially all" or similar wording.

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consultation with actuaries, may assess whether rates are excessive, inadequate, or unfairly discriminatory.

Home insurance rate regulation is a customizable framework for evaluating whether the rates charged to consumers are justified, sustainable, and fair. That framework matters because home insurance affects not only the private transfer of risk, but also household financial security, mortgage lending, and the stability of insurance markets. Regulatory oversight of rates, forms, underwriting practices, and market conduct provides a layered system of consumer protection that compensates for the limitations of consumer sophistication and the vulnerability of individual homeowners to market failure.

B. Home Insurance and the Importance of Market Forces

Insurers consider competitive dynamics when they price home insurance. Thus, the market can discipline home insurance pricing. This works best when there are a large number of insurers active in the home insurance markets and consumers shop around for insurance. Competitive market dynamics are meaningful, but do not always work efficiently because home insurance policies are complex, making comparison between companies difficult, and there are market disruptions such as when there is withdrawal of coverage in high-risk markets, insolvencies following catastrophic events, and persistent availability and affordability problems in coastal and wildfire-exposed regions. There may also be other issues such as areas with vacant properties and high crime rates. Thus, regulatory engagement is a complement to competitive markets in affecting rates for the consumers' benefit.

Competition remains an important discipline on prices, but home insurance presents conditions in which market forces alone may not fully protect consumers, preserve availability, or ensure that rates remain adequate and fair. The next question is how that balance is implemented in practice: how insurers develop home insurance rates, how those rates are supported actuarially, and how regulators evaluate the data, assumptions, and methods underlying them.

II. How Home Insurance Rates Are Built and Reviewed

This section turns to the mechanics of regulatory oversight. Home insurance rates are not arbitrary charges, nor are they retrospective attempts to recover past losses. They are prospective

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Commented [GS11]: Add an apostrophe after "consumers", as this is also a case of the plural possessive form of the noun being used, as in "homeowners' insurance".

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Commented [GS12]: They are not, but some insurer decision-makers may be tempted to see them that way, especially in the wake of large and well-publicized catastrophe losses in one or more of the loss-prone states.

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estimates of the cost of providing coverage during a future policy period, supported by actuarial analysis and reviewed against applicable regulatory standards. The price paid for a home insurance policy provides the consumer with protection during the policy period, referred to as risk transfer, whether or not the policyholder has a claim. This is not a flaw of insurance pricing; it is the purpose of insurance. Rates are established before the outcome is known and are intended to fund the expected cost of coverage, the expenses of providing that coverage, the cost of capital and reinsurance needed to support the obligation, and a reasonable return for assuming the risk.

This section explains how those estimates are developed, how state-specific and broader data may be used, and how catastrophe risk and reinsurance are incorporated into the analysis.

A. Home Insurance Rating

Home Insurance Rating Overview

Home insurance is a promise to cover uncertain future losses. The ultimate cost of an insurance policy is unknown at the time of sale, which complicates the pricing process[3]. As a result, the price consumers pay, referred to as the premium, is calculated based on the expected risk of loss to the home. The premium is an estimate of the future costs associated with transferring risk over the policy period. To support this estimation, insurers pool the risks of many policyholders, which allows losses to be financed by the premiums collected from many insureds. This results in diversification across risks and produces stable outcomes. The premium is not a mechanism to recoup past losses.[4] Thus, at the end of a policy period, the consumer and the insurer are "even"—the insurer having covered the risk of loss for the policy period and the consumer having paid the premium.

A home insurance premium generally includes provisions for expected losses, loss adjustment expenses, underwriting expenses, and profit and contingencies.

$$Premium = Expected\ Losses + Loss\ Adjustment\ Expenses + UW\ Expenses + Profit\ and\ Contingencies$$

For home insurance, the largest component of the premium is typically the expected losses, also referred to as pure premium or loss cost. This is an estimate of the expected losses over a policy term. Historical loss data is typically used to estimate the expected losses of relatively high-

[3] https://www.casact.org/sites/default/files/old/studynotes_werner_modlin_ratemaking.pdf
[4] https://www.casact.org/sites/default/files/2021-05/Statement-Of-Principles-Ratemaking.pdf

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Commented [GS13]: If the insurance pricing mechanism works as theoretically outlined, that is the case. But what happens if the insurer is systematically earning 20%-30% profits year after year in one state, while earning more typical profits in other states - and *still* seeks to raise rates in the highly profitable state? At what point can it be said that a departure from the theoretically intended functioning of the pricing mechanism has occurred? I emphasize that this is an empirical question and cannot simply be assumed away by explaining how the pricing mechanism is *intended* to work. The question before us is whether it *does* work that way, and whether significant attempts have been made to get it to "work" differently.

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frequency perils, such as fire or water damage. For lower-frequency but higher-severity events, such as hurricanes, wildfires, and earthquakes, insurers may rely on catastrophe models, as discussed in the catastrophe pricing in Section II. The premium is expected to cover future losses; thus, adjustments are made to the historical data to ensure it is predictive of future costs. Trending, the process of adjusting historical data to reflect expected future conditions, is one of the principal tools used in that process. Actuarial Standard of Practice 13[5] (ASOP No. 13), which is part of a comprehensive set of standards promulgated by the Actuarial Standards Board to govern ratemaking analysis, addresses trending procedures in property/casualty (P/C) insurance and states that actuaries can consider historical insurance and non-insurance data when estimating future expected values. In home insurance, that is especially important because the cost to repair or rebuild a home may change materially between the historical experience period and the future period for which the filed rates are intended to apply. In addition to trending, actuaries adjust historical data for development (the maturation of claims over time) and on-level factors (the conversion of historical premiums to current rate levels).

Insurers also typically refine premiums based on characteristics of the home and the policyholder that are associated with differences in loss experience. These characteristics, known as rating factors, may include such things as the home's construction type, credit-based insurance score, age, geographical location, and roof type. For example, houses with clay tile roofs tend to be more fire-resistant than houses with architectural shingle roofs, and thus usually receive lower premiums if all other characteristics are the same. All of these factors need to be supported by analysis showing differences in expected loss experience. In addition to expected losses, the premium should also cover the cost of adjusting claims and the expenses associated with issuing, servicing, and administering the policy. Additionally, the premium includes a provision for profit and contingencies, which reflects the need to support the business amid uncertainty. The level of that provision may be influenced by expected after-tax investment income and the return required on the capital supporting the insurer's operations.

Home Insurance Rating Influences

Although the general actuarial methodology used to determine home insurance premiums is consistent across lines and jurisdictions, home insurance ratemaking is fundamentally state-

[5] https://www.actuarialstandardsboard.org/asops/trending-procedures-propertycasualty-insurance-2/, Effective Date: Nov. 1, 2009.

Commented [GS14]: But then the question arises as to whether the catastrophe models are accurate and relevant to the jurisdiction where they are being used to set the rates, or whether there is some implicit cross-subsidization through assumptions or misapplications of the catastrophe model(s).

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Commented [GS15]: What happens if an insurer's actual realized underwriting profit exceeds its own target profit and contingencies provision within its indication for many years consistently and by a wide margin? I would recommend that this paper develop a benchmark - at least for analytical purposes - as to when such an observed phenomenon (when paired with a proposed rate increase by the insurer) could be considered evidence of an excessive rate level for that insurer in the jurisdiction in question.

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based. Expected losses are usually derived from expected state experience and from the conditions affecting insured risks in that state, such as local peril exposure, geographic concentration of risk, construction characteristics, legal environment, and claims settlement patterns. However, this does not mean that every input to a home insurance filing is derived from purely local data or is unaffected by broader market conditions. Some influences on the indicated rate level can extend beyond a single state, even where the filing itself remains state-specific. One example is repair-and-rebuild cost inflation. Home insurance claim severity is directly affected by the cost of labor, construction materials, transportation, and related rebuilding inputs, some of which can be affected by regional, national, and even worldwide conditions.

Another broader influence is reinsurance. Reinsurance is part of the mechanism through which insurers manage the impact of catastrophe on their enterprise solvency and, consequently, their ability to pay claims. Changes in reinsurance conditions can affect the cost structure underlying home insurance filings.

Broader inputs may also arise for other components of a home insurance rate indication. For example, underwriting expense provisions are often supported by company or countrywide analyses rather than a single state's experience alone. Likewise, where company-specific state data is limited, actuaries may supplement that experience with industry data and apply credibility-weighting, a technique that blends limited state data with broader experience to produce more reliable estimates of future loss and projected loss trends.

Given that insurance companies derive their profits from both underwriting and investment income, capital market conditions can also affect home insurance ratemaking. When anticipated investment income is projected to be high, companies often need lower future underwriting profits and vice versa. Higher expected after-tax investment returns can lead to the need for a lower profit provision in the ratemaking process, and ultimately lower rates.

In summary, home insurance rates are derived based on the expected future cost of losses and expenses associated with the insured risks in the state being rated, including catastrophe exposure where applicable. However, some inputs relevant to a state filing may be influenced by broader economic and insurance-market conditions, including rebuilding-cost inflation, reinsurance conditions, capital market expectations, nationwide expense analyses, and updates to catastrophe models. Regulators reviewing rate filings are expected to examine each element of the ratemaking analysis: the adequacy of the historical period; the credibility procedures used

Commented [GS16]: Add a hyphen, as "state-based" is a compound modifier.

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Commented [GS17]: Add a hyphen, as "state-specific" is a compound modifier.

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Commented [GS18]: The issue here arises when changes to the cost of reinsurance due to natural disasters in some states lead to higher reinsurance loads in the rate indications in other states that did not experience those natural disasters.

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Commented [GS19]: If some of these expenses are the result of the insurer responding to a large natural disaster in one state, they should not be allocated to other states. If they are allocated to other states, either explicitly or inadvertently (because the insurer does not distinguish in its expense loads between more and less catastrophe-prone states), this could create a potential for cross-subsidization.

Commented [GS20]: Both the use of industry data and credibility-weighting could lead to catastrophe data from other states being smuggled into a given state's rate indication, unless specific safeguards are implemented to intentionally exclude catastrophe experience from other states from any complement of credibility or industry data set.

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Commented [GS21]: The question is whether the "broader economic and insurance-market conditions" are uniformly operating in all states, or whether, by insurers merely considering them to be "broader", some states that experience those conditions to a lesser extent might be disproportionately burdened if those conditions are presupposed to apply to those states in a simplistic way.

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to blend the insurer's state-specific experience with other data or experience; the appropriateness of the assumptions used to bridge from broader datasets to the specific risks of the state in question; the reasonableness of development factors; the appropriateness of trend selection (particularly in a period of rapidly changing loss cost environments); the justification for expense loads; the support for the profit provision; and more. A filing that relies exclusively on nationwide data without any state-specific adjustments, or that applies implausible adjustment factors, raises legitimate regulatory concerns regardless of the ultimate rate level requested. States vary in the depth and formality of this review, but the actuarial framework provides a common language for insurer submissions and for regulatory responses. Two of these influences, catastrophe risk and reinsurance, warrant closer examination because of their significance to home insurance ratemaking and their relevance regarding cost distributions across states.

B. Catastrophe Pricing and Reinsurance Implications in Home Insurance Rating

Catastrophe Risk and Pricing

Catastrophe risk is one of the most important and most challenging components of home insurance ratemaking. Catastrophe risk fits within that same prospective pricing framework described in the home insurance rating section but requires unique treatment because catastrophe losses are materially different from the types of losses that occur regularly and independently from house to house. A kitchen fire, theft, non-weather water loss, or isolated liability claim may affect one policyholder at a time. A hurricane, wildfire, earthquake, tornado outbreak, hailstorm, or other severe weather event can affect thousands of policyholders at once. That potential for concentrated losses creates pricing, capital, solvency, and reinsurance considerations that are not fully captured by traditional pricing techniques.

Because catastrophe losses are low-frequency, high-severity, and spatially correlated, traditional pricing techniques are generally not appropriate for these perils. A state may not experience any major hurricane, earthquake, or wildfire losses during a five, 10, or even 20-year historical experience period, even though the risk of such an event remains material. Conversely, a state may experience one or more unusually severe events, which could dominate a recent experience period and drive rates up, even to the point of being excessive compared to the long-run expected

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Commented [GS22]: This may sometimes be true, but it does not follow from this that any departure by an insurer from traditional pricing techniques is necessarily and automatically reasonable. Many such departures, including incorrect applications of catastrophe models, may result in cross-subsidization if they result in either inflated assumptions pertaining to catastrophe risk in one state or an incorrect configuration by an insurer of the parameters of a model that may be reasonable qua model but is misapplied in this way.

Commented [GS23]: There does, nonetheless, need to be some feedback from empirical experience. One could assert, with some validity, that just because no one has been mauled by a tiger (a large CAT) in a small town in North America in X years, does not mean that it will not happen someday (e.g., a traveling circus might pass through town, and its vehicle transporting animals might take a spill and release such a tiger). However, if for many years or decades no tiger-mauling incidents occur, this would be a justification for revisiting one's priors and re-evaluating the anticipated risk of such losses happening.

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cost for this risk. ASOP No. 39[6] recognizes that catastrophe losses can cause extreme volatility in historical insurance data and generally require separate treatment in ratemaking. This ASOP defines a catastrophe as a relatively infrequent event or phenomenon that produces unusually large aggregate losses, and catastrophe ratemaking procedures as procedures that adjust for catastrophe losses in experience data and determine a provision for catastrophe losses and loss adjustment expenses.

For this reason, catastrophe risk is often evaluated separately from non-catastrophe home insurance losses. Non-catastrophe losses may be estimated using several years of historical claim experience, adjusted for trend, coverage changes, claim settlement practices, inflation, and other changes in conditions as described in the prior section. For catastrophe losses, while historical data remain relevant, they may be incomplete or insufficient because the historical period may not include the full range of possible events, nor the current exposure based on building characteristics, location of the properties, and environmental conditions. Catastrophe models are commonly used to address this problem.

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A catastrophe model is a computerized process that simulates many scientifically plausible catastrophic events and estimates their financial impact on a portfolio of insured properties. The catastrophe provision included in the overall indicated rate level in a home insurance rate filing is typically based on the long-term expected annual cost generated by a catastrophe model. Other rate components, such as retained risk or reinsurance provisions, are also often based at least in part on catastrophe models. Because catastrophe models are complex and rely on specialized scientific and engineering assumptions, their use in ratemaking requires judgment and review. A filing that is based at least in part on catastrophe model output should explain which model or models were used, what exposure data were input, how policy terms were reflected, whether secondary perils (e.g., storm surge, wildfire smoke), demand surge, loss adjustment expense, or secondary uncertainty were included, how any model alternative features were selected, or how the model results were adjusted. When using catastrophe models in ratemaking, actuaries should also refer to ASOP No. 38[7], which applies to actuaries selecting, using, reviewing, or evaluating catastrophe models, including models for perils such as hurricanes, earthquakes, severe

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[6] https://www.actuarialstandardsboard.org/asops/treatment-catastrophe-losses-propertycasualty-insurance-ratemaking/, Effective Date: Dec. 15, 2000.
[7] https://www.actuarialstandardsboard.org/asops/actuarial-standard-of-practice-no-38-revised-edition/, Effective Date: December 1, 2021.

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convective storms (SCS), terrorist acts, and pandemics. Regulators may also review the vendor model documentation and validation of the model by the insurer, as well as any rating factors, surcharges, and discounts that may have been informed or priced using catastrophe model output.

The use of catastrophe modeling is consistent with the broader actuarial principle that rates should reflect expected future costs. ASOP No. 53[8] states that actuaries estimating future costs should select appropriate methods or models, use reasonable assumptions, consider adjustments for changes in conditions, and consider the treatment of catastrophes and reinsurance when those items are reflected in future cost estimates. For example, a home with materially greater wildfire, hurricane, earthquake, or SCS exposure is expected to incur greater losses than an otherwise similar home with lower exposure. Cost-based rating attempts to reflect these differences through territory, construction, deductible, coverage, and mitigation discounts.

Commented [GS24]: Instead of "is consistent", I would recommend stating "may be consistent" - since the specific use and the nature of the assumptions behind it will determine whether the "broader actuarial principle" is satisfied.

This risk differentiation is also tied to the regulatory standard that rates should not be excessive, inadequate, or unfairly discriminatory. In actuarial terms, unfair discrimination does not mean that all policyholders pay the same rate. Rather, it generally concerns whether differences in premiums bear a relationship to differences in expected losses and expenses. For catastrophe risk, rating factors such as location, roof characteristics, construction type, or mitigation are often appropriate when supported by data, catastrophe modeling, or other credible evidence showing differences in expected costs.

Cost of Reinsurance

Reinsurance is closely related to catastrophe pricing because catastrophe risk can threaten an insurer's surplus, profitability, and solvency. Reinsurance is insurance purchased by an insurer to transfer part of its risk to a reinsurer. In home insurance, catastrophe reinsurance often protects against severe aggregate losses from hurricanes, wildfires, earthquakes, severe convective storms, or other large events.

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The cost of reinsurance is therefore a legitimate component of the cost of providing home insurance. However, reinsurance costs must be allocated carefully. Many insurers purchase reinsurance at a portfolio level rather than separately for each state. A single catastrophe

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[8] https://www.actuarialstandardsboard.org/asops/estimating-future-costs-prospective-propertycasualty-risk-transfer-risk-retention/, Effective Date: August 1, 2018.

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reinsurance program may cover home insurance exposures in multiple states and may respond to losses from multiple perils. That does not mean the cost should be spread evenly across all policyholders or all states. The actuarially sound approach is to allocate the cost in a manner that reflects the expected benefit and risk contribution of the business being rated. Relevant measures may include modeled catastrophe losses, expected reinsurance recoveries, contribution to reinsured layers, exposure distribution, premium, coverage, peril, and other risk characteristics.

Because the cost of reinsurance ultimately flows into home insurance rating, fluctuations in the cost of reinsurance can cause home insurance rates to change, particularly in catastrophe-exposed markets. The reinsurance market is global, with many reinsurers operating internationally to provide coverage for multiple insurers and risks. Reinsurance protection is not unlimited; the market generally has limited capacity for taking on risk before reinsurance may become unavailable or unaffordable. Recent loss experience on a global scale can impact reinsurer profitability and short-term capacity. As such, seemingly unrelated catastrophe events can affect US home insurance rates. For example, if a major typhoon were to impact Japan, reinsurers would likely pay out on reinsurance contracts and potentially would have lower capacity in the following years to take on additional risk, even in the U.S. This constrained reinsurance market can drive general reinsurance costs upward, causing U.S. insurers to pay more for their reinsurance, and thus pass these higher costs on to their policyholders.

Reinsurance also interacts with the profit and contingency provision and the cost of capital. Catastrophe-exposed home insurance requires capital because actual losses can deviate substantially from expected losses. Reinsurance can provide an insurer with some relief from required capital by transferring tail risk, but it has a cost. Conversely, retaining more catastrophe risk may reduce reinsurance premium but increase required capital and earnings volatility. A rate indication should avoid double-counting by treating modeled losses, reinsurance recoveries, reinsurance premiums, retained risk, and profit or cost-of-capital provisions consistently. ASOP No. 53 specifically states that when reinsurance is reflected in future cost estimates, the actuary should select appropriate methods or models and reasonable assumptions for estimating the cost associated with expected reinsurance arrangements.

In summary, catastrophe pricing in home insurance applies the same prospective ratemaking framework used for other home insurance costs, but with additional tools and considerations. Catastrophe models help estimate losses that are too infrequent, severe, and correlated to be

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Commented [GS25]: The issue is that many reinsurance contracts do not actually seem to do the latter and may instead cover the ceding insurer's risk exposures in all states but a few highly distinctive ones (e.g., New York, Florida, and California). If a state is not among those, then it would be covered under a reinsurance treaty pertaining to "all other" states, and some reinsurers have asserted that it would be *more* expensive for them to separate coverage out by state and contemplate state-specific terms, even for lower-catastrophe-risk states. Thus, for such a treaty, if the insurer attempted to allocate catastrophe risk by state, artificial (and potentially simplistic or inaccurate) allocation assumptions would need to be made, again creating the potential for cross-subsidization.

Commented [GS26]: Allocating reinsurance costs based on modeled catastrophe losses may be problematic if the catastrophe model either inflates the risk of loss for a less catastrophe-prone state or if its settings are misconfigured by the insurer to produce such an impression.

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Commented [GS27]: If this can happen due to a major typhoon in Japan, it could surely happen due to a major disaster - whether a large wildfire, a hurricane, or a series of tornadoes - in the United States. If policyholders in states that did not experience those disasters (and where the geographical and climate features are not prone to those disasters) end up paying higher premiums because of them, this would *be prima facie* cross-subsidization in my view.

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measured reliably using only recent historical experience. Reinsurance helps insurers manage the volatility and capital strain created by those losses, and its cost is an appropriate part of home insurance premiums when it is actuarially supported and allocated in relation to risk and expected benefit. Together, catastrophe modeling, risk classification, reinsurance allocation, and capital provisions support the central ratemaking objective: premiums should reasonably reflect the expected future cost of the risk being transferred during the policy period.

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Commented [GS28]: This statement assumes that "the expected future cost of the risk being transferred" is accurately reflected *within the jurisdiction in question* - yet the very vulnerability of the above approaches, which this statement assumes away, is that they could indeed be used to allocate losses from one jurisdiction to another if they are improperly configured or applied - and the end result would be the same as overt cross-subsidization: policyholders in some states would be paying higher premiums because of catastrophe losses that occurred in other states.

III. What is Cross-Subsidization?

A. Defining Cross-Subsidization

It is important for researchers and others to define cross-subsidization. At the May 12, 2026, meeting of the Casualty Actuarial and Statistical (C) Task Force, Mike Goldman (Perr & Knight) identified three distinct claims of cross-subsidization. The first was residual markets, such as the Fair Access to Insurance Requirements (FAIR) plan and the Texas Windstorm Insurance Association, where costs are spread within the same state. The second was cross-state subsidization within national carrier portfolios. The third was a federal cross-subsidization through the National Flood Insurance Program (NFIP) and disaster aid, which can be analyzed with NFIP subsidies. This paper is only focused on the second type.

In theory, cross-state subsidization could be structural and systemic across the market or could be focused on an individual company's actions. For purposes of this white paper, the question is whether there is systemic cross-subsidization between states. Structural cross-subsidization between states can be described as follows:

> Policyholders in one state systematically pay rates that are inadequate for their own expected costs while policyholders in another state pay more than their expected costs to offset it.

Commented [GS29]: This definition is highly problematic and assumes away the problem that this paper should be analyzing. The existence of cross-subsidization should not require inadequate rates in any jurisdiction (and I highly doubt that home insurance rates are inadequate in any state, as strong incentives exist for the majority of insurers - especially large, multi-state insurers - to avoid inadequate rates). Rather, if rates are at least adequate in all jurisdictions, but an insurer wishes to earn above-market returns on its countrywide portfolio, the insurer could consider in which jurisdictions it would be possible to implement higher rates than actuarially indicated. Of course, attempting to do so explicitly or announcing such an intention would contravene actuarial standards in the manner that this paper discusses. Therefore, such attempted cross-subsidization, in order to be successful, would need to be masked through ratemaking assumptions (e.g., credibility, trending, catastrophe loads and catastrophe-model applications) that may superficially appear to be relevant to a given state but that in reality smuggle in catastrophe experience from other jurisdictions.

In order for **structural** cross-subsidization between states to occur, two conditions need to be met:

1. **Market-Wide Distortion:**
   Structural cross-subsidization is a market-wide phenomenon. If an individual company determines rates in a way that causes one state to subsidize another, and the subsidization exists only within that company's portfolio, that would likely not be

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considered regulatory cross-subsidization between states (unless the insurer was of significant, material size). *(Note: This is still an issue regulators address; it just doesn't meet the definition of structural cross subsidization.)*

2. **Not-Actuarially-Justified Rates in Both States:**
   If rates in one or both states are determined to be actuarially justified, structural cross-subsidization between states has not occurred. In a market that is structurally cross-subsidized, one or more states would experience inadequate rates while other state(s) would experience excessive rates.

Actuarial work inherently involves professional actuarial judgment, ranges of reasonable outcomes, evolving claims experience, and uncertainty. Sometimes, actuarially justified scenarios may lead to the incorrect perception of cross-subsidization.

B. Mischaracterizations of Cross-Subsidization

There are numerous scenarios commonly mischaracterized as cross-subsidization, including the following:

1. **Differences in Actuarial Assumptions and Methodologies from One State to Another State**
   Actuarially justified rates may reasonably differ state by state based on assumptions, credibility treatments, catastrophe loadings, trend selections, development methodologies, expense allocations, reinsurance strategies, or differing views of emerging risk conditions.

   Rates in one state may reflect more conservative assumptions or greater provision for uncertainty than rates in another state, while both remain actuarially justified.

2. **Rate Filing Timing Differences and Non-Mandatory Rate Filings**
   In many jurisdictions, insurers are not required to submit a rate filing unless they are voluntarily revising rates. A company may choose to absorb year-to-year cost fluctuations rather than regularly adjusting rates. Similarly, a company may delay or sequence filings due to competing priorities and limited resources. These timing differences may create temporary differences between indicated and implemented rate levels across states without constituting structural cross-subsidization.

Commented [GS30]: Again, the criterion that cross-subsidization be market-wide assumes away a lot of the practical problems regarding which regulators must be vigilant. Often it is a single large insurer's countrywide strategy, or a few such large insurers' countrywide strategies, that would lead such an entity or entity to either seek above-market returns or recoup large catastrophe losses incurred in certain jurisdictions. This may also lead to follow-on market distortions if other insurers adopt a "follow-the-leader" mentality and attempt to implement rate increases, despite their own favorable underwriting performance, simply because the "market leaders" are doing this and the smaller insurers fear being adversely selected against.

Commented [GS31]: Again, I strongly disagree with this limitation. Rates may be fully adequate in a state that has had large catastrophe losses - and yet a large insurer which has experienced outsized losses in those states may seek excessive (more-than-actuarially-justified) rate increases in other states, where the insurer may perceive those increases to be more easily attainable.

Commented [GS32]: If there is systematic bias in how actuarial judgment is being applied within potentially individually reasonable ranges of results, depending on the jurisdiction, that may also lead to cross-subsidization in practice.

For instance, if in State X an insurer wishes to maintain a large market share and always prices using the low ends of the reasonable ranges of assumptions, but in State Y (where the insurer might not be as concerned about retaining market share) the insurer always prices using the high ends of the reasonable ranges of assumptions, this means that on a systematic basis over time, rates in State Y will be significantly higher than in State X relative to the risk of loss.

Commented [GS33]: Again, if in one state an insurer always uses more "conservative" assumptions, this raises the concern that the insurer is either intentionally trying to redistribute premium from one state to another, or the insurer thinks that the policyholders in the latter state will tolerate higher premiums relative to their risk of loss, or the insurer does not care about losing business in a less catastrophe-prone state with more favorable loss experience.

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3. Mix of Business Considerations

Differences in rate change decisions across states may also reflect varying growth dynamics within an insurer's portfolio, rather than structural cross-subsidization between states.

When a book of business is experiencing rapid growth, insurers may elect to utilize more conservative pricing assumptions to account for uncertainty associated with changing policyholder composition.

Conversely, a shrinking or more stable book of business may support less conservative assumptions where the insurer believes the underlying risk profile is better understood or more predictable.

As new business enters or existing policyholders exit, the distribution of risks, geographic concentrations, coverage selections, or underwriting characteristics may shift in ways that reduce the predictive value of historical experience.

4. Regulator Disapproval of Rate Filings

Regulatory actuaries are tasked with reviewing a rate indication based on information provided in the rate filing to determine whether it complies with actuarial, legal, and regulatory standards.

Rate regulation is prospective in nature and evaluates whether the proposed rates are adequately supported under the applicable statutory framework and reasonably reflect the underlying risk.

Importantly, regulatory disagreement does not necessarily indicate that an insurer's proposed rates represent a significant departure from accepted actuarial practice. Reasonable actuarial and regulatory differences may arise even when all parties are operating within accepted actuarial and legal frameworks. Different actuaries may reasonably select different assumptions related to trend, credibility, expense provisions, catastrophe and reinsurance provisions, profit provisions or other relevant assumptions. Additionally, regulatory actuaries are highly familiar with the statutory requirements, market considerations, public policy objectives, approved actuarial methodologies, and other constraints unique to their jurisdiction.

Commented [GS34]: Even if assumptions with a rate filing are within some broadly reasonable actuarial range, this does not mean that those assumptions are appropriate for the state in question, and it is ultimately the regulator's responsibility to evaluate this and arrive at a decision consistent with applicable laws.

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In many cases, a regulator's concern may relate to the sufficiency of supporting data, the reasonableness of selected assumptions, the applicability of a methodology, or compliance with a statutory or procedural requirement unique to the jurisdiction. A filing disapproval may also reflect a determination that additional actuarial support or alternative actuarial treatment is necessary before the proposed rates can be approved.

Examples of situations that could result in filing disapproval without establishing that the proposed rates are not actuarially sound include circumstances where sufficient support was not provided, deadlines for submission of additional information were not met, or statutory and procedural requirements were not satisfied.

Insurance markets perform differently across jurisdictions. A rate that is actuarially sound in one state is often not actuarially sound in another state due to differences in laws, regulations, litigation environments, catastrophe exposure, consumer profiles, risk characteristics, and other market conditions.

The existence of a regulatory disagreement or filing disapproval should not be interpreted as evidence of cross-subsidization between states. Rather, actuarial review is intended to help ensure that rates remain related to risk within the applicable jurisdictional and regulatory framework.

Commented [GS35]: Regulatory disapproval of a single filing may not by itself be an indicator of attempted cross-subsidization. But again, how many instances of proposals that appear to be excessive - especially if they pertain to consistently profitable books of business - and that happen to occur or to spike in the aftermath of highly publicized disasters in other states - would be considered sufficient evidence that cross-subsidization is occurring? This paper seems to be assuming that *no* among of such attempts would ever suffice to establish the existence of cross-subsidization, because of how "structural cross-subsidization" is defined. I favor an empirical approach to this question rather than deciding at the onset that structural cross-subsidization cannot occur by definition no matter how many filings regulators disapprove or moderate the impacts of.

5. Credibility and Use of Non-State Data as the Complement of Credibility

A common challenge in ratemaking is determining the extent to which an insurer should rely on its own experience as compared to broader external data sources. Actuaries use credibility procedures to determine the appropriate weight to assign to a particular set of insurance data when developing rates. For example, a large insurer with many years of experience in a given state may receive high credibility on its own statewide data, while a smaller insurer or more niche program may rely more heavily on countrywide data or may rely on other benchmarks that are relevant to the product.

Commented [GS36]: If the countrywide data being relied upon does not explicitly exclude catastrophe losses, then this is a way in which losses from other, more catastrophe-prone states could be redistributed to the lower-catastrophe-risk state in question.

ASOP No. 25[9], titled "Credibility Procedures", provides definitions for terms such as credibility, credibility procedure, full credibility, and relevant experience, among other concepts important to actuarial credibility analysis.

[9] https://www.actuarialstandardsboard.org/asops/credibility-procedures/, Effective Date: May 1, 2014.

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Credibility procedures are intended to balance responsiveness to actual experience with the statistical reliability needed to support stable and predictive rate indications. These procedures help reduce volatility and lessen the likelihood that isolated or short-term fluctuations disproportionately affect indicated rates.

When an insurer's statewide experience is not considered fully credible under actuarial credibility procedures, the statewide experience may be weighted together with a complement of credibility, often referred to simply as the "complement". ASOP No. 25 discusses the importance of the complement reflecting relevant experience, including risk characteristics that are reasonably similar to the product being analyzed.

Actuarial literature can be consulted for additional guidance regarding credibility procedures and selection of the appropriate complement.

Because professional judgment is required in determining the appropriate credibility treatment and selection of complement, insurer practices may reasonably differ depending on the circumstances and underlying data. Overreliance on broad averages may obscure meaningful emerging trends, while overreliance on limited experience may produce indications that are less predictive of future costs. Differences among insurers in the application of credibility procedures or selection of complements do not imply that either insurer's rates are not actuarially sound, nor do such differences, by themselves, establish the existence of cross-subsidization.

IV. What State-Based Ratemaking Means for Consumers and Markets—Is there Cross-subsidization?

Section II explained how home insurance rates are developed and reviewed: as prospective estimates of expected loss, expense, catastrophe exposure, reinsurance cost, and other elements associated with the risk being insured. This section applies that ratemaking framework to a recurring question in public discussion: whether catastrophe losses in one state are being shifted into rates charged to policyholders in another. The answer requires distinguishing direct loss shifting from broader market effects. State-based ratemaking does not support the direct allocation of one state's catastrophe losses to another state's policyholders, but catastrophe events may still affect broader inputs such as rebuilding costs, reinsurance pricing, capital costs, and catastrophe model assumptions.

Commented [GS37]: This section does not sufficiently delve into the specific ways in which credibility assumptions could lead to cross-subsidization. For instance, if a given low-catastrophe-loss state's experience is deemed "insufficiently credible" because of a low number of claims, then the favorable claims experience is necessarily under-emphasized. If the complement of credibility is countrywide experience or experience from more catastrophe-prone states with more claims, then catastrophe experience from other states would get applied to the low-catastrophe-loss state through the complement of credibility and the high percentage of credibility assigned to it. This may occur not just in the credibility-weighting of losses, but in the credibility-weighting of loss trends, where trends from other, more catastrophe-prone states, could be given greater weight than the trends from the subject state.

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Commented [GS38]: It is through these "broader inputs" that a similar effect could be achieved to a direct allocation of one state's catastrophe loss experience to another. For example, if a catastrophe model is predominantly trained on losses in a few large, catastrophe-prone states, this could lead to insufficient emphasis being given to distinctive conditions in other states that lower their risk of catastrophe loss in practice. Moreover, if rebuilding costs and reinsurance pricing pertain to losses in other jurisdictions, but would be less directly relevant to what losses would cost in the specific state in question, then building those countrywide phenomena, or broadly averaging them across states, could lead to rates in some states increasing far beyond the expected costs of losses and expenses.

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A. Catastrophe Losses and State-Based Ratemaking

A recurring theme in academic research, media coverage, and consumer advocacy is the concern that home insurance policyholders in relatively low-risk states may be financially subsidizing policyholders in states with high catastrophe exposure. These sources suggest that insurers spread catastrophic losses across their entire book of business, causing premiums in less disaster-prone states to rise to offset losses sustained in states like California, Florida, or Louisiana.

Several academic studies have examined insurer pricing behavior and rate-change patterns across states following major catastrophe events. Media investigations—particularly following the 2017–2018 California wildfire seasons, Hurricane Ian in 2022, and repeated hurricane seasons in Florida—have amplified these concerns, with reporting suggesting that consumers in other states are bearing costs attributable to coastal or wildfire-zone losses. Consumer advocacy organizations have similarly raised concerns that insurers are insufficiently transparent about cost allocations and that policyholders lack the information necessary to evaluate whether their premiums reflect local risk or a national pooling of catastrophic exposure.

These concerns deserve serious engagement. However, several important methodological limitations and industry structural features are frequently overlooked in both academic and media treatments of this issue and understanding them is essential to evaluating the subsidization hypothesis fairly.

B. How Insurers Deploy Capital and Reinsurance

While catastrophe pricing is state-specific, as discussed in Section II, insurers deploy capital and reinsurance on an enterprise-wide basis to ensure claims-paying ability regardless of where a catastrophe occurs. A national insurer writing policies in all 50 states maintains a single pool of surplus capital that supports its obligations everywhere and for every line of business it writes. When a hurricane causes billions in losses in Florida, the same surplus that backs policies in Ohio is drawn upon—if necessary—to pay those claims.

Additionally, capital supports the entire company and not just its homeowners' line of business. Most insurers do not write only homeowners' insurance policies, and those few that do rely very heavily on reinsurance because of the extreme risk associated with a monoline portfolio. Like the way carriers manage their adopted risk from policyholders by diversifying their exposure

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Commented [GS39]: To seriously engage these concerns, systematic studies across multiple states (not just a handful of examples) are needed to evaluate whether, in the aftermath of disasters in some states, *profitable* insurers in other states have attempted to increase rates there with a greater frequency or to a greater extent than they did during times when such disasters did not happen.

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geographically, they also mitigate their risk by writing other types of insurance. Most homeowners' carriers will also sell a wide variety of property and casualty coverages including personal auto and personal umbrella policies. Furthermore, these same carriers may sell a wide portfolio of commercial insurance products including commercial auto and property, plus commercial liability and workers' compensation policies. A carrier's surplus built up by underwriting and investment income associated with all these products is then available to them in the unlikely event of a catastrophic loss.

This enterprise-level capital deployment, however, is not equivalent to Ohio policyholders subsidizing Florida policyholders. The surplus is the insurer's own capital, contributed by shareholders and accumulated from retained earnings. It is the mechanism by which the insurer guarantees its financial promises; it is not a transfer of premium dollars from one state's policyholders to another's.

The reinsurance program layered above the insurer's retained risk functions similarly: reinsurance is purchased at the enterprise level, but its cost is allocated back to individual states based on the catastrophe exposure each state contributes to the reinsurance need. A state with low catastrophe exposure contributes less to the reinsurance cost allocation and, therefore, pays a smaller reinsurance load in its rates.

Different layers of reinsurance protection serve different purposes. Per-risk or per-occurrence excess-of-loss treaties respond to large single-event losses. Aggregate covers respond to the accumulation of smaller losses over a policy period. Catastrophe bonds and other capital market instruments provide additional protection against tail events. The cost of each layer is reflected in state-level rates in proportion to the catastrophe exposure that creates the demand for that layer of protection. A consumer in a low-catastrophe state is not paying for a reinsurance program designed to protect against losses in a high-catastrophe state; they are paying for the portion of the reinsurance program that protects against losses in their own state.

C. What Pooling Does (and Does Not) Mean

Insurance is, by design, a pooling mechanism. A home insurer pools the risks of many policyholders so that the losses of the few are spread across the premiums of the many. This within-state pooling is the core economic function of insurance and is what makes coverage affordable for individual policyholders who could not self-insure against a catastrophic loss.

Commented [GS40]: It is true that surplus accumulated from operations in some states could (legitimately) be used to pay for losses in other states, and that is not in itself evidence of cross-subsidization. However, if insurers were to set aside specified funds dedicated to paying for catastrophe losses in states where policyholders have paid those funds in premiums, then this could go a long way toward assuring the public that premiums that they paid arising from "catastrophe loads" do not simply get consumed by miscellaneous insurer expenditures, while resources to actually pay for any future catastrophe losses in the state in question might be no greater than before.

Commented [GS41]: One would hope and should seek that this would be the case - but empirically, it has not always been observed to be the case.

Commented [GS42]: Again, this is a conclusion asserted without evidence. It assumes that all insurers' treatments of their reinsurance programs within their rate indications are perfectly allocated among states based on the specific risk of natural-disaster losses in those states. This is a conclusion that would need to be demonstrated empirically, not simply taken as the inevitable way of things. Regulators who review home insurance rates devote considerable effort to ensuring that reinsurance provisions do get allocated more accurately by state than some insurers might initially propose.

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Cross-state pooling within a national insurer operates on a different principle. The insurer is not pooling the catastrophe losses of State A and State B policyholders together and averaging the cost across both groups. Rather, the insurer is pooling the uncertainty about whether State A losses will be higher or lower than expected, against the uncertainty about whether State B losses will be higher or lower than expected. The insurer benefits from the fact that these two sources of uncertainty are not perfectly correlated. The economic benefit of this diversification accrues primarily to the insurer's shareholders in the form of reduced capital requirements and to policyholders in the form of improved insurer financial stability; it does not translate into State B policyholders paying for State A losses.

Commented [GS43]: Differences in loss ratios between State A and State B do not by themselves demonstrate the existence of cross-subsidization. However, if State B is systematically more profitable than State A over the course of many years, *and* the insurer seeks greater rate increases in State B than in State A, at what point does this stop being due to random variation and provide evidence that the insurer is seeking for rates in State B to be systematically higher relative to the risk than in State A?

D. Indirect Effects: How Catastrophe Losses May Affect Rates Elsewhere

While direct cross-state premium subsidization does not occur through normal ratemaking, there are legitimate indirect pathways through which a catastrophe in one state can affect premium levels in other states, and these indirect effects are important to acknowledge.

The most significant indirect effect operates through supply-chain economics. Following a major catastrophic event, such as a hurricane, wildfire, or flood, the demand for building materials, skilled labor, and construction equipment surges in the affected region. Lumber prices, roofing material costs, drywall, and structural components all experience sharp price increases, driven by both genuine supply constraints and demand concentration in the affected area. These elevated material costs do not remain geographically confined. A homeowner in Indiana filing a non-catastrophic claim, such as a burst pipe, a fallen tree, or a kitchen fire, may find that the cost of repairs has risen meaningfully because the same lumber being used to rebuild Gulf Coast homes is now more expensive everywhere. Insurers writing home insurance policies across the country may experience increased claim severity in all states following a major catastrophe, and this elevated severity can feed into the loss experience used to support future rate changes nationwide. This is a real, quantifiable, and economically rational indirect linkage between catastrophe losses in one state and premium levels in others, and it deserves recognition in the research literature as a legitimate channel distinct from, and not confused with, direct subsidization.

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Catastrophic events can also affect reinsurance pricing globally. A particularly severe hurricane season or a large wildfire loss may increase reinsurance costs for the subsequent policy year, and those increased costs are reflected in rate filings across all states that purchase catastrophe

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reinsurance — even states that were not directly affected by the event. This is not to compensate reinsurance carriers for losses sustained in a prior event; rather, the severe event serves as an additional data point that could cause reinsurers to adjust their predictions of future loss.

Commented [GS44]: However, if global reinsurance costs rise because of natural disasters, it would still be unreasonable to allocate any increase in those costs to states that have not had and are unlikely to have those disasters. Rather, states that did or are likely to experience those particular types of disasters should be bearing the increase within the insurer's allocation methodology.

As with the rebuilding-cost effects discussed above, this is a market-driven indirect effect, not a regulatory or actuarial mechanism for cross-state subsidization.

Finally, catastrophes provide the opportunity for models to be updated for what is learned about resiliency. Insurers and third-party modelers may calibrate rating values associated with certain types of construction, roof materials, mitigation efforts, etc., and use the revised discounts and factors throughout the country.

E. Could Companies Hide Cross-State Subsidization?

A more sophisticated version of the cross-state subsidization hypothesis asserts that even if rate filings are state-specific, insurers might use the flexibility within ratemaking to shift value between states in ways that are difficult for regulators to detect. For example, an insurer might inflate the profit provision in low-catastrophe states to build a surplus that effectively offsets losses in high-catastrophe states. Or an insurer might systematically understate the catastrophe load in a high-exposure state by using older, less sensitive catastrophe models, while compensating with higher expense loads in other states.

The Center for Insurance Policy and Research (CIPR) performed a qualitative analysis of rate filings to explore the hypothesis that carriers are subsidizing catastrophic losses incurred in one state with higher rates in another state. If the hypothesis were true, the expectation is rate filings would either 1) directly include out-of-state catastrophe losses in the development of the indicated rate need or 2) indirectly increase the indication by changing methodology (e.g. using more conservatism) after catastrophic loss in another state. The analysis, while qualitative and limited in scope, did not support the hypothesis that carriers are raising rates in one state to support losses in another state.

Commented [GS45]: The analysis in question appears to be limited to disasters in a few states in a few years and responses in a few other states as a result. But this is not an across-the-board review of what happened after major, well-publicized disasters in large states that are well-known to be catastrophe-prone - in regard to the indications and rate proposals of insurers in other states (particularly neighboring states) that are less catastrophe-prone.

Minnesota Hail Event: Found No Effect on Iowa Rates

For example, in 2017 there was a hail event (part of a June Derecho) in Minnesota. Iowa rate filings were examined for some companies writing insurance in both Minnesota and Iowa. No Minnesota loss data (or any other out-of-state losses) were reflected in five Iowa rate filings prior

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to Derecho and six after Derecho. Rate provisions and methodologies were also reviewed to test for any indirect 'cross subsidization' via selection of more conservative factors or changes in methodology intended to yield a higher indication in the post event filings.

The methodologies and provisions reviewed were: 1) Indication methodology: number of years of experience, weighting of years; 2) Loss and Trend: development and selection of; 3) Catastrophe provision development including which CAT models were used; 4) Reflection of reinsurance; 5) Development of underwriting profit and contingencies provision; 6) Other expense development; 7) Indicated vs proposed rates; 8) Credibility methodology and the selected complement of credibility; 9) Premium Trend; and 10) Other factors (e.g., Large loss procedure that may be impacted by out-of-state losses). No methodology changes were observed that would indicate an indirect allocation of losses from the catastrophe events into Iowa rate indications. "Indirect effects" such as reinsurance costs, countrywide expenses or profit provision selection did not appear to be affected by the experience of out-of-state losses. When indications were higher in the post period, the driver was an increase of in-state losses or loss trends. Changes observed were due to companies having more internal experience to rely on, updates to catastrophe models, updated factors such as profit provisions, or other methodology changes that adhere to standard actuarial principles.

With changes to profit provisions, carriers maintained a consistent methodology to develop their profit provisions, but some updated inputs such as the rate of return, which resulted in small changes in the underwriting profit. In some cases, the underwriting profit provision increased from pre-to-post event filings. One carrier increased their profit provision from 6% to 7%. In some cases, the underwriting profit provision decreased: one carrier decreased their profit provision from 7.2% to 5.4% and another from 7% to 5%.

Regarding methodology changes, one company changed its credibility procedure which resulted in a small increase in the credibility attributed to its own statewide data; the complement of credibility was applied to a trended permissible loss ratio (not to loss experience from other states).

Hurricanes Harvey & Irma and 2018 California Wildfires: Found No Effect on Virginia Rates

Using the same methodology, four Virginia rate filings were studied before and four after the hurricanes Harvey & Irma in 2017 and eight filings before and eight after the 2018 California

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wildfires (7/23/18-8/30/18). Findings in the Virginia rate filings were consistent with the findings from the review of Iowa rate filings: There were no out-of-state losses included in any of the rate filings in Virginia. There were no methodology changes or rate provision selections that would indicate an indirect allocation of loss experience from the catastrophes to Virigina.

While these are only two limited scope case studies, they support this paper's assertion that cross-subsidization is not occurring. CIPR has not found support for the subsidization hypothesis. Analyses of profit provisions, expense ratios, and loss ratios across states have not revealed the systematic patterns that would be expected if insurers were deliberately routing value from low-catastrophe to high-catastrophe states. This does not foreclose the possibility that individual insurers in specific circumstances might engage in such behavior, but the available evidence at the industry level is not consistent with cross-state subsidization as a widespread or systematic phenomenon.

F. How Evolving Catastrophe Models Affect the Debate

One final dimension that is essential to understanding the cross-state subsidization debate is the evolution of catastrophe modeling. Insurers and their actuaries rely on probabilistic catastrophe models to estimate the expected losses from hurricanes, wildfires, earthquakes, and other catastrophic perils. These models, developed and maintained by specialized vendors and insurers, translate meteorological, geophysical, and engineering science into probabilistic loss distributions for any portfolio of insured properties.

Catastrophe models have changed significantly over time, and the transitions between model generations can create apparent discontinuities in rate levels that are sometimes misinterpreted as evidence of subsidization or cross-market cost shifting. When a major vendor releases a new version of a hurricane model that substantially increases estimated loss costs for Gulf Coast exposures, insurers using that model will file for rate increases in the affected states. The timing and magnitude of those increases may differ across insurers depending on when they transition to the new model, how much credibility they give to the model versus their own historical data, and how their reinsurance programs respond to the updated loss estimates. A researcher observing this pattern without knowledge of the model transition might incorrectly attribute the rate increases to a redistribution of costs rather than to an improved scientific understanding of the underlying peril.

Commented [GS46]: Not only are the case studies of limited scope, they pertain to the years 2017 and 2018, which predate the major push by some insurers to increase rates in less catastrophe-prone states. A much more relevant study would consider, for example, insurer rate proposals in *all 50 states* in the aftermath of the devastating Los Angeles wildfires of January 2025.

Commented [GS47]: Again, a few examples from a few states in 2017 and 2018 do not equate to "the available evidence at the industry level". They may not even comprise 0.01% of "the available evidence at the industry level" that could be analyzed in a more systematic study.

Commented [GS48]: What justifies the a priori assumption that these discontinuities are "misinterpreted" as evidence of subsidization rather than serving as a mechanism or cover for attempted subsidization?

Commented [GS49]: What justifies the a prior assumption that a later model necessarily reflects an "improved scientific understanding", rather than just a different set of assumptions that could be better or worse than those of the preceding model? It is the job of regulators to evaluate the merits of those assumptions, not simply to take for granted that a later model will be more accurate.

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The practical implication for the subsidization debate is that large, sudden shifts in catastrophe-state rate levels, particularly following a major loss event or a model update, do not indicate that prior rates in those states were subsidized by other states. They indicate that the industry's understanding of the catastrophe risk has changed, and that rates are being updated to reflect that improved understanding. The absence of prior rate increases does not mean policyholders elsewhere were overpaying; it may mean that the risk was systematically underestimated by the best available models at the time.

G. Important Methodological Considerations for Researchers and Media

It is worth flagging several recurring misconceptions that appear in research and reporting on this topic, because they can significantly distort conclusions about cross-state subsidization.

1. Rate Filings Are Not "Exact Rate Needs."

A rate filing reflects an indicated rate need and the proposed rates. As discussed, actuarial rate indications involve projecting future (unknown prospective) losses and expenses from historical data using loss development factors, trend factors, and catastrophe load adjustments—all of which carry significant uncertainty and some of which can vary depending on the degree of conservatism in estimates. The "indicated rate change" is a point estimate within a plausible range. No actuary, regulator, or researcher knows with certainty how many claims will occur in a future policy period, what those claims will cost, or how the catastrophe environment will evolve. What appears to be an over- or under-indication when examined with a fixed historical dataset may look quite different when evaluated across multiple years or under different model assumptions. Research conclusions based on a single point-in-time snapshot of rate indications should be interpreted cautiously and evaluated against longer time horizons.

2. Claim Count Definitions Vary Across Insurers and Datasets.

Comparisons of claim frequency across companies or states frequently encounter the problem that insurers define and count claims differently. Some insurers record a claim for each person injured, each site damaged, each coverage affected, etc. Zero-payment claims (opened and closed without indemnity, such as claims below the policyholder deductible or not caused by a covered peril) may or may not be included in reported counts. Researchers using industry databases or statutory filings should account for these

Commented [GS50]: Is it the "understanding of the catastrophe risk" or, rather, the *fear* of the catastrophe risk? Studies of sociological responses in relation to natural and manmade disasters have indicated that humans are systematically prone to exaggerate and over-respond to the risk of disasters that happened recently and to neglect or disregard the risk of disasters that happened in the more distant past. "Social contagion" effects - including signaling within industry peer groups - can amplify those distortions relative to what would be an objective risk perception.

Commented [GS51]: Again, this paper assumes that the prior models necessarily underestimated the risk and the new models estimate it correctly - but there is no empirical corroboration of this. It could be that the prior models were more accurate in estimating the risk, and the new models exaggerate it, either inadvertently or due to motivated reasoning and assumptions. Regulatory scrutiny exists to help understand which of these scenarios is likely to be the case.

Commented [GS52]: The concerns of those who think that cross-subsidization is happening are not limited to single point-in-time snapshots. Indeed, those who hold such concerns will point to systematic tendencies across time when some insurers will propose increases is less catastrophe-prone states, where their books of business have been profitable for a decade or longer, and may propose lesser increases in states that are more catastrophe-prone and that have recently experienced highly publicized natural disasters.

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definitional differences, as unadjusted comparisons can produce false or misleading conclusions about relative loss frequency and severity, or average claim amounts.

3. The Indicated Rate vs. Rate Received: A Critical Assumption.

Much of the academic literature on cross-state subsidization implicitly or explicitly assumes that the rate a company files, or the actuarially indicated rate, represents the true economic cost of risk in that state, and that any gap between the indication and the approved rate must be recovered elsewhere, including potentially from policyholders in other states. This assumption does not withstand careful examination. Rate indications are inputs to a regulatory analysis, not binding financial obligations. Insurers regularly file for rate changes that are less than their full indication, particularly in competitive markets. The gap between indicated and implemented rates is not uniformly under-charging—it may reflect competitive pricing, regulatory compliance, or the fact there is a range of reasonable actuarial estimates. Research that uses this gap as direct evidence of cross-state subsidization without accounting for these dynamics is fundamentally flawed.

4. Catastrophe Pricing Is a State-Level Construct.

A foundational principle of property insurance pricing, and one that is frequently misunderstood in cross-state subsidization discussions, is that catastrophe loss costs are estimated for the state where they are expected to occur. California wildfire claims experience does not enter the rating calculation for a home insurance policy in the Midwest. Each state's rate level is derived from that state's own expected loss experience, adjusted for trend and development, with catastrophe loads built from catastrophe models calibrated to the geographic exposures within that state. State insurance regulators enforce this principle by requiring that rates be filed and justified on a state-specific basis.

Confusion arises because state insurance rating laws may allow insurers to use both state-specific and other data, such as regional or nationwide data. In practice, an insurer will use state-specific data to the extent it is credible and will supplement it with other credible, relevant information where needed. To be “relevant,” that data must be a reasonable estimate of expected losses and expenses for the policies to be written in the state.

Commented [GS53]: This is true. However, the *extent to which* insurers choose to file for increases less than their indications may be reflective of attempted cross-subsidization. For instance, if an insurer always files for its full indication in State A but always files for much less than its full indication in State B, this may be a sign of concern. It could be that the insurer thinks that regulators in State B will be more stringent and thus will attempt at the onset to file what those regulators are likely to approve, whereas the insurer expects less resistance to its full indication in State A, or at least is willing to engage in a more protracted back-and-forth exchange with the regulators of that state.

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Commented [GS54]: This is generally true when it comes to states that are extremely different from one another in terms of the very possibility of certain perils arising. In other words, insurers are generally not going to specifically try to redistribute wildfire losses to states that have little to no wildfire risk at all. Yet somehow, after major California wildfires, some large insurers tend to propose larger rate increases in certain Western states that are not California and that have not had those large wildfires, than they do in California.

Commented [GS55]: Some insurers will take liberties with what they consider “relevant”, and regulators will often identify complements of credibility that are of questionable relevance to a given state’s experience.

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This distinction is especially important for catastrophe risk. Updated catastrophe models may incorporate new scientific understanding, new claims information, changes in exposure, or changes in environmental conditions that affect more than one state. For example, a major hurricane in Florida may reveal that certain types of structures perform more poorly than expected, or that loss amplification effects are more significant than previously understood. Though these findings came from experience in Florida, hurricane catastrophe models used across the entire Atlantic coast will be updated to reflect these new learnings, which could increase rates in all hurricane states. While this may appear at the surface to be cross-subsidization, there is a distinct difference: this is not insurers using out-of-state losses to increase rates (cross-subsidization), but rather a best practice of using the latest science – catastrophe events in other states may teach insurers, modelers, and regulators something new about the risk that is relevant to other states exposed to the same peril.

When it comes to some parts of the insurer's rating plan, such as determining the rates for customers based on their individual risks, insurers are encouraged to use their most credible data, which may include nationwide or regional information on issues such as how fire damages buildings, what roofing materials perform best when neighborhoods burn, etc. When discussing state cross-subsidization, it is the overall indication by coverage or peril that is most important and the overall indication is a state-based number. A filing that attempted to recover California wildfire losses through Midwest premiums would be actuarially unsound and would not survive regulatory scrutiny, whether through front-end rate regulation or back-end market regulation. The regulatory architecture of state-based insurance oversight, therefore, provides a structural barrier to the kind of direct cross-state subsidization that researchers and media often allege, while still allowing insurers and regulators to recognize credible, relevant scientific information that improves the assessment of catastrophe risk within each state.

5. **Refer to the CIPR website** (*link pending*) **for considerations when using insurance data.**

This section has distinguished the direct allocation of catastrophe losses from the broader market effects that may influence home insurance rates. That distinction matters because it shows why

Commented [GS56]: Again, it is a significant and unproven assumption to assert that these changes that affect more than one state are necessarily in the direction of improvement. The burden of proof here is on the insurer and the modeler; we do not know *a priori* that a newer model will be better or especially that it will be reflective of the risk of catastrophe loss in states where the recent disaster(s) did not occur.

Commented [GS57]: More accurately, such a filing *should not* survive regulatory scrutiny. However, in a state where regulators' authority to disapprove rates is limited, or a state where insurers may exert significant political pressure or informal influence to circumvent any existing regulatory process, these kinds of proposals may have greater survival potential than anticipated or hoped. Market regulation may still serve as a check in those instances, whether explicit market-conduct regulation or regulation through the discipline of the market - but that would only work on insurers that care about gaining or keeping business in the state.

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rate regulation must both recognize genuine cost pressures and require that those costs be reflected through supported, risk-based, and reviewable ratemaking. Section V places that role in the broader architecture of home insurance regulation: a layered system designed to protect consumers, preserve market stability, and maintain actuarial discipline.

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V. Conclusion: Rate Regulation as Layered Consumer Protection

Rate regulation is a calibrated system that supplements competitive market forces with regulatory oversight proportionate to the degree of market imperfection and the magnitude of consumer vulnerability.

The architecture of state-based regulation described in Sections I through IV, with its uniform three-part legal standard for insurance rating, delegation of authority to state insurance commissioners, and diverse rate filing requirements, and with a complement of market conduct oversight, reflects the accumulated wisdom of more than a century of insurance regulatory experience.

Present regulatory needs include attention to using sophisticated actuarial staff (as rate filing models and support continue to get more complex) and effective market monitoring. The engagement of the actuarial profession, through its standards, its certifications, and its independent professional obligations, is indispensable to the integrity of the rate regulatory process. Actuaries who conduct rate indication analysis in rate filings occupy a position of public trust and professional obligation, and the regulatory system depends on the actuarial community's commitment to honest, rigorous analysis as a foundation for sound ratemaking.

The home insurance market faces significant challenges in the years ahead, from increasing catastrophic disasters to rising replacement costs to the evolving legal environment. Rate regulation, when properly designed and effectively administered, will remain an important tool for ensuring that these challenges are met in a manner that protects consumers, maintains market stability, and preserves the availability of coverage that protects the most important financial asset most American families will ever own.

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In summary, the goal of property and casualty ratemaking is to predict the rates that need to be charged on a specific cohort of insurance policies that will be written in the future. The application of appropriate actuarial practices and techniques ensures that those rates are adequate, but not

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excessive or unfairly discriminatory for covering the expected losses and expenses on those policies, while also allowing for a reasonable return for the risk undertaken. Ratemaking is inherently a prediction of unknown future values. To the untrained eye, a year with few severe storms and catastrophic events might make it seem as if the rates were excessive. And a year with many severe storms and catastrophic events might look like the rates were inadequate. But the ratemaking process accounts for such random fluctuation and prices to the expected frequency of, and claim values associated with, these events in any given year.

Insurers typically use their own state-specific experience to the extent possible for ratemaking purposes. But that experience often needs to be supplemented with additional information to make credible predictions about future losses and expenses on policies that haven't yet been written. This supplemental information can include catastrophe models, other insurers' experience and their rates, experience and statistics made available by advisory and rating organizations, and regional or even countrywide experience and statistics. However, it is important to understand that supplemental information is adjusted and used only to the extent that it helps predict expected losses and expenses on a specific set of policies in a specific state that will be written in the future. Any insurer that would attempt to charge excessive rates in one state to make up for inadequate rates in another would be in violation of actuarial standards of practice (and their actuaries subject to discipline by the Actuarial Board of Counseling and Discipline), would receive regulatory disapproval or nonacceptance where rate filing requirements exist, and would fail to meet their growth and retention goals in that state due to the competitive home insurance markets that exist in most states.

Rate regulation can and should ensure that cost trends are accurately measured, that actuarial justification is genuine, that unfair discrimination is absent, and that insurers are not exploiting information asymmetries or market concentration to extract excessive profits.

Property and casualty insurance ratemaking is a complex endeavor undertaken by professionals with standards of practice governing their work. Those studying the actuarial soundness of insurance rates, and effectiveness of state-based rate regulation, would produce more accurate and beneficial research by meeting with state insurance regulators to discuss their methodology and findings as part of their research and in advance of publishing any reports.

Commented [GS58]: It is that "additional information" that makes it easy for cross-subsidization to arise either intentionally or inadvertently, and this underscores the need for regulators to be vigilant. Assuming away the problem by suggesting that all such "additional information" is reasonable to use (because sometimes it theoretically is)does not aid in the task of actually ensuring that rates are not excessive or unfairly discriminatory.

Commented [GS59]: There is a difference between "would" and "should". If the latter word were used here, I would agree. But whether something actually "would" happen is an empirical question, for which the outcome cannot be postulated in advance.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

References and Further Reading

American Property Casualty Insurance Association (APCIA). The Economic Justification for Rate Regulation in Personal Lines Insurance. Washington, D.C.: APCIA Policy Research.

Cummins, J. David, and Sharon Tennyson. “Regulation, Efficiency, and Competitiveness in the U.S. Property-Liability Insurance Industry.” Journal of Insurance Issues (1994).

Harrington, Scott E. “Insurance Rate Regulation in the Twenty-First Century.” Journal of Insurance Regulation 21, no. 1 (2002).

Klein, Robert W. “Insurance Market Regulation: Catastrophe Risk, Competition and Systemic Risk.” Working Paper, Risk Management and Insurance Program, Georgia State University (2012).

McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011–1015.

National Association of Insurance Commissioners (NAIC). Model Rate and Policy Form Regulation Act. Kansas City, MO: NAIC.

National Association of Insurance Commissioners (NAIC). Property/Casualty Insurance: An Industry Overview. Kansas City, MO: NAIC.

United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944).

Actuarial Standards Board. Actuarial Standard of Practice No. 25: Credibility Procedures. Washington, D.C.: ASB.

Actuarial Standards Board. Actuarial Standard of Practice No. 53: Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention. Washington, D.C.: ASB.

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August 5, 2026

Angela L. Nelson, Chair
Timothy N. Schnott, Vice Chair
Casualty Actuarial and Statistical (C) Task Force
National Association of Insurance Commissioners (NAIC)

Re: CASTF Rate Regulation White Paper Draft

Dear Chair Bettencourt and Vice Chair Nelson:

On behalf of the Casualty Practice Council's Homeowner's Insurance Task Force (Task Force) of the American Academy of Actuaries[1], we appreciate the opportunity to comment on the June 26 draft Rate Regulation white paper from the Casualty Actuarial and Statistical (C) Task Force (CASTF). The Task Force has reviewed the exposure and offers the following comments.

Professionalism and Actuarial Standards of Practice

While the exposure draft touches on actuarial standards of practice (ASOPs)[2] and the duty of actuaries to adhere to professionalism standards, the Task Force recommends this point receive a heightened emphasis throughout the paper. ASOPs and the CAS Statement of Principles[3] provide guidance in how actuaries should provide a rate that is "the expected value of all future costs associated with an individual risk transfer." Precept 8 of the Code of Professional Conduct specifically calls out that an actuary "shall take reasonable steps to ensure that such services are not used to mislead other parties[4]," which can include regulatory audiences reviewing and approving actuarial communications. Deliberate implementation of cross-state subsidization in violation of ASOPs and actuarial principles could constitute a violation of the Code of Professional Conduct. Such violations could lead to disciplinary review and/or action by the Actuarial Board for Counseling and Discipline (ABCD).

Cost of Capital and Reinsurance

The exposure draft provides some detail on the possibility of cross-subsidization if an insurer charges a profit margin different than indicated by the actuarial data in certain states due to regulatory requirements around allocation of capital and profit. The underwriting profit provision in each state's rates compensates the insurer for the surplus allocated to that state based on risk. If the profit provision required by regulatory requirements differs from the indicated profit provision, or if profit provisions are not calibrated to each state's actual cost of capital, there may be cross-subsidization between states.

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
[2] "Actuarial Standards of Practice", Actuarial Standards Board
[3] "Statement of Principles Regarding Property and Casualty Insurance Ratemaking", Casualty Actuarial Society, 2021
[4] "Code of Professional Conduct", American Academy of Actuaries, 2001

Within a reinsurance context, the cost of reinsurance is commonly purchased on a company basis, so the reinsurance premium would be allocated among states. For example, consider these four types of reinsurance and how their costs would be allocated among states:

1. Property excess reinsurance can pay when a natural disaster exceeds a specified dollar amount.
2. Parametric "insurance" can pay when a natural disaster meets or exceeds specified parameters, such as wind speed.
3. Facultative reinsurance may cover a specific unique structure, such as a sports stadium or a home along a beach, coast, or river.
4. Proportional reinsurance shares premiums or losses according to an agreed percentage.

Each of these four types of reinsurance has a cost to the primary insurer. There are several possible allocation methods for a catastrophic event that triggers a reinsurance payment, which, if not appropriately accounted for in the allocation methodology, could result in cross-subsidization among states:

- Cost can be allocated by incurred or paid losses by state.
- Cost can be allocated by premiums or exposures (such as average insured home value) by state.
- Cost can be allocated by output from statistical models (such as average annual loss or modeled variability)

CASTF may want to consider the following additional clarifications to identify the advantages and disadvantages of each allocation method, address best practices for allocation among states, or distinguish practices by type of reinsurance, while also showing how limits of reinsurance layers can also impact allocations.

Recommended Revisions to the White Paper

- **Executive Summary.** The discussion should recognize that actuaries have independent professional obligations to use appropriate methods, assumptions, and standards when estimating prospective costs. References to ASOP No. 53[5] and the Statement of Principles would clarify that this discipline applies regardless of the filing framework.
- **II A. Homeowners Insurance Rating: Homeowners Rating Overview.** Consider adding references to ASOP No. 12[6] for risk classification and ASOP No. 30[7] for profit, contingencies, investment income, and required capital.
- **II A. Homeowners Insurance Rating: Homeowners Rating Influences.** Consider adding a reference to ASOP No. 25[8] in the discussion of credibility.
- **II B. Homeowners Insurance Rating: Catastrophe Risk and Pricing.** We recommend distinguishing modeled catastrophe perils from other severe weather or high-severity losses. The text should not imply that every listed model consideration is specifically mandated by regulation or an ASOP. Actuaries should consult applicable standards, including ASOP No. 38[9], ASOP No. 39[10], and ASOP No. 41.[11] Add "among other factors" to the illustrative list of rating variables.

[5] "Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention", Actuarial Standards Board
[6] "Risk Classification (for All Practice Areas)", Actuarial Standards Board, 2005
[7] "Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking", Actuarial Standards Board
[8] "Credibility Procedures", Actuarial Standards Board, 2013
[9] "Using Models Outside the Actuary's Area of Expertise (ASOP No. 38, Revised Edition)", Actuarial Standards Board
[10] "Treatment of Catastrophe Losses in Property/Casualty Insurance Ratemaking", Actuarial Standards Board
[11] "Actuarial Communications", Actuarial Standards Board, 2010

- **II B. Homeowners Insurance Rating: Cost of Reinsurance.** Consider broadening "aggregate" to "individual event and/or aggregate" to recognize per-occurrence, per-risk, aggregate, and blended structures. Also consider revising the concluding objective to state that premiums should be an actuarially sound estimate of the expected future cost of the risk transferred during the policy period.
- **III B 2. What is Cross-Subsidization?: Rate Filing Timing Differences.** Carriers may sequence filings strategically because filing laws differ, such as prior-approval versus use-and-file systems, and because approval may be perceived as easier in some jurisdictions. Staffing constraints at departments of insurance can also lengthen reviews. The paper should consider acknowledging these operational factors because additional agency funding and hiring could improve oversight and reduce perceptions of cross-subsidization.
- **III B 3. What is Cross-Subsidization?: Mix of Business.** Consider framing rapidly growing books as a credibility and data-reliability issue, as their experience may be less credible or less predictive of future experience.
- **III B 5. What is Cross-Subsidization?: Use of Non-State Data.** Consider replacing "external" with "external to the state" or "non-state data" to accurately describe the contrast with state-specific data.
- **IV B. What State-Based Ratemaking Means for Consumers and Markets: How Insurers Deploy Capital and Reinsurance.** The enterprise-level capital discussion is central and warrants elaboration. Each state's underwriting profit provision is intended to compensate the surplus allocated to that state based on risk, generally through a target return on surplus. The paper should examine how often that target return is set at a flat enterprise-wide level rather than calibrated to each state's actual cost of capital, as this may be a potential source of cross-subsidization.
- **IV G. What State-Based Ratemaking Means for Consumers and Markets: Terminology and Methodology.** Replace "CAT model" with "catastrophe model;" add "among other factors" to the listed indication inputs; use "reasonable range" instead of "plausible range;" and clarify that comparing an indication with later emerged losses does not establish that it was over- or under-indicated.
- **IV G 3. What State-Based Ratemaking Means for Consumers and Markets: Indicated versus Implemented Rates.** The paper should more fully explain why an insurer may file below its full actuarial indication. In particular, the paper should describe what competitive pricing entails and why insurers and regulators may accept it as a valid basis for implementing less than the indicated rate in a state.

The Task Force looks forward to the continued collaborative dialogue with the NAIC as CASTF continues work on this project. If you have any questions or would like to discuss these comments further, please contact Rob Fischer, policy project manager, casualty (fischer@actuary.org, 202-785-7865).

Sincerely,

Ken Doss, MAAA, FCAS
Chairperson, Homeowners Insurance Task Force

American Property Casualty Insurance Association℠
INSURING AMERICA apci.org

August 3, 2026

Kris DeFrain, MAAA, FCAS, CPCU
Director of Research and Actuarial Services
National Association of Insurance Commissioners (NAIC) Central Office
(via email: kdefrain@naic.org)

RE: NAIC CASTF Draft White Paper (U.S. Homeowners Insurance Rate Regulation – A Regulatory Perspective)

Dear Ms. DeFrain,

On behalf of the American Property Casualty Insurance Association (APCIA)[1], thank you for the opportunity to review and provide comments on the draft white paper, U.S. Homeowners Insurance Rate Regulation – A Regulatory Perspective.

Overall, APCIA supports the paper and appreciates NAIC's efforts to explain how state-based risk-based ratemaking operates in practice. The paper appropriately recognizes that homeowners insurance rates are prospective, risk-based, actuarially supported, and subject to state-specific regulatory review. We also agree that competitive market forces serve as an important safeguard against any possible inappropriate pricing practices. The U.S. property and casualty insurance market remains highly competitive, making it difficult for insurers to sustain rates that materially deviate from underlying risk. Any attempt to shift costs across states would be inconsistent with Actuarial Standards of Practice, fundamentals of basic ratemaking, and subject to regulatory review under state insurance laws. For these reasons, APCIA shares the paper's conclusion that systemic cross-state subsidization is not occurring and commends the NAIC for developing a thoughtful, fact-based resource that helps address misconceptions regarding homeowners insurance ratemaking.

While APCIA is supportive of the white paper, we respectfully offer the following recommendations and clarifications.

Recommended Clarification #1: Scope of the Paper and Individual Company Conduct

Clarify that the paper is evaluating whether state insurance regulation permits or results in systemic, market-wide cross-state subsidization. The paper should not be interpreted as suggesting that insurer-specific cross-state subsidization is occurring.

Recommended Clarification #2: Avoiding Absolute Statements Regarding Regulatory Detection

[1] The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA membership consists of over 1,200 member companies (or over 300 member groups). APCIA member companies P&C countrywide market share is 66% (total 74% commercial lines, 60% personal lines).

Replace statements suggesting regulators will always identify cross-state subsidization with language stating that the regulatory framework is designed to identify, evaluate, and prevent unsupported attempts to allocate costs across states.

Recommended Clarification #3: Distinguishing Market-Wide Cost Pressures from Cross-Subsidization

Reinforce that changes in reinsurance costs, catastrophe models, rebuilding costs, and other market-wide inputs reflect evolving assessments of future risk and cost rather than allocation of prior losses across states.

Recommended Clarification #4: Context Regarding the Role of Reinsurance in Homeowners Insurance Pricing

Several references may overstate the impact of reinsurance on homeowners premiums. Reinsurance is an important component of insurer risk management, but for most homeowners policies the primary drivers of premium remain expected claims costs, loss adjustment expenses, administration, distribution expenses, taxes, and capital costs. Reinsurance costs are typically a relatively small component of the overall premium and often reflect the same underlying cost pressures affecting the primary market, including construction inflation, catastrophe losses, legal system costs, financial market conditions, and supply-demand dynamics for reinsurance capacity.

Additional Observation Regarding International Reinsurance References

The discussion of global reinsurance markets would benefit from emphasizing that reinsurance pricing remains fundamentally risk-based. While global events may affect overall market conditions and capacity, coverage for specific perils and exposures is generally priced according to the risk characteristics of those exposures rather than as a direct allocation of losses from unrelated geographies. The paper's statement that consumers pay for the portion of reinsurance that protects the risks in their own state is an important principle and a similar concept applies internationally.

Thank you again for the opportunity to comment. APCIA appreciates the Task Force's work and hopes the final paper will help inform policymakers, researchers, regulators, and consumers while countering inaccurate narratives regarding alleged cross-state subsidization.

Sincerely,

Norman Niami, FCAS, MAAA, Affiliate IFoA
Vice President, Actuary, Policy, Research and International
Norman.Niami@APCI.org
Cell: 202-880-4082

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August 5, 2026

Julie Lederer (MO), Chair
NAIC Casualty Actuarial and Statistical (C) Task Force
c/o Kris DeFrain, Director, Research and Actuarial Department
Via email kdefrain@naic.org

Re: NAMIC Comments on the Draft White Paper

Dear Chair Lederer and Members of the Task Force:

On behalf of our members, the National Association of Mutual Insurance Companies (NAMIC)[1], this letter offers comments on the draft white paper *U.S. Homeowners Insurance Rate Regulation- A Regulatory Perspective.* Overall, the draft is thoughtful, balanced, and useful; it does a strong job explaining that homeowners' insurance rates are prospective, state-based estimates of expected future costs rather than mechanisms to recoup prior losses or shift catastrophe costs from one state's policyholders to another's.

The draft also effectively explains several issues that are frequently misunderstood in public discussion, including the role of catastrophe modeling, reinsurance, state-specific regulatory review, and competitive market forces. With targeted revisions, the paper would even more clearly reflect the legal, actuarial, and market disciplines that constrain unsupported claims of cross-state subsidization while remaining accessible to regulators, policymakers, researchers, and other non-technical audiences.

NAMIC offers the following comments for the Task Force's consideration.

Actuarial Standards
A central recommendation is to expand the discussion of actuarial professionalism and standards of practice. The current draft notes that actuaries evaluate data, assumptions, and methods and references ASOP Nos. 13, 25, 38, 39, and 53 in specific sections, but

[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 $467 billion in annual premiums, representing 61% of the homeowners and 53% 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.*

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the paper would be stronger if it more directly explained that actuaries are independently bound by professional standards and subject to discipline for material departures from those.

The concept of actuarial professional obligations should be added in at least two places. First, the executive summary or introduction should note that the actuarial profession provides an independent layer of consumer protection because ratemaking actuaries must estimate future costs using appropriate methods and assumptions under applicable professional standards, not merely satisfy a filing requirement.
Second, the conclusion should retain and modestly strengthen the sentence recognizing that actuaries who depart from professional standards may be subject to discipline, including the potential loss of credentials and ability to practice. The gravity of such a consequence helps explain why intentional cross-state subsidization would be inconsistent not only with regulation but also with actuarial ethics and professionalism.
We additionally recommend the paper modestly expand the references to specific standards where relevant. For example, the discussions of risk classification, credibility, profit and contingencies, catastrophe modeling, and actuarial communications may benefit from references to the most directly applicable standards in each instance, so readers better understand the professional framework underlying those topics.

Technical Revisions
NAMIC supports several targeted edits that would improve technical precision without changing the overall substance of the draft. First, the statement on page 6 that the NAIC Model Rating Law [2]is adopted, with variations, "across most states" should be revised to "across all states, with variations," consistent with the current state adoption status.

Second, several passages would benefit from modest wording changes:

- On page 8, revise "produces stable outcomes" to "produces more stable outcomes" or "less variable outcomes."
- On page 8, remove "typically" from the sentence stating that expected losses are the largest component of homeowners' premium.
- On page 9, clarify that "age" refers to the age of the home, or reorder the illustrative rating variables to make that clear.
- On page 9, move credit-based insurance score later in the list of illustrative variables so that the discussion begins with more direct property-related characteristics.
- Ensure the first several footnotes are formatted consistently with the linked footnotes that appear later in the paper.

[2] https://content.naic.org/model-laws

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Several passages would also benefit from minor refinements for completeness and consistency. Where the paper lists factors affecting actuarial indications, it should note that those lists are illustrative, not exhaustive, and may refer to development, trend, catastrophe provisions, expenses, credibility, reinsurance, capital, and other relevant items among other factors. Likewise, the paper should use "reasonable range" rather than "plausible range," and "non-state data" or "data external to the state" where the intended distinction is between state-specific experience and broader data sources.

Competition, Catastrophe Risk, and Reinsurance

The discussion of market forces is generally sound, but several edits would improve balance and precision. On page 7, the sentence describing competition should acknowledge that competitive market dynamics are meaningful, but do not always function totally efficiently because homeowners' insurance policies are complex and market disruptions can interfere with comparison shopping and normal competitive responses. On page 30, the paper should refer to the competitive homeowners' insurance markets that exist in most states, rather than phrasing that could be read to imply equally robust competition in every jurisdiction.

The catastrophe and reinsurance sections would also benefit from several clarifications. The catastrophe discussion should distinguish perils commonly modeled from other severe weather or high-severity losses; the catastrophe-model section should avoid implying that every listed item is universally required in every filing; and the reinsurance section should recognize that programs may protect against individual-event and/or aggregate losses. NAMIC also supports adding that enterprise-level reinsurance purchasing is often more efficient than state-by-state purchases and can benefit policyholders when costs are reasonably allocated according to expected benefit and risk contribution.

The section addressing whether catastrophe losses may affect rates elsewhere should also sharpen the distinction between true cross-state subsidization and broader market consequences. A company's intentional decision to require a higher future profit provision in one state because it expects another state to be unprofitable may raise subsidy concerns, but changes in future countrywide reinsurance costs, reduced reinsurance capacity, or higher overall cost of capital following major catastrophe losses are not cross-state subsidies in the ordinary regulatory sense. Clarifying that distinction would strengthen the paper's treatment of the issue and help prevent mischaracterization of normal market-wide effects as impermissible cost shifting.

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Conclusion

NAMIC appreciates the substantial work reflected in this exposure draft and supports its central premise that state-based rate regulation provides important consumer protections while requiring rates to reflect expected future costs. With the revisions described above, the final paper will fully reflect the layered safeguards that constrain unsupported cross-state subsidization, including state rating laws, actuarial standards, market conduct oversight, and competition where present.

Sincerely,

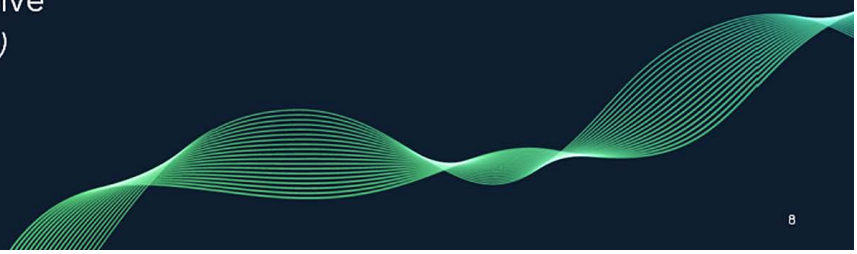
Erica Weyhenmeyer

Erica Weyhenmeyer, CPCU, MCM, AIE, WCP
Sr. Policy Vice President- Market Regulation & Workers' Compensation
NAMIC

5. Hear Updates on Activities and Research from Professional Actuarial Associations

Attachment Twelve

Julie Lederer (MO)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Academy Professionalism Update

NAIC Summer National Meeting

Casualty Actuarial and Statistical (C) Task Force

Aug. 12, 2026

American Academy of Actuaries

Housed in the Academy: The Professionalism Structure

- U.S. Code of Professional Conduct
- U.S. Qualification Standards (USQS)
- Actuarial Standards Board &
  Actuarial Standards of Practice (ASOPs)
- Actuarial Board for Counseling and Discipline (ABCD)

All of these are accessible via the Academy's professionalism page, actuary.org/professionalism, along with Discussion Papers, the Applicability Guidelines, and Professionalism Counts (in Actuarial Update). Up to Code (in *Contingencies*) columns may be found on the ABCD's website (abcdboard.org).

American Academy of Actuaries

Committee on Qualifications

The Committee on Qualifications (COQ)

- Recommends to the Academy's Board of Directors the minimum qualification standards, including continuing education requirements, necessary to qualify credentialed actuaries to issue statements of actuarial opinion in the United States.
- Answers questions relating to qualifications.
  - As of mid-July, the COQ received 14 questions in 2026, covering qualifications for non-US actuaries to issue SAOs, specific qualifications, CE, and documentation requirements.

The most recent U.S. Qualification Standards took effect Jan. 1, 2022.

Actuarial Standards Board (ASB)

General ASOPs under revision

- ASOP No. 1, *Introductory Standard of Practice*
- ASOP No. 12, *Risk Classification (for All Practice Areas)*
- ASOP No. 41, *Actuarial Communications*

Learn more at: [*www.actuarialstandardsboard.org*](http://www.actuarialstandardsboard.org)

Actuarial Standards Board (ASB)

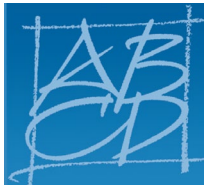
Property/Casualty ASOPs under revision

- ASOP No. 30, *Profit Provisions, Contingency Provisions, and the Cost of Capital in Property/Casualty Risk Transfer and Risk Retention*
- ASOP No. 39, *Treatment of Catastrophe Losses in Property/Casualty Insurance Ratemaking*
- ASOP No. 43, *Property/Casualty Unpaid Claim Estimates*

Recently approved

- ASOP No. 20, *Analysis of Property/Casualty Cash Flows, Including Discounting*
  - Effective June 1, 2026

Actuarial Board for Counseling and Discipline (ABCD)



Recent ABCD activities

- In the first half of 2026, the ABCD handled a total of 83 cases, consisting of 55 requests for guidance (RFGs) and 28 inquiry cases.
- In addition, the ABCD conducted nine outreach presentations, both virtually and in person, for actuarial organizations, regulators, and actuarial clubs and firms across all major regions of the United States.

In *Contingencies* magazine

- July/August 2026 Up to Code article, Don't Be 'That Actuary'
- May/June 2026 Up to Code article, Are You Offside?
- March/April 2026 Up to Code article, A Show of Hands

American Academy of Actuaries

Questions?

For more information, or to send suggestions/comments on the U.S. Qualification Standards, please contact

Virginia Hulme, Assistant Director, Professionalism

professionalism@actuary.org

American Academy of Actuaries

Academy Update—Casualty Practice Council

Casualty Actuarial and Statistical (C) Task Force (CASTF)

Aug. 12, 2026

About the Academy

Mission:
To serve the public and the U.S. actuarial profession

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Serving over 20K MAAAs & public stakeholders for 60 years

Standards:
Setting qualification, practice, and professionalism standards

Impact:
Delivering over 300 insight-driven publications & resources annually

Visit www.actuary.org to learn more.

Casualty Practice Council Priorities

Recent Publications

- Issue Briefs: *Potential Bias in Marketing and Underwriting Practices* and *Tariffs and Their Effects on Personal Auto Insurance Costs*
- Webinar: Bias in P&C Insurance
- Comment letter to DISB: Auto Insurance Balancing Test

Cross Practice Areas of Interest

- Retirement Symposium
- Behavioral Economics Survey
- *AI Use Cases in Insurance and Pensions*
- Climate Change Activities (Insurance Affordability, AI Data Center Impact, Emerging Climate Products)

Casualty & Risk Management Preview

- Survey of the Commercial Liability Market
- Anatomy of Bias in a Commercial Multi-Peril policy paper
- Portability of Telematics Data brief
- Update to the 2022 Wildfire Monograph
- Annual P/C practice note, law manual, and Opinion Seminar
- Climate Change Impact on Insurance Affordability, Availability and Accessibility paper
- Auditing Algorithms for Bias-Performing an Audit paper
- The Climate Impact of AI Data Centers brief
- An Actuarial Perspective on Attribution Science Methodology paper
- Climate Risk and Insurance Innovation—An Actuarial Perspective on Current and Emerging Products paper

Anatomy of Bias in a Commercial Multi-Peril Policy

PURPOSE OF ANALYSIS

To engage actuaries on investigating how different types of bias apply to the commercial multiple peril policy lifecycle.

Anatomy of Bias in a Commercial Multi-Peril Policy—Key Takeaways

- CMP involves significant qualitative aspects in every part of the policy life cycle.
- Human cognitive bias is still the key bias risk, though systemic biases influence pricing, catastrophe management and renewal underwriting.
- Openness to ask questions allows us to consider and potentially mitigate human cognitive bias.

New Academy Staff Role

The Academy is currently recruiting for a Senior Actuary, Casualty & Risk Management. This new full-time role with the Academy will further enhance our ability to engage strategically with key stakeholders and support the Academy's mission of serving the public and the U.S. actuarial profession.

The role is currently posted on our website.

Questions?

For policy information, please contact

Rob Fischer
Policy Project Manager, Casualty
fischer@actuary.org

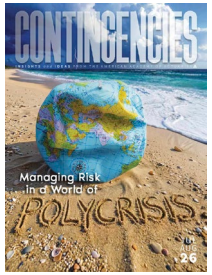
Upcoming Events

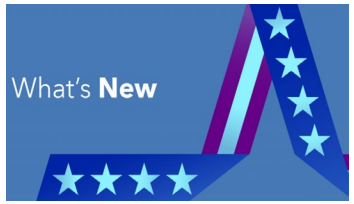
- **VM-22 Forum,** Aug. 26, 2026
- **Retirement Symposium, D.C.,** Sept. 2026
- **Casualty Loss Reserve Seminar (CLRS) with CAS, Las Vegas,** Sept. 14-16, 2026
- **Life and Health Qualifications Seminar, Arlington,** Sept. 28-Oct.1, 2026
- **Seminar on Effective P/C Loss Reserve Opinions, Nashville,** Dec. 7-8, 2026

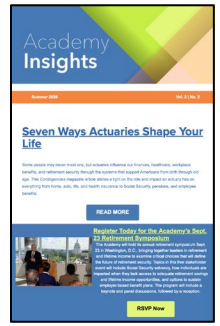
Other Academy Resources

Follow the Academy on LinkedIn

Access the Following Resources:







[*Contingencies* Magazine]

[Policy Forum]

[Actuarially Sound Blog]

[Actuary Voices Podcast]

[Academy Insights]

Casualty Actuarial Society Update

NAIC CASTF Summer Meeting

August 12, 2026

Columbus, OH

The Brand Promise

P&C Experts. Proven. Trusted. Worldwide.

CAS members turn actuarial expertise into decisions that strengthen the P&C insurance system and help businesses and communities navigate risk.

Casualty Actuarial Society

P&C Experts.
Proven. Trusted.
Worldwide.

Casualty Actuarial Society

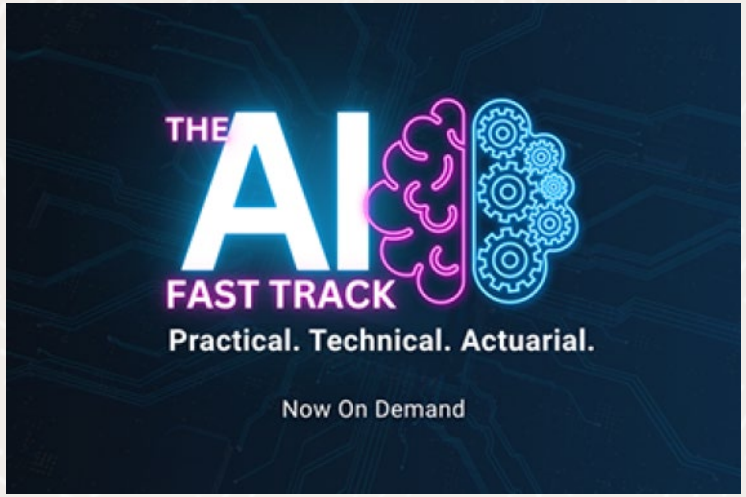
A Clearer Expression of Our Strategic Direction

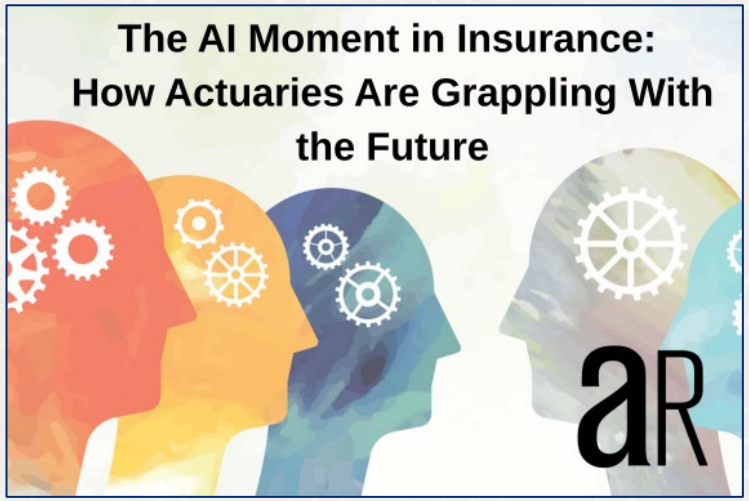
- **For CAS:** Clarifies our position as the only actuarial organization focused exclusively on property and casualty and general insurance risk.
- **For members:** Strengthens recognition of CAS credentials and the expertise members bring to critical risk decisions.
- **For partners:** Brings 100+ years of specialized P&C expertise, the reach of more than 10,000 members worldwide and greater credibility to shared research and industry initiatives.

Key Strategic Priorities

Building Capabilities for AI-Driven Work

Continuing education & professional development opportunities

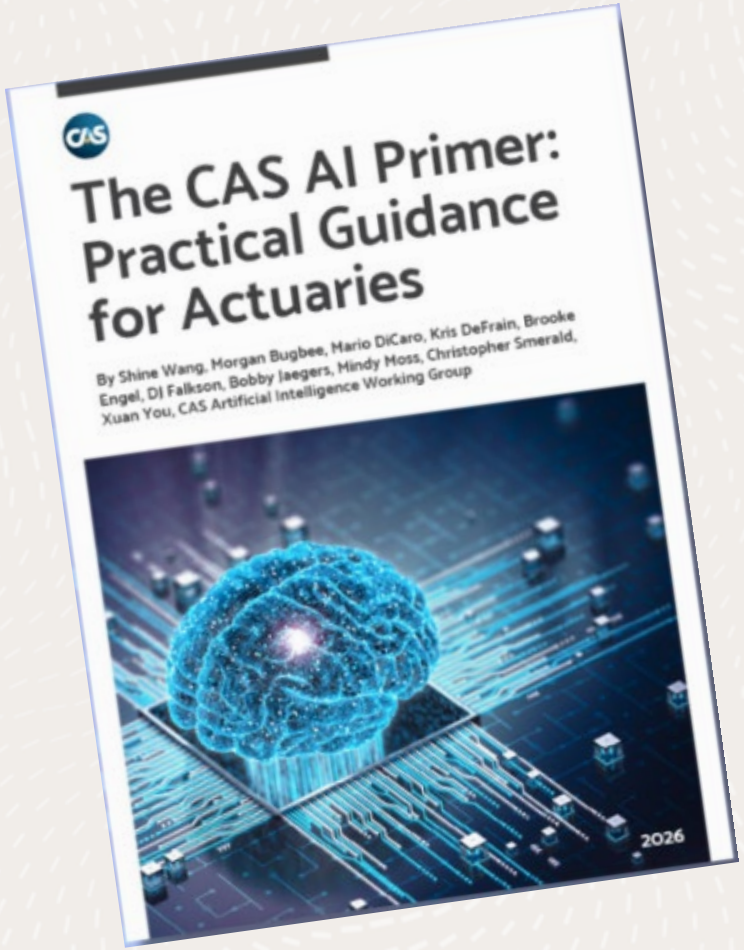




Access these resources and more!

Building Capabilities for AI-Driven Work

Continuing education & professional development opportunities



casact.org/ai-primer

Opportunities for Regulators

CAS welcomes session and research proposals from the regulatory community.

Calls for presentations:

- CAS 2027 Ratemaking, Product and Modeling Seminar (RPM)
  - Deadline: August 20, 2026
- CAS 2027 iCAS Data Science & Analytics Forum at RPM
  - Deadline: September 13, 2026
- CAS 2027 Spring Meeting
  - Deadline: September 19, 2026
- CAS Webinars – Submissions accepted on a rolling basis.

CAS Research Opportunities & Data Resources

Research Opportunities

Quick Start Grants: Proposals accepted at any time for research funding up to $50,000.

Requests for Proposals: Issued by research working groups on a rolling basis. Funding varies but typically is between $50,000 and $80,000.

Calls for Papers: Issued by research working groups on a rolling basis. No funding, but prize money may be awarded for best papers.

Individual Research Grants: Annual competition by the CAS and the SOA to advance knowledge in actuarial science. Announced in July. Funding varies.

CAS Research Working Groups

- Artificial Intelligence
- Climate & Sustainability
- Ratemaking
- Reinsurance
- Reserves
- Risk
- Open-Source Projects

GitHub and Data Resources

CAS GitHub: A data repository for open-source code. Includes repos su as chainladder-python for reserving capital-modeling (CAS Monograph 1

Available Data Resources
(for CAS Research Projects)

- Loss Reserving Data Pulled from NAIC Schedule P
- ActSim
- S&P Data License
- Regrid
- VerdictSearch
- Pricing Data Set

Research Opportunities for Regulators

Contact CAS Research Manager Heather Davis at hdavis@casact.org for more information.

Upcoming Marquee Events

Regulators get a 50% discount on registration fees.

- Casualty Loss Reserves Seminar (CLRS)
  - Las Vegas, NV, Sept 14–16, 2026
  - Jointly sponsored with American Academy of Actuaries
- Annual Meeting
  - Honolulu, HI, Nov 8–11, 2026
- Ratemaking, Product, and Modeling Seminar
  - Indianapolis, IN, March 15-17, 2027
- Spring Meeting
  - Chicago, IL, May 16-19, 2027

Upcoming Webinars

50% regulatory discount for live webinars

- Special Circumstances In Professionalism - What Would You Do?
  - August 27, 2026
- Scaling Laws, Tabular Data and Actuarial Ratemaking Models
  - September 10, 2026
- Navigating the Impact of Vehicle Automation on Commercial Auto Ratemaking and Reserving
  - September 22, 2026
- Climate Risk in Practice: Translating Climate Risk into Operational Decisions
  - September 30, 2026

2026 Spring Meeting
Innovate for Tomorrow - Connect for Success
May 3 – 6, 2026

- Over 900 in-person attendees and over 150 virtual attendees
- Celebrated 39 new Fellows and 162 new Associates
- Featured Speaker and General Sessions
  - *Gaining that Competitive Edge: Accepting AI and New Technology in the Workplace* - Mike Massimino former NASA Astronaut
  - *Four General Sessions on Tariffs, Alternative Risk Market Trends in P&C Insurance, How Consulting Actuaries Are Redefining Their Role and Expanding the Role of Actuaries in Today's Critical Issues*
- Over 40 other sessions
  - Climate session featuring NAIC Actuary Dorothy Andrews

Recent Variance Articles

- "Gini Score Under Ties and Case Weights" Brauer & Wüthrich, July 2026
- "Alternative Reinsurance Calculations and Metrics for Organizational Accessibility and Decision-Making" Murphy, July 2026
- "Using Large Language Models to Generate New Features from Text Data for Loss Prediction" Gan & Shultz, June 2026
- "Applications of Graph Theory in Territorial Ratemaking" Virgilis & Lupton, May 2026
- "Graph-Based Embedding for Categorical Features in Actuarial Applications" Shi, April 2026.
- "Embeddings and Attention in Predictive Modeling" Kuo & Richman, April 2026

#6. Discuss Any Other Matters Brought Before the Task Force

Julie Lederer (MO)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS