CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

Casualty Actuarial and Statistical (C) Task Force Dec. 9, 2025, Minutes
- Casualty Actuarial and Statistical (C) Task Force Nov. 4, 2025, Minutes (Attachment One)
  - *NAIC Model Review Manual* (Attachment One-A)
  - Unknown Risk Characteristics Comments (Attachment One-B)
- Casualty Actuarial and Statistical (C) Task Force Oct. 23, 2025, Minutes (Attachment Two)
  - 2026 Proposed Charges (Attachment Two-A)
- Casualty Actuarial and Statistical (C) Task Force Oct. 14, 2025, Minutes (Attachment Three)
- Casualty Actuarial and Statistical (C) Task Force Sept. 9, 2025, Minutes (Attachment Four)
- Actuarial Opinion (C) Working Group Sept. 30, 2025, Minutes (Attachment Five)
  - 2026 P/C Statement of Actuarial Opinion (SAO) Instructions Exposed (Attachment Five-A)
  - Regulatory Guidance Exposed (Attachment Five-B)
- Actuarial Opinion (C) Working Group Aug. 20, 2025, Minutes (Attachment Six)
  - 2026 P/C SAO Instructions for Discussion (Attachment Six-A)
  - Regulatory Guidance for Discussion (Attachment Six-B)
- Statistical Data (C) Working Group Nov. 19, 2025, Minutes (Attachment Seven)
- Statistical Data (C) Working Group Oct. 29, 2025, Minutes (Attachment Eight))
- Statistical Data (C) Working Group Sept. 24, 2025, Minutes (Attachment Nine)
- Statistical Data (C) Working Group Aug. 20, 2025, Minutes (Attachment Ten)

Draft Pending Adoption

Draft: 12/15/25

Casualty Actuarial and Statistical (C) Task Force
Hollywood, Florida
December 9, 2025

The Casualty Actuarial and Statistical (C) Task Force met in Hollywood, FL, Dec. 9, 2025. 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 Sian Ng-Ashcraft (AK); Mark Fowler represented by Charles Hale and Kyle Ogden (AL); Ricardo Lara represented by Tina Shaw (CA); Jared Kosky represented by Wanchin Chou (CT); Michael Yaworsky represented by Richie Frederick (FL); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Larry Steinert (IN); 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 (PA); Michael Wise represented by Will Davis (SC); Cassie Brown 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 Robert Grishaber (WV).

1. Adopted its Nov. 4, Oct. 14, Sept. 9, and Summer National Meeting Minutes

Citarella said the Task Force met Nov. 4, Oct. 23, Oct. 14, and Sept. 9. During its Nov. 4 meeting, the Task Force took the following action: 1) adopted the reports of its working groups; 2) adopted the NAIC *Rate Model Review Manual*; and 3) discussed unknown risk characteristics. During its Oct. 23 e-vote meeting, the Task Force adopted its 2026 proposed charges. During its Oct. 14 meeting, the Task Force took the following action: 1) adopted the reports of its working groups; 2) heard a report on NAIC generalized linear model (GLM) regulator training; and 3) discussed its 2026 proposed charges. During its Sept. 9 meeting, the Task Force took the following action: 1) adopted the reports of its working groups; 2) provided feedback on the Center for Insurance Policy and Research (CIPR) catastrophe model training; 3) heard liaison reports; and 4) discussed a trade association's podcast about unknown rating characteristics.

The Task Force also met Nov. 18, Oct. 21, and Aug. 19 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

Additionally, the Task Force held a Predictive Analytics Book Club meeting on Oct. 21. The meeting included the presentation "How Actuarial Science Can Benefit from AI ... and Vice Versa" from Frank Chang, PhD (Past Casualty Actuarial Society [CAS] president and current vice president at Uber Technologies Inc.), James Guszcza, PhD (Stanford University Research Affiliate and co-founder of Clear Risk Analytics), and Max Martinelli (Lead Actuarial Data Scientist at AKur8).

Botsko made a motion, seconded by Darby, to adopt the Task Force's Nov. 4 (Attachment One), Oct. 23 (Attachment Two), Oct. 14 (Attachment Three), Sept. 9 (Attachment Four), and Summer National Meeting (*see NAIC Proceedings – Summer 2025, Casualty Actuarial and Statistical (C) Task Force*) minutes. The motion passed unanimously.

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

Fisk reported the Actuarial Opinion (C) Working Group met Sept. 30 and Aug 20. During the Aug. 20 meeting, the Working Group continued refining the 2025 Regulatory Guidance document and the *2026 Property/Casualty (P/C) Statement of Actuarial Opinion Instructions*. Subsequent edits were made based on that discussion. Documents were released for a 30-day public comment period ending Sept. 26. No comments were received.

During the Sept. 30 meeting, the Working Group voted to adopt the 2025 Regulatory Guidance document and the blanks proposal to make changes to the *2026 P/C Statement of Actuarial Opinion Instructions*. Following adoption by the Working Group, the changes to the opinion instructions were submitted to the Blanks (E) Working Group, and the Regulatory Guidance Document was published on the Working Group's website.

Fisk made a motion, seconded by Botsko, to adopt the report of the Actuarial Opinion (C) Working Group, including its Sept. 30 (Attachment Five) and Aug. 20 (Attachment Six) minutes. The motion passed unanimously.

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

Darby reported that the Statistical Data (C) Working Group met Nov. 19, Oct. 29, Sept. 24, and Aug. 20 to hear comments and consider proposed updates to the *Statistical Handbook of Data Available to Insurance Regulators* (Statistical Handbook). Due to the handbook's size, the Working Group is working section by section to dive into the current data elements and definitions, with a goal to complete sections one through three, which include the introduction, data quality information, the summary of reports available to regulators, and all of the personal line sections in 2026. To date, the Working Group has opened sections on homeowners and mobile homes; dwelling, fire, and allied lines; and private passenger auto, and has discussed the addition of a pet insurance section.

These meetings have included participation from regulators, statistical agents, insurance companies, and consumer representatives, all of whom have offered suggestions and provided feedback on each section. The Working Group will continue to meet regularly and welcomes participation from all parties. The next Working Group meeting is scheduled for Dec. 17.

As an update to the current year's statistical reports, the *2022/2023 Auto Insurance Database Report* (Auto Report) was adopted by the Working Group this month. 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) will be sent to the Working Group in the coming weeks for review and adoption.

Darby made a motion, seconded by Vigliaturo, to adopt the report of the Statistical Data (C) Working Group, including its Nov. 19 (Attachment Seven), Oct. 29 (Attachment Eight), Sept. 24 (Attachment Nine), and Aug. 20 (Attachment Ten) minutes. The motion passed unanimously.

4. Heard a Report on Rate Filing Issues

Citarella reported that there is value in speaking broadly about rate-filing topics that are discussed in regulator-to-regulator session, without sharing names of carriers, vendors, or jurisdictions.

Two recent topics of discussion were vehicle history score models, which led to a conversation about a newer concept called vehicle build scores, and a new flood risk model. The regulators discussed concerns about some variables being included in the models that might lead to unfair discrimination. Also discussed were the kinds of

data sets used for these models and the supporting documentation needed. Citarella said a new flood risk model has a higher complexity level than previously seen.

Filing entities have been invited to present to regulators in a regulator-to-regulator session to present a new product or modeling approach to regulators. Darby noted that vendors can contact Kris DeFrain (NAIC) if they want to present something new or technical to the group in a confidential setting.

5. Received Liaison Reports

Darby reported on System for Electronic Rates & Forms Filing (SERFF) modernization early-adoption activity. The platform will not be ready until the first quarter of 2026, so it is expected that the first early adopters will transition by the second quarter of 2026. Natural language processing will be used to compare forms and rules to state checklists or state law and provide advice to a human about compliance. Once a specific rule is working well, states can make it available to industry as a pre-filing check.

Citarella reported that the Big Data and Artificial Intelligence (H) Working Group has developed a regulatory tool to be piloted in 10 to 12 states for use in financial analysis, financial exams, and market conduct exams. The tool's current version is essentially a set of interrogatories and checklists that enable the regulating entity, the state, to understand the scope of AI being used.

Chou reported that the Third-Party Data and Models (H) Working Group exposed its *Risk-Based Regulatory Framework for Third-Party Data and Model Vendors.* He said a goal is for regulators to have access to third-party data and models, and for third parties to report their governance practices regarding data and models.

Chou reported that the Cybersecurity (H) Working Group is working on developing a cybersecurity event notification portal and analyzing data from cyber reporting.

Darby said the homeowners market data call timeline is to release the call letter in early 2026, with a due date in June. They are also discussing a threshold for when reporting is required.

Botsko said the Catastrophe Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group completed wildfire analysis and plans to remove the "informational only" limitation. The catastrophe peril factors will be adjusted to remove any double-counting.

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

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

7. Discussed Other Matters

Citarella said he wanted to correct what was said by a consulting firm during a webinar regarding the NAIC rate model review team's acceptance of its model. He emphasized that the team does not accept, approve, or endorse rate models. Regulators do not cede any regulatory authority to the NAIC. He said regulators reviewing the same NAIC report may draw two different conclusions or make different decisions based on different state laws and regulations. Dyke added that the NAIC rate model review team is a valuable resource for states, helping regulators do their jobs effectively.

Steinart asked if the team notifies regulators when they find significant problems or fundamental flaws. Dorothy Andrews (NAIC) said all issues are documented within the report and posted to the shared model database.

Chou said some regulators are discussing a panel about rate filing issues at the CAS 2026 Spring Meeting, and others are welcome to join.

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

SharePoint/NAICSupportStaffHub/Member Meetings/C CMTE/2025_Fall/CASTF/120925 Minutes CASTF FNM.docx

Draft: 11/12/25

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
November 4, 2025

The Casualty Actuarial and Statistical (C) Task Force met Nov. 4, 2025. 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 Sian Ng-Ashcraft (AK); Mark Fowler represented by Charles Hale (AL); Ricardo Lara represented by Tina Shaw and Mitra Sanandajifar (CA); Andrew N. Mais represented by Wanchin Chou (CT); Michael Yaworsky represented by Jane Nelson (FL); Holly W. Lambert represented by Larry Steinert (IN); Vicki Schmidt represented by Marsha Hanson (KS); Timothy J. Temple represented by Amber Schreve (LA); Robert L. Carey represented by Sandra Darby (ME); Marie Grant represented by Walter Dabrowski (MD); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); Remedio C. Mafnas (MP); 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 Kate Yang (OK); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Elizabeth Byckovski (TX); Kaj Samson 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 Statistical Data (C) Working Group

Darby reported that the Statistical Data (C) Working Group met Oct. 29 to continue discussing updates to the *Statistical Handbook of Data Available to Insurance Regulators*.

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

2. Adopted the *NAIC Model Review Manual*

Kris DeFrain (NAIC) said written comments on the *NAIC Model Review Manual* were received at the Summer National Meeting. A small drafting group led by Tom Zuppan (AZ) reviewed the comments and submitted a revised manual to the Task Force in early October. Sam Kloese (NAIC) highlighted some of the changes.

McKenney made a motion, seconded by Darby, to adopt the *NAIC Model Review Manual* (Attachment One-A). The motion passed unanimously with one abstention.

3. Discussed Unknown Risk Characteristics

Citarella said the Task Force received written responses to the Sept. 18 letter requesting input from interested parties (Attachment One-B). He clarified that the discussion is about carriers assigning rating factors to a category labeled "unknown" as a risk classification and not about missing data in a model or how much insurers rely on third-party data vendors. While those topics may be related, the Task Force is currently focusing on whether it is appropriate, reasonable, and ultimately legal under each state's laws and regulations to include "unknown" as a risk class in a rating manual. He said the Task Force might later explore broader issues and will collaborate with other committee groups where needed.

McKenney said the Task Force should encourage as much dialogue as possible around this issue because it is important that everyone understands the breadth of what is happening. He said "unknown" risk classifications show up in countless filings in Pennsylvania; it is pervasive. He said that all reviewed rating variables have had some kind of failed "unknown" classification attached to them. He said the status quo, which is that regulators are expected to address this issue one filing and one variable at a time without any agreed-upon standards for what is acceptable, is not recommended.

McKenney said his comment letter referenced the *Price Optimization White Paper* written by the Task Force, which states that insurance customers with the same risk profile should be charged the same premium for the same coverage. He said that it is a cornerstone of rate regulation and rate regulatory law. He said that statutes tell us that two customers with the same risk profile being charged different rates for the same coverage constitutes unfair discrimination.

McKenney referenced a chapter in Robert Finger's book about risk classification, which was on the Casualty Actuarial Society (CAS) Exam 5 syllabus at one time, that talked about balancing the selection of risk classes with the ability to obtain and verify the data. McKenney gave the following quote from Finger's book: "[a]nother important practical consideration is administrative expense. The cost of obtaining and verifying information may exceed the value of incremental accuracy. For example, driving mileage or when and where someone drives might be good indicators of cost, but they're probably too expensive to verify."

McKenney said that today, insurers are solving the expense problem by assigning everyone to the "unknown" risk class when something cannot be immediately returned from a third-party data vendor for any reason. He said regulators have seen filings where the classification is "unknown" because the vendor's system was down when the query was made. He said insurers are claiming that "vendor system down" is a valid class of risk. Regulators are also told that "no hits" happen because of things like a misspelled name or a misplaced character in a 17-digit string. Instead of correcting the error or asking for clarification, the insurer just assigns "unknown" and says that it is informative about the exposure. McKenney said that cannot be how the industry operates. If an insurer is going to charge two consumers different rates, they should be able to point to something that is different about those consumers. Now, if the consumer is told about the missing information and chooses not to provide it, that is acceptable. What regulators are seeing is insurers throwing up their hands and saying that the vendor does not know, the system was down, or there was a typo, and that is the end of it. When the percentage of unreturned or unknown data is that high, it is unacceptable.

McKenney said that this morning in Pennsylvania, an actuarial staff member shared an example where the vendor could not provide a consumer score for 45% of the policies in a filing. That percentage is nearly half the book, yet the insurer still proposed using that variable for rating.

The Pennsylvania comment letter laid out several recommendations:

- There is a safe harbor threshold. If the unknown population is very low, no further action is needed. If it is high, then it is not a valid rating variable. If it is in between, insurers should either ask the consumer for the missing data or issue a disclosure explaining what the customer was rated on and what was missing so the consumer can provide the information if they choose.
- Certain variables, like rating territory, are designated as ones that simply cannot have an "unknown" classification. Last week, Pennsylvania did not approve a proposal where the "unknown" territory rate was more than 1,000% higher than the known territory rate. It took communicating about the issue three times before the insurer removed it, and the filing could be approved.

- In some cases, lack of information defines a valid class, and those variables can be identified and exempted from these requirements.
- "Rate neutrality" is not defined, but 1.00 is often not "neutral" or appropriate for the rating factor selection. Actuaries know that when a new rating variable is introduced, the base rate is offset by the weighted average relativity. If the average relativity is less than 1.00, then the base rate increases, meaning that a 1.00 is actually a surcharge. Therefore, Pennsylvania recommends using the weighted average relativity whenever "unknown" classifications are validly used.

The Pennsylvania Insurance Department urges regulators and industry to come together and establish clear parameters around the use of "unknown" risk classifications. McKenney stated that this issue is not going away. He said that if regulators continue to handle the issue one filing at a time, it will slow down the review process and drain regulatory resources.

Bradner agreed and said he is interested in continuing the discussion. He said there are buckets of variables that should be treated similarly, and it would make sense for regulators to discuss potential actions for those groupings. He said the current state of rates is all over the board; some states are catching issues, and some states do not have the manpower. He said consistency across the board should be desired, and guidance could help companies know what to do. Citarella said there is value in having some consistency across states, and there is value in having consistency within the state. He said a continued conversation will help him to make decisions in his state.

Lederer said that Missouri does not believe the Task Force needs to take further action. She said the comments have been helpful and serve as a reference for states to make their own policy. She said it is highly unlikely the Task Force can settle on one coherent response.

Norman Niami (APCIA) cautioned regulators not to write rules based on extreme cases. Citarella said some of those extreme cases provide an opportunity for low-hanging fruit, where it is easily agreed that the case is not appropriate; other areas are gray areas that would require more discussion.

Stolyarov said states have essentially the same general statutory authority to make sure rates are not excessive, inadequate, or unfairly discriminatory. He said this is in place regardless of whether there is a prior approval, file and use, or other framework. Regulators have the authority to identify practices that are unfairly discriminatory and take action. He said the wording was introduced in 1971, before predictive models existed, before most insurers gathered data from third-party vendors, and before the issue of unknown rating characteristics arose. Most information at that time was collected directly from the policyholder or from three objectively easily verifiable sources. The current situation was not envisioned in 1971. He said the statutes provide a good principles-based framework, and in Nevada, there is a provision stating the legislature intends that these statutes be liberally construed to achieve the purposes of consumer protection.

Stolyarov said he does not believe a statutory change is necessary, but he also does not believe that "anything goes." He said regulators need to apply the principles in the law to ensure that consumers are protected. He said the key question is whether insurers are accurately rating the risks that come before them, and if there is information that could be easily obtained about those risks or corrected by the consumer, but it is not. Even more of a concern is when there is punitive treatment of a consumer based on system failures, inaccuracies, or deficient data. Insurers should do due diligence, and Pennsylvania's framework contains useful principles-based guidance to regulators. He said that the framework can be applied and customized to each state.

Citarella said the Task Force will continue discussions at its monthly rate filing issues meetings and report on open calls as needed. Numerous states reported that discussions are occurring in their states.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/110425 min.docx

Link to exposed NAIC Model Review Manual

(Can also be found on Task Force Web page under Documents.)

1. *NAIC Model Review Manual* **Exposure Comments Received**

2. Revised Appendix C (with tracked changes)

COMMENT LETTERS:

From: ZEMAN, ROBERT <Bob.ZEMAN@allstate.com>
Sent: Friday, July 25, 2025 3:26 PM
To: DeFrain, Kris <kdefrain@naic.org>
Cc: ZEMAN, ROBERT <Bob.ZEMAN@allstate.com>
Subject: FW: DRAFT NAIC CASTF Model Review Manual

Hi Kris, here are the comments from Allstate on the Draft Model Review Manual. Let me know if you have any questions. Thank you!

Allstate appreciates the opportunity to provide these comments on the NAIC Model Review Manual dated 6/5/25. Allstate recognizes the additional transparency that publication of this draft manual provides. We asked our company experts including but not limited to those involved in the filing process to review the manual and offer insights on the draft.

Our overriding comment is that we respectfully suggest the manual, and the process it is designed to reflect, allow additional opportunities earlier in the process for dialogue with the insurer making the model filing to answer questions and give context to the filing. This could further assist NAIC and state DOI staff in their review of the filing. Our staff indicated they of course would be willing to answer questions at any point throughout the review process.

Our staff understands that NAIC has indicated it will not share information as to which states have signed the agreement with the NAIC. While we respect that point of view, we suggest it could be useful for insurers to know which states participate in the review process and have access to prior NAIC reports. For example, for states that have signed the agreement, our filing memos could be tailored to identify existing model reports that could in turn help expedite another state's review.

It would also be helpful if the process would provide for notification to the filing company that the filing is being reviewed by the NAIC Model Review team. This could help the company respond to subsequent requests by other states for information relating to the filing. It would also help the company more efficiently plan for future filings.

Our staff indicated it would be helpful to receive, at some point in the process, a copy of the NAIC team's report relating to analysis of the company's filing. While we understand the report is prepared by the NAIC team to assist a given state in its review, the information

and feedback could help the company modify future filings and help shape responses to subsequent inquiries.

Similarly, our experts indicated it would be helpful to know if possible what information exists about review by the NAIC team of similar filings made by other insurers. This would be relevant in instances where we are considering a “me-too” filing consistent with law and procedure for such filings in a given state.

Our comments are given in the spirit of offering thoughts designed to help provide a more efficient process for the benefit of regulators, insurers and the consumers we serve.

Bob Zeman

Allstate

Rzema@allstate.com

July 17, 2025

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: Draft Model Review Manual Comments

Dear Ms. DeFrain,

Thank you for this opportunity to provide feedback regarding the NAIC Model Review Manual.

APCIA[1] supports actions that assist in understanding and reviewing models. While most of the requirements are feasible, some seem unlikely to provide value. It is not clear what the intended use of some the information gathered may be. NAIC's actions on the data collected could lead to inappropriate regulation which would negatively impact our shared goal of assuring that premiums and reserves are aligned with risk.

Our members' concerns are outlined below.

1. Data Gathered Before Submission to the NAIC

(*Including High-level comments on* Appendix C)

- **General Concern**: Model Checklists are overly prescriptive and create the risk of limiting metrics that are more relevant than those addressed in the Checklists.
    - We recommend allowing greater adaptability in the selection of statistical metrics used to demonstrate appropriate model validation. The same metrics may not be suitable for all model types or use-case scenarios.
- **General Concern**: Model checklist requirements are excessively detailed.
    - We suggest refocusing the checklist on key areas such as model validation and usage, rather than emphasizing detailed technical aspects of model development.

2. Detailed Suggestions on the Model Checklists

- **General comments**

[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 315 member groups). APCIA member companies P&C countrywide market share is 67% (total 75% commercial lines, 57% personal lines).

We recommend a less prescriptive approach. Regulators should identify critical validation concepts but allow companies flexibility in demonstrating validation. Prescriptive mandates impose undue burdens, especially when companies use comparable yet differing validation methods.

Specific examples include:

- P-values and confidence intervals do not always provide meaningful validation for parameter estimates, since their usefulness varies with the size of the dataset and other considerations. Flexibility to utilize alternative methods should be permitted.
- Companies should have the flexibility to choose various suitable metrics to assess model performance. For instance, Lorentz curves can be used to effectively validate overall model performance.
- Shapley values may provide more meaningful views of variable importance as opposed to Variable Importance Plots in certain contexts. Flexibility is selecting appropriate methods should be allowed.
- The number of categories used in quantile plots should reflect data specifics, model application, and dataset size. A fixed number (e.g. 20 categories) does not always provide the optimal validation information.

- **Essential Information Sections**
  - Clarification is needed on the term "target consumer," as its meaning is unclear and potentially ambiguous across multiple checklists.

- **Sometimes Needed Information Sections**
  - Requiring detailed individual credentials for modeling team members, especially in larger companies where staffing may rotate during the course of a multi-year modeling project, creates excessive administrative burden. If individual credentials, as opposed to model information, is considered relevant from a regulatory perspective, it would be more practical to request qualifications only from the lead modeler accountable for the model's overall development.

3. Focus on Nationally Significant Companies and Licensed Third Parties

- **General Concern**: Company size alone is not a reliable indicator of model risk and should not be the criterion for achieving impactful regulatory oversight.
  - Larger companies may often have more resources to hire skilled modelers, develop proprietary models, or tailor third-party models to have a better fit to their books of business.
  - Relying solely on size may inadvertently confer an unfair competitive advantage to some firms, potentially stifling innovation while not addressing the risk of inadequately resourced models use by other firms.

- **Recommendation**: We suggest that the NAIC consider incorporating additional or alternative criteria beyond company size.
    - Possible criteria include:
        - The ratio of market conduct complaints to policies in force.
        - A qualitative evaluation of an insurance group's Model Risk Management framework or other relevant governance framework, as assessed by the group's lead regulator. For example, if a qualitative scale of A (highest rated), B (medium rated), or C (lowest rated) were used to rank model risk governance frameworks, prioritizing a C rated company over an A rated company may result in more impactful regulatory oversight. Such a qualitative rating could be applied alone or in conjunction with company size.

4. Factors of Tree-Based Model

A simple decision tree will have a limited number of "factors," which can easily be expressed by a series of if/then statements ("if A, B, ~C, D, E, ~F, G, then $2,300"). Such a tree would lead to dozens, perhaps hundreds of factors at most. In practice, companies generally don't use such a simple tree in a regulatory process, and may use methods such as Random Forests or Gradient Boosting Machines. In those cases, the model would be based on hundreds or thousands of underlying trees, each potentially with its own set of factors. The ensembled trees with different sets of features could lead to additional challenges with compliance:

- Column C (current factor): There is no sense in which any tree in the proposed model corresponds to a specific tree in a current model. It is <u>not</u> feasible to present a set of proposed and current factors in this manner.
- Column D, E, F (indicated factor): It is neither efficient nor practical for data scientists and companies to adjust factors in these models as they might in GLMs. It is reasonable to assume that these columns will always be equivalent. Submitting them for regulation would be practical but meaningless.
- Presentation: While it is possible to show every single tree, the weights applied to each tree, and the if/then statements that represent which leaf of each tree would get activated, it is not clear how the NAIC intends to use the lengthy documentation which may have no added value and insight. We request that the intended process for using this data is shared before the close of the review period.
- Table of every possible combination: This is no more feasible for decision trees (or neural nets) than it is for GLMs. We request that the usage of such information for GLM regulation in the past is shared before the close of the review period.

Additional comments for neural nets

We are confused by the thrust of this section which implies that neural nets are synonymous with classification. It is neither the case that neural nets can only be used for classification, nor that classification can only rely on neural nets. Due to their layered structure and nonlinear transformations, the "factors" in neural networks may be even less meaningful to regulators than they are for decision trees. We believe that this serves to illustrate the concerns expressed above in the comments in the decision tree section.

Please do not hesitate to contact me with questions.

Thank you,

Norman Niami, FCAS, MAAA, Affiliate IFoA

Vice President, Actuary, Policy, Research and International

Norman.Niami@APCI.org

Cell: 202-880-4082

NAMIC
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

3601 Vincennes Road, Ind anapolis, Indiana
202.628.1558 | [F] 202.628.1601
20 F Street N.W., Suite 510 | Washington, D.C. 20001

July 25, 2025

Commissioner Bettencourt (NH), 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 Casualty Actuarial and Statistical (C) Task Force's NAIC Model Review Manual

Dear Commissioner Bettencourt and Members of the Committee:

On behalf of the National Association of Mutual Insurance Companies (NAMIC)[1], we would like to thank the NAIC Casualty Actuarial and Statistical (C) Task Force for requesting and accepting comments on its recent NAIC Model Review Manual exposure. NAMIC appreciates the Task Force's attention to transparency in how the rate model reviews are conducted on behalf of states, as well as the effort to streamline the review process across states to achieve efficient speed-to-market. That said, we do wish to emphasize the importance of adhering to proper procedure and state specific laws for contracting directly with states.

NAMIC has substantive comments on the draft exposure below, and we are looking forward to continuing robust dialogue as the Task Force continues its review process.

SUBSTANTIVE COMMENTS BY DOCUMENT

[1] NAIC Model Review Manual

The original concept of contracting with the NAIC and using its staff for rate model reviews was rooted in the intent to provide a streamlined and technically consistent process, particularly as state Departments of Insurance work to develop their own internal expertise and staffing capacity. Given the principles and intent behind the process itself, transparency behind the need for, and genesis of, any changes to the process are of utmost importance. In an effort to more fully understand the changes being proposed, NAMIC requests greater clarity in the areas of the manual outlined below.

The comments we outline below are provided notwithstanding the fact that we strongly encourage Departments to prioritize rebuilding and maintain suitable in-house staffing levels. Preserving these functions at the Departments, where the statutory and regulatory authority ultimately resides, will help

[1] The National Association of Mutual Insurance Companies consists of nearly 1,500 member companies, including seven of the top 10 property/casualty insurers in the United States. The association supports local and regional mutual insurance companies on main streets across America as well as many of the country's largest national insurers. NAMIC member companies write $391 billion in annual premiums and represent 68 percent of homeowners, 56 percent of automobile, and 31 percent of the business insurance markets. Through its advocacy programs NAMIC promotes public policy solutions that benefit member companies and the policyholders they serve and fosters greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

ensure that oversight remains closely aligned with the needs and legal responsibilities of each individual state.

[a] Introduction

NAMIC recommends that the Model Review team apply and rely upon relevant Actuarial Standards of Practice, and other actuarial principles related to the ratemaking process, in addition to ensuring compliance with applicable state statutes and regulations.

Additionally, the manual does not provide definitions for "complex predictive models" nor for "predictive models;" to create consistency from an actuarial standpoint, NAMIC recommends replacing these terms with simply "model" and utilizing the definition adopted in 2019 with ASOP 56.[2]

[b] Rate Review Support Services Agreement

Confidentiality continues to be a high priority for members, particularly in the case of model reviews, which often contain highly sensitive trade secret information from an insurance company. In this vein, NAMIC recommends:

1. The manual should include a page that lists all participating states and each state's specific authority for sharing information with the NAIC, along with mandating the NAIC's confidential treatment of the information. As we expressed during the development and execution of the Property Casualty Market Intelligence data call, companies want to provide all required information but will only do so with the confidence in statutory confidentiality.
2. NAIC exposure of the master Information Sharing and Confidentiality Agreement referenced in the manual.
3. Articulating how confidentiality will be maintained on the information is uploaded into the database. For example, will access be audited and maintained to ensure only appropriate stakeholders can access confidential information?
4. Establishing and maintaining open communication with the filing insurance company and sharing of any written report created by the NAIC to the insurance company.

[c] State, Insurer, and Model-Type Priorities

We are concerned this area of the manual may introduce inefficiencies into the filing process, which contradicts the stated goal of providing faster speed-to-market. Focusing primarily on "nationally significant companies" raises issues of fairness, as all insurers- regardless of size- should be subject to consistent regulation by the states. Additionally, based on member feedback, it has generally been an insurer's experience that the NAIC review process tends to be slower than current state reviews, notwithstanding the commitment to a 30-day turnaround. Finally, limits on the number of NAIC reviews allowed per state each month could cause delays in filings, hindering timely market access.

[2] https://www.actuarialstandardsboard.org/asops/modeling-3/

[2] The Rate Review Support Services Agreement

NAMIC appreciates the opportunity to review a currently in-force agreement between the NAIC and Maine. Providing this is an outstanding example of genuine transparency in the spirit of collaboration that can improve safety and confidence for all stakeholders. The agreement appears to be strong, primarily because of its reliance on Maine statutes. Not all states currently have similarly strong statutory protections, which may create gaps or weaknesses if they execute comparable agreements that lack explicit protection.

With this in mind, we have recommended amendments for the agreement that would enhance the confidentiality protection of companies:

- 8. As between the parties, the NAIC agrees that the Confidential Information disclosed by the BOI remains the property of the BOI and agrees that it will take no action the effect of which would be to limit, waive or jeopardize any privilege or claim of confidentiality held by the BOI or any other third party related to the Confidential Information.
- 10. With the exception of the Report described herein, and any Confidential Information or any derivatives thereof, the NAIC retains any and all rights, title and interest in any work papers, methodologies, models, standards, and any other type of material whatsoever ("Proprietary Materials"), which it may have developed or employed in the performance of the Support Services under this Agreement, and neither the BOI nor the State of Maine shall have any right, title or interest in or to the Proprietary Materials for any purpose. The BOI agrees to take no action adverse to the rights of the NAIC as owner of the Proprietary Materials.
- Suggested additional new paragraph 19. To the extent any of the Confidential Information shared by the BOI with the NAIC under this agreement originates from a third party, such third party is an intended beneficiary of the Confidential provisions set forth in this Agreement.

[3] Appendix C

[a] Page 3- Generalized Linear Model (GLM) List

NAMIC requests the task force clarify, and make explicit in the manual, what is considered a "new model" vs a "state-specified version of a model" vs a "refresh." By way of example, because many areas of a model can be adjusted, it is unclear what would constitute the threshold for a "new model".

[b] Page 4- GLM Data

Relative to the GLM data section, NAMIC provides the following feedback:

1. NAMIC has concerns around the point in the manual that requests a listing of the rational explanation for each modeled variable and why it would plausibly impact insurance risk. Variables are selected based on correlation with loss experience. A rational explanation can be interpreted differently and therefore could introduce subjectivity biases into the analytical process which is not supported by ratemaking practices.

2. The request for 100 anonymized sample modeling records is a very large number given the need to provide all possible values. For consistency and to reduce supply and review burden, we suggest reducing to 10 records as requested on page 7.
3. The request for SERFF filing numbers where the use of data was previously approved warrants more clarity. Not all states require a filing to be approved, or generally a rate filing may be approved not specifically data.

SUMMARY

In summary, thank you again to the Task Force for allowing NAMIC to submit comments in response to the exposure of the NAIC Model Review Manual and associated documents. We look forward to continued discussions with the Task Force through robust and transparent conversations on this matter. NAMIC and our members seek to achieve efficient and effective methods of review as well as processing of model reviews in order to maximize speed-to-market. Such results are inherently beneficial not only to the Departments of Insurance, but companies and consumers alike, and fosters competitive marketplaces.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer, CPCU, AIE, MCM
Policy Vice President – Market Regulation & Workers' Compensation
NAMIC

From: Herrington, Whitney <Whitney.Herrington@floir.com>
Sent: Monday, July 7, 2025 11:46 AM
To: DeFrain, Kris <kdefrain@naic.org>
Subject: RE: Updated FW: CASTF Exposure: NAIC Model Review Manual

Good morning Kris,

Our team has the following to submit for the exposure:

CASTF may consider revising the section titled "SERFF Access" under "Rate Review Support Services Agreement" on page 4.

Here is the current language:

SERFF Access

The System for Electronic Rate and Form Filing (SERFF) allows insurers, advisory organizations, and third-party filers to submit insurance product filings (typically rate, rule, and form filings) electronically to state insurance regulators. This is a multi-state electronic filing system (licensed in all jurisdictions), but SERFF access is limited to a regulator's individual state. NAIC Staff will request access to every state with a signed Rate Review Support Services Agreement.

Access to NAIC and State Reports

Access to the Model Database and NAIC or state reports is restricted to regulators only.

REVIEW SUBMISSIONS AND DUE DATES

Before submission of a review request, the regulator will check the model database to see if the model has already been reviewed. Upon receipt of a regulator's request to review model support and/or objections (compliance issues), NAIC Staff will review the model complexity and the current state of the filing's supporting documentation. NAIC Staff will reply within 2 business days to share their availability and a date of when they can complete a review. The regulator will respond whether that date is acceptable, or they wish to withdraw the model review request.

This does not account for states that do not use SERFF for rate filings. In these cases, would the NAIC team need direct access to the state's filing system?

Whitney Herrington

Research and Projects Coordinator

whitney.herrington@floir.com

Office: (850) 413-5017

Florida Office of Insurance Regulation

200 East Gaines Street,
Tallahassee, FL 32399
www.FLOIR.com

From: Meyer, Connor (COMM) <connor.meyer@state.mn.us>
Sent: Tuesday, July 1, 2025 6:02 PM
To: Kloese, Sam <skloese@naic.org>
Cc: DeFrain, Kris <kdefrain@naic.org>
Subject: RE: Updated FW: CASTF Exposure: NAIC Model Review Manual

Hi Sam,

I just wanted to follow up about this question I had regarding the 7-year retention for modeling datasets on the Model Review Team checklists, and also I had one additional question about the checklist for neural networks.

On the fourth page of the neural network checklist (Neural Network Model Validation), one of the items is:

- A confusion matrix arranged as follows:
    - Predicted Class in the row names
    - Actual Class in the column names
    - Test Dataset count in the table

I am wondering if this item should also include a confusion matrix for any holdout/validation datasets rather than just the testing dataset, since holdout/validation datasets are also often utilized. If you're looking for feedback on the checklists, and think it would be a good idea to have confusion matrices for holdout datasets as well, perhaps this item of the checklist could be revised to:

- A confusion matrix for the Test and/or Holdout Datasets arranged as follows:
    - Predicted Class in the row names
    - Actual Class in the column names
    - Test Dataset (and/or Holdout Dataset) count in the table

Please let me know your thoughts on this matter.

On Jun 30, 2025, at 4:25 PM, Meyer, Connor (COMM) <connor.meyer@state.mn.us> wrote:

Hi Kris,

Phil Vigliaturo forwarded me the NAIC Model Review Manual that is being exposed for comments. I'm not sure if this is the kind of comment/question you were looking to get, but I was wondering about one of the items on the Model Checklists in Appendix C. All the checklists have a line about guaranteeing that the modeling dataset will be retained for at least 7 years. I was wondering what the reasoning behind this is, and why it is deemed as "Essential Information" on the checklists rather than "Sometimes Needed Information". Does it come from an academic paper or an ASOP?

Again, I'm not sure if this is the kind of comment you were looking to get since it's more to do with the checklists rather than the Manual. Could you perhaps pass this question along to the Model Review Team?

Thanks,

Connor Meyer

Actuarial Analyst

651-539-1759

mn.gov/commerce

Minnesota Department of Commerce

85 7th Place East, Suite 280 | Saint Paul, MN 55101

<image006.png>

Washington State Comments

BACKGROUND

The NAIC model review project officially began in April 2018 when the Executive Committee adopted the recommendation of the Big Data (EX) Working Group to direct NAIC management to "conduct research on the appropriate skills and potential number of resources for the organization to help NAIC members in coordinating their reviews of predictive models." NAIC senior management conducted the research and recommended gradual build-up of expertise at the NAIC to aid regulators' review of P/C rate models.

In 2019 with existing actuarial, legal, and IT staff, the NAIC did 3 things:

1) Drafted a contractual agreement called the Rate Review Support Services Agreement (Appendix A) to be used so a state can gain access to the model database and can request a rate model technical review from the NAIC.
2) The NAIC developed the initial NAIC rate model technical review process with a consulting Actuary, and
3) the NAIC created a model database for confidential regulatory communication.

The NAIC does not do the following actions:

- Assume any regulatory authority,
- Create objections ("compliance issues") to be sent to the company,
- Recommend acceptance or rejection of the model or any specific rating variable and,
- Separate analysis to determine any correlation with unlawful characteristics or to assess disparate impact.

Model reviews conducted by NAIC Staff were initially guided by the NAIC white paper *Regulatory Review of Predictive Models* (Attachment 2). This includes the initial paper and Appendices for different types of models adopted by the Task Force over time.

INTRODUCTION

This *Manual* is intended to guide NAIC Staff to assist insurance regulators in the state's review of predictive models. The aim is to provide a consistent and documented review of complex predictive models used in insurance products while providing appropriate speed to market. To the extent possible, the *Manual* is intended to add uniformity when NAIC Staff produce reports applicable to all states. Compliance with a state's laws and regulations will be performed by the state insurance regulator.

RATE REVIEW SUPPORT SERVICES AGREEMENT

This Rate Review Support Services Agreement (Agreement) identifies the NAIC services that can be requested and utilized:

1) Rate Model Reviews: Develop reports so state insurance regulators can review and decide if the insurer's rate model support is in compliance with state law and regulations.

WilliamW160 Jul 2

The purpose seems to both guide NAIC staff and regulators

Cancel Post

Review submissions should include any specific instructions. The Task Force can also request that specific policy questions be answered with each NAIC model review.

After a model is reviewed in one state, Comparison Reports were completed to compare an insurer's model in one state with the model reviewed in another state. At this time with limited NAIC resources, NAIC Staff will only create Comparison Reports if there are current resources available in the 30 days following the request. A Comparison Report template is maintained by NAIC staff.

STATE, INSURER, AND MODEL-TYPE PRIORITIES

1. **Data Gathered before Submission to the NAIC**

- **Objective**: Ensure complete support documentation is received from the insurer prior to asking for an initial report from the NAIC. This should facilitate a smooth and more efficient review process. Insisting that companies provide complete information will reduce the review time of a model and will effectively reduce the number of NAIC reports per filing by one.

- **Process**:
  - States will be responsible for collecting and compiling relevant model support information prior to NAIC review.
  - The NAIC Model Checklist (Appendix C) provides information that must be submitted by regulators to the NAIC. The current Appendix C contains only GLM information. The Task Force will add the following to the GLM information in Appendix C: 1) checklists for non-GLM models, 2) modifications to support information when a model is a refresh to a previously filed model, and 3) guidance for any other special circumstances (e.g., specific components of a telematics filing to be reviewed).
  - States are encouraged to continually update their model filing requirements in SERFF upon adoption of new guidance from the Task Force.
  - Regularly review and adjust model support requirements to maintain efficiency and relevance.

2. **Focus on Nationally Significant Companies and Licensed Third Parties**

- **Objective**: Prioritize NAIC efforts on entities with the greatest impact.

- **Process**:
  - Limit NAIC review work to top 20 insurance groups (by market size) and third-party vendors licensed or operating in 10 or more states.
  - Exceptions may arise; as in the case of an innovative modeling approach initiated by a smaller company or a new product.

3. **Scheduling with Priorities -- Limiting the Number of Reports by State**

WilliamW160 Jul 23

I'm glad there can be exceptions to this since having to say no to a filer just because they are a smaller insurer would have some difficult political ramifications.

Reply or use @ to invite others

NAIC STAFF RESOURCES

The Task Force will quarterly evaluate the queue of filings and the NAIC model review staff/resources. If the Task Force and/or Task Force leadership determine regulatory needs are not being met, the Task Force will first attempt to find efficiencies or suggest using other resources. If the Task Force wishes the needs to be met by NAIC Staff, the Task Force chair will discuss NAIC resources with the chair of the Property and Casualty Insurance (C) Committee.

WilliamW160 Jul 23

I'd prefer more active language than "discuss". Something like "advocate" or "encourage" or "partner with ... to develop a plan".

Reply or use @ to invite others

MANUAL REVISIONS

NAIC will evaluate the prioritization and utilization of NAIC resources to ensure that they are meeting the needs of those states participating in this process. Suggestions for improving or correcting information contained in the *Manual* may be made via written proposal to the Task Force. The Task Force will determine if changes should be made. Substantive changes made will be discussed in open session, while mechanical corrections (e.g., editorial or typographical changes) will be made without announcement or discussion.

APPENDIX

A. Rate Review Support Services Agreement Template
B. The Task Force's white paper and all adopted appendices
C. NAIC Model Checklists

Appendix C: Rate Model Checklists

v2025.1

Predictive Model Checklists Introduction

Regulators frequently using the NAIC rate model review service asked the NAIC rate model review team to create a list of rate filing documentation needed for the NAIC to complete a full-scope rate model review. The goals of such lists are to make the NAIC review process more efficient and expeditious. Regulators may evaluate these lists and determine the state's needs. Regulators can share this list with insurers, revise the state's rate filing checklists, or communicate with insurers through rate filing objections, when needed.

The lists below are divided by "Essential Information" and "Sometimes Needed Information." These terms are defined in this table:

Category	Description
Essential Information	Information that the NAIC rate model review team requests before writing a full-scope initial assessment of a model.
Sometimes Needed Information	Information that the NAIC model review team finds useful for model reviews but may only be needed if something appears non-standard about the modeling approach. Regulators may want to wait to request such information from insurers only when requested in the initial NAIC report.

This document is meant to address multiple model types. There are some differences in model documentation available for different model types. The sections below are divided by model type. Today, the majority of predictive models used in personal automobile and home insurance rating plans are GLMs. According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. Tree-based models, including random forests and gradient boosting machines, can capture complex non-linear relationships between predictor variables and the target variable. Tree-based models can account for deep interactions between predictor variables. Penalized regression methods can mitigate the risk of overfitting and multi-collinearity in a multi-variate model. Some penalized regression methods (such as lasso regression) also offer automatic variable selection. This checklist document details the rate filing documentation requested by the NAIC Model Review Team for efficient review of standard GLMs, Tree-based models, and penalized regression models.

WilliamW160 Jul 23

Suggest there is a clear statement that regulators can edit this checklist. Just to make sure everyone knows this.

Reply or use @ to invite others

Tree-based Model Data

Essential Information

- A narrative providing the description of each data source including the following:
  - Informational materials or website links for each 3rd party
  - Commentary on how the company reviewed the veracity of the data source
  - Why the company believes the data source is useful for the model's intended purpose
  - Disclosure of known data errors
  - SERFF filing numbers where the use of the data was previously approved (if applicable)
- A description of the relevance of the data
  - The lines of business and companies included should be identified
  - Description of any considerations or adjustments made to make the data more applicable for its intended use
- A data dictionary provided as a table with the following columns:
  - Data Source (Vendor name or "Internal")
  - Variable name
  - Alternate names appearing in other filing documents
  - Data types (discrete, continuous, logical, categorical)
  - Treatment Type (Model, Control, Offset, Target)
  - Possible values (Empirical min and max for numerical variables, all categories for categorical variables)
- Tables showing summary metrics for each dataset by year (training, testing, holdout)
  - Year
  - Losses
  - Exposures (or Policy Count)
  - Claim Count (if applicable)
- A narrative on the candidate variable selection process prior to the model building.
- A narrative on the data accuracy and data reconciliation process
  - Description of the methods used to compile, filter, and/or merge data from different sources
  - How the data was reconciled to other sources
- A listing of the rational explanation for each modeled variable that discusses why it would plausibly impact insurance risk as discussed in the CASTF white paper.
- A guarantee that the modeling dataset will be retained for at least 7 years
- A description of any dimensionality reduction techniques (PCA, clustering, etc.) that were applied to the data.
- An Excel file with 100 anonymized sample modeling records including all predictor variables and target variables.

Sometimes Needed Information

- A description of steps taken to meet state requirements regarding unfair discrimination (if applicable).
- A listing of variables which are subject to the fair credit reporting act (if applicable).
- A table showing the data volume distribution by state for each dataset (training, testing, holdout)
- A listing of variables initially considered but later removed from the model.

WilliamW160 Jul 23

Perhaps a more direct reference to page and location within the white paper.

@ Cancel Post

TRACKED CHANGE DOCUMENT: NAIC PREDICTIVE MODEL REVIEW CHECKLISTS

Contents

Predictive Model Checklists Introduction 2
Generalized Linear Model (GLM) List 3
GLM Introduction 3
GLM Data 4
GLM Modeling 6
GLM Validation 7
GLM Implementation 9
Tree-based Model (Random Forest, GBM, etc.) Checklist 10
Tree-based Model Introduction 10
Tree-based Model Data 11
Tree-based Modeling 13
Tree-based Model Validation 14
Tree-based Model Implementation 15
Penalized Regression Model (GAM, Elastic Net, Lasso, Ridge, Derivative Lasso, Lasso Credibility, etc.) Checklist 16
Penalized Regression Model Introduction 16
Penalized Regression Model Data 17
Penalized Regression Modeling 19
Penalized Regression Model Validation 21
Penalized Regression Model Implementation 22
Neural Network Checklist 23
Neural Network Model Introduction 23
Neural Network Model Data 24
Neural Network Modeling 26
Neural Network Model Validation 27
Neural Network Model Implementation 28

Predictive Model Checklists Introduction

Regulators frequently using the NAIC rate model review service have asked the NAIC rate model review team to create a list of rate filing documentation needed for the NAIC to complete a full-scope rate model review. The checklists below refer to "new model" vs. "model refresh." A "model refresh" is a model where a prior iteration of the model was already filed with the department of insurance requesting review and the latest iteration uses the same data sources, variables, and modeling assumptions (model type, error distribution assumptions, etc.) as the prior iteration. A model which does not meet this definition of a model refresh is considered a new model.

The goals of ~~such lists~~the NAIC model checklists~~-~~ are to make the NAIC review of models process more efficient and expeditious. Regulators may evaluate these lists and determine the state's needs. Regulators can share this list with insurers, revise~~insurers,~~ the state's rate filing checklists, ~~or communicate~~or communicate with insurers through rate filing objections, when needed.

The lists below are divided by "Essential Information" and "Sometimes Needed Information." These terms are defined in this table:

Category	Description
Essential Information	Information that the NAIC rate model review team requests before writing a full-scope initial assessment of a model.
Sometimes Needed Information	Information that the NAIC model review team finds useful for model reviews but may only be needed if something appears non-standard about the modeling approach. Regulators may want to wait to request such information from insurers only when requested in the initial NAIC report.

This document is meant to address multiple model types. There are some differences in model documentation available for different model types. ~~The sections~~The sections below are ~~divided by~~divided by model type. Today, the majority of predictive models used in personal automobile and home insurance rating plans are GLMs. According to many in the insurance industry, GLMs introduce significant improvements over univariate-based rating plans by automatically adjusting for correlations among input variables. Tree-based models, including random forests and gradient boosting machines, can capture complex non-linear relationships between predictor variables and the target variable. Tree-based models can account for deep interactions between predictor variables. Penalized regression methods can mitigate the risk of overfitting and multi-collinearity in a multi-variate model. Some penalized regression methods (such as lasso regression) also offer automatic variable selection. This checklist document details the rate filing documentation requested by the NAIC Model Review Team for efficient review of standard GLMs, Tree-based models, and penalized regression models.

Generalized Linear Model (GLM) List

GLM Introduction

Essential Information

- A narrative discussing what the company is trying to accomplish with the model, including the following details:
  - Is this a new model or refresh? What is the prior model's SERFF number (if applicable)?
  - Does the filing impact existing renewals?
  - ~~Who is the target consumer?~~ What is the target market for the product?
  - What is the target variable of the model? (Frequency, Severity, Loss Ratios, Pure Premium, etc.) How is it defined?
  - What is being optimized? Does the model consider anything other than differences in loss cost?
- A narrative discussing the specifications and high-level assumptions of the model, including the following details:
  - Number of GLMs
  - Split of the data into models (by coverage, by peril, etc.)
  - Split of the data into datasets (training, test, holdout)
  - How models were combined to derive the final rating algorithm

Sometimes Needed Information

- A narrative discussing the credentials of the ~~modeling team~~lead modeler and actuary reviewing the model (if applicable), including the following details:
  - Name of each individual
  - Relevant educational experience
  - Relevant credentials and designations
  - Years of experience building ~~predictive~~ models
  - Years of experience in the insurance industry
- Discuss how Actuarial Standards of Practice (ASOPs) 12, 23, 41, and 56 were considered in building the models.
- Describe the software (including packages and libraries if applicable) used to build the models.
- Provide copies of or links to academic references for their modeling techniques.
- A table listing the states where the model has been filed for review, the SERFF tracking number, and an indicator showing whether the filing has been approved.

GLM Data

Essential Information

- A narrative providing the description of each data source including the following:
  - Informational materials or website links for each 3rd party
  - Commentary on how the company reviewed the veracity of the data source
  - Why the company believes the data source is useful for the model's intended purpose
  - Disclosure of known data errors
  - The filing number representing the latest prior iteration of the model which contains the same proposed third-party data variables (if applicable).
  - ~~SERFF filing numbers where the use of the data was previously approved (if applicable)~~
- A description of the relevance of the data
  - The lines of business and companies included should be identified
  - Description of any considerations or adjustments made to make the data more applicable for its intended use
- A data dictionary provided as a table with the following columns:
  - Data Source (Vendor name or "Internal")
  - Variable name
  - Alternate names appearing in other filing documents
  - Data types (discrete, continuous, logical, categorical)
  - Treatment Type (Model, Control, Offset, Target)
  - Possible values (Empirical min and max for numerical variables, all categories for categorical variables)
- Tables showing summary metrics for each dataset (training, testing, holdout)
- by year, when applicable ~~(training, testing, holdout)~~
  - Year
  - Losses
  - Exposures (or Policy Count)
  - Claim Count (if applicable)
- A narrative on how the company determined the variables to include in the final model
- A narrative on the data accuracy and data reconciliation process
  - Description of the methods used to compile, filter, and/or merge data from different sources
  - How the data was reconciled to other sources
- A listing of the rational explanation for each modeled variable that discusses why it would plausibly impact insurance risk as discussed in the CASTF white paper.
- A guarantee that the modeling dataset will be retained for at least 7 years.
- A description of any dimensionality reduction techniques (PCA, clustering, etc.) that were applied to the data.
- ~~An Excel file with 100 anonymized sample modeling records including all predictor variables and target variables.~~

Sometimes Needed Information

- A description of steps taken to meet state requirements regarding unfair discrimination (if applicable).
- A listing of variables which are subject to the fair credit reporting act (if applicable).

Formatted

Commented [SK1]: NAMIC wants this removed as it introduces "subjectivity biases into the analytical process". I disagree, and the regulators want it based on the CASTF white paper.

Commented [KB2R1]: I disagree as well.

Commented [PR3R1]: I think we should keep as well

Commented [YA4R1]: I also think we should keep it.

Commented [AD5R1]: Ditto

Commented [SK6R1]: Add reference to where it is. (Look at APCIA)

- ~~A table showing the data volume distribution by state for each dataset (training, testing, holdout)~~ The percentage of data coming from the state where the model is filed for each dataset (training, testing, holdout).
- A listing of variables initially considered but later removed from the model.
- An Excel file with 10 anonymized sample modeling records including all predictor variables and target variables.

GLM Modeling

Essential Information

- A narrative discussing the specifications and assumptions of the model, including the following details:
  - Form of the regression equation
  - Distribution assumed for the error term
  - The link function
  - Weights used in regression (if appliable)
- A description of how the model differs from prior versions of the model (if applicable).
- A narrative on the steps taken to eliminate the effects of other rating plan variables from the model (e.g. offsets).
- A description for each control or offset variable of why it was necessary to treat them as control/offset variables.
- A description of how the variables with null or missing values will be treated, including the following:
  - A table showing the rate of null or missing values for each variable
  - A description of the scenarios which generated null or missing values
  - A description of how each null or missing value is treated (might include imputation method or simply left in as a control)
  - A description of what happens to null and/or missing values when generated in production. (Is there a rating factor applied for null/missing or is the data populated before policy issuance?)
- A description of any large loss capping applicable to the dataset
  - Identify the size of the large loss cap
  - Identify the percentile of claim severity represented by large loss cap
- A description of adjustments and modifications to the data including trending, loss development, capping at minimums or maximums, and removal of outliers.
- A description of variable transformations applied to the data. The description should include the name of each transformation technique used, and an example transformation complete with a sample unadjusted value and a final transformed value.
- A description of each feature engineered variables. The description should include the rationale behind the feature engineered variable and a sample calculation including unadjusted original variable values and the final feature engineered variable value.
- A description of how binning was applied to numeric variables and how categorical variable values were grouped together.

Sometimes Needed Information

- Deviance residual plots for each model demonstrating the appropriateness of the model assumptions.

GLM Validation

Essential Information

- A narrative on how the model was validated and assessed for model stability
- A narrative on how the model was assessed for improvement over the prior version of the model (if applicable)
-
- Provide a demonstration of each variable's statistical significance, via at least one of the following ways:
  - GLM output with beta coefficients and corresponding p-values
  - AIC analysis comparing the full model AIC versus each subset model excluding one variable at a time
  - F nested model tests comparing the full model to subset models excluding one variable at a time
  - Double lift charts comparing the full model versus each subset model excluding one variable at a time
  - Error analysis showing that the full model error is lower on a test dataset than each subset model excluding one variable at a time
- ~~An Excel file containing model output in this format:~~
  - ~~Each model is a separate worksheet~~
  - ~~Column A is Variable Name~~
  - ~~Column B is Variable Level Name~~
  - ~~Column C is the coefficient~~
  - ~~Column D is the p-value (if applicable)~~
  - ~~Column E is the 95th confidence interval lower bound (if applicable)~~
  - ~~Column F is the 95th confidence interval upper bound (if applicable)~~
- Ventile plots (quantile plots with at least 12~~0~~ buckets) for both state specific data and countrywide data, built on data not used for model training. Each plot should include lines for both predicted averages and actual average.
- Lorenz curve for each model built on countrywide data. The plot should include the Lorenz curve and the equality reference line. The plot should also include the Gini value for the model.
- An Excel file containing correlation matrices in this format:
  - Each model's correlation matrix is a separate worksheet
  - Row 1 and Column 1 include variable names
  - The rest of the table displays the correlation metrics
- Commentary on which correlation metric (Pearson's, Cramer's V, etc.) was provided in the correlation matrix Excel file

Sometimes Needed Information

- A description of how often the model will be validated against new data in the future.
- A double lift chart comparing the newly proposed model and the current model (if applicable)
- Actual vs. Expected plots by model and variable (aka "Univariate Plots") which show the closeness between actual averages and predicted averages.
- ~~Akaike Information Criterion (AIC) analysis showing AIC for the full model and each subset model excluding one variable at a time to demonstrate the potential impact on AIC of removing each variable.~~
- ~~F nested model tests comparing the full model to subset models excluding one variable at a time to demonstrate the significance of each term. Each test should include the following:~~
  - ~~F-statistic~~

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted

- ~~F-test critical values~~
- ~~Numerator degrees of freedom~~
- ~~Denominator degrees of freedom~~

- Variance Inflation Factors (VIFs) for each variable

GLM Implementation

Essential Information

- A description of how the models being filed are ultimately integrated into the company's final rating algorithm
- A narrative about all post modeling adjustments, such as smoothing, mapping to scores, and tempering of factors
- A narrative identifying the ~~variables~~ risk classes where deviations from indicated were made and commentary on the reason for the deviations
- A dislocation analysis accounting for all rate changes within the filing, including the following:
    - Histograms showing percentage premium change on uncapped and capped basis (if applicable), using buckets of 5%
    - Descriptions of the scenarios with the highest increases
    - Descriptions of the scenarios with the biggest decreases
- Commentary on the differences between rating new and existing policyholders
- An Excel file which documents deviations between indicated and selected in this format:
    - Each model is a separate worksheet
    - ~~Column A is Variable Name~~
    - ~~Column B is Variable Level Name~~Risk Class
    - Column B~~C~~ is the Current Factor (if applicable)
    - Column ~~D~~C is the Indicated Factor
    - Column ~~E~~D is the Proposed Factor
    - Column ~~F~~E is the percentage difference between indicated and proposed. If the absolute value of the percentage difference is > 10%, the cell should be highlighted.
- Sample rating/scoring exhibits for 10 risks in Excel, which show risk characteristics, all intermediate adjustments, and the final algorithm output considering the company's final selections.

Sometimes Needed Information

- ~~None are listed at this time.~~Description of how the results of the model will be displayed or explained to policyholders.

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Tree-based Model (Random Forest, GBM, etc.) Checklist

Tree-based Model Introduction

Essential Information

- A narrative discussing what the company is trying to accomplish with the model, including the following details:
  - Is this a new model or refresh? What is the prior model's SERFF number (if applicable)?
  - Does the filing impact existing renewals?
  - ~~o~~ What is the target market for the product?~~Who is the target consumer?~~
  - What is the target variable of the model? (Frequency, Severity, Loss Ratios, Pure Premium, etc.) How is it defined?
  - ~~What is being optimized?~~ Does the model consider anything other than differences in loss cost?
- A narrative discussing the specifications and high-level assumptions of the model, including the following details:
  - Number and Type of models (GBM, Random Forest, etc.)
  - Split of the data into models (by coverage, by peril, etc.)
  - Split of the data into datasets (training, test, holdout)
  - How models were combined to derive the final rating algorithm

Sometimes Needed Information

- A narrative discussing the credentials of the lead modeler and actuary reviewing the model (if applicable),~~modeling team~~, including the following details:
  - Name of each individual
  - Relevant educational experience
  - Relevant credentials and designations
  - Years of experience building ~~predictive~~ models
  - Years of experience in the insurance industry
- Discuss how Actuarial Standards of Practice (ASOPs) 12, 23, 41, and 56 were considered in building the models.
- Describe the software (including packages and libraries if applicable) used to build the models.
- Provide copies of or links to academic references for their modeling techniques.
- A table listing the states where the model has been filed for review, the SERFF tracking number, and an indicator showing whether the filing has been approved.

Tree-based Model Data

Essential Information

- A narrative providing the description of each data source including the following:
  - Informational materials or website links for each 3rd party
  - Commentary on how the company reviewed the veracity of the data source
  - Why the company believes the data source is useful for the model's intended purpose
  - Disclosure of known data errors
  - The SERFF filing number representing the latest prior iteration of the model which contains the same proposed third-party data variables (if applicable).
  - ~~SERFF filing numbers where the use of the data was previously approved (if applicable)~~
- A description of the relevance of the data
  - The lines of business and companies included should be identified
  - Description of any considerations or adjustments made to make the data more applicable for its intended use
- A data dictionary provided as a table with the following columns:
  - Data Source (Vendor name or "Internal")
  - Variable name
  - Alternate names appearing in other filing documents
  - Data types (discrete, continuous, logical, categorical)
  - Treatment Type (Model, Control, Offset, Target)
  - Possible values (Empirical min and max for numerical variables, all categories for categorical variables)
- Tables showing summary metrics for each dataset by year (training, testing, holdout)
  - , when applicable ~~(training, testing, holdout)~~
  - Year
  - Losses
  - Exposures (or Policy Count)
  - Claim Count (if applicable)
- A narrative on the candidate variable selection process prior to the model building.
- A narrative on the data accuracy and data reconciliation process
  - Description of the methods used to compile, filter, and/or merge data from different sources
  - How the data was reconciled to other sources
- A listing of the rational explanation for each modeled variable that discusses why it would plausibly impact insurance risk as discussed in the CASTF white paper.
- A guarantee that the modeling dataset will be retained for at least 7 years
- A description of any dimensionality reduction techniques (PCA, clustering, etc.) that were applied to the data.
- ~~An Excel file with 100 anonymized sample modeling records including all predictor variables and target variables.~~

Sometimes Needed Information

- A description of steps taken to meet state requirements regarding unfair discrimination (if applicable).
- A listing of variables which are subject to the fair credit reporting act (if applicable).

Formatted

Formatted: Indent: Left: 0.5", No bullets or

- The percentage of data coming from the state where the model is filed for each dataset (training, testing, holdout).~~A table showing the data volume distribution by state for each dataset (training, testing, holdout)~~
- A listing of variables initially considered but later removed from the model.
- An Excel file with 10 anonymized sample modeling records including all predictor variables and target variables.

Formatted: Font: Bold

Commented [PR7]: Remove stray bullet

Commented [SK8R7]: Will update later

Tree-based Modeling

Essential Information

- A narrative discussing the specifications and assumptions of the model, including the following details:
  - Form of the regression equation (if applicable)
  - Distribution assumed for the error term (if applicable)
  - The link function (if applicable)
  - Weights used in regression (if appliable)
  - Description of the tuning procedure for all hyperparameters
  - Description of how the component trees are combined to arrive at final predictions
- A description of all hyperparameters, including the following:
  - Number of component trees
  - Number of features considered at each split in the trees
  - Sampling size (number of rows)
  - Maximum tree depth
  - Minimum volume of data per node
  - "Shrinkage" or learning rate (applicable to GBMs)
- A description of how the model differs from prior versions of the model (if applicable).
- A narrative on the steps taken to eliminate the effects of other rating plan variables from the model (e.g. offsets).
- A description for each control or offset variable of why it was necessary to treat them as control/offset variables.
- A description of how the variables with null or missing values will be treated, including the following:
  - A table showing the rate of null or missing values for each variable
  - A description of the scenarios which generated null or missing values
  - A description of how each null or missing value is treated (might include imputation method or simply left in as a control)
  - A description of what happens to null and/or missing values when generated in production. (Is there a rating factor applied for null/missing or is the data populated before policy issuance?)
  - A description of how the Tree-based model treats null or missing values.
- A description of any large loss capping applicable to the dataset
  - Identify the size of the large loss cap
  - Identify the percentile of claim severity represented by large loss cap
- A description of adjustments and modifications to the data including trending, loss development, capping at minimums or maximums, and removal of outliers.
- A description of variable transformations applied to the data. The description should include the name of each transformation technique used and an example transformation complete with a sample unadjusted value and a final transformed value.
- A description of each feature engineered variables. The description should include the rationale behind the feature engineered variable and a sample calculation including unadjusted original variable values and the final feature engineered variable value.
- A description of how binning was applied to numeric variables and how categorical variable values were grouped together (if binning or grouping were applied before running the Tree-based model).

Formatted: Indent: Left: 0.5", No bullets or

Sometimes Needed Information

- Deviance residual plots for each model demonstrating the appropriateness of the model assumptions.

Tree-based Model Validation

Essential Information

- A narrative on how the model was validated and assessed for model stability
- A narrative on how the model was assessed for improvement over the prior version of the model (if applicable)
- Ventile plots (quantile plots with at least 1~~2~~0 buckets) for both state specific data and countrywide data, built on data not used for model training. Each plot should include lines for both predicted averages and actual average.
- Lorenz curve for each model built on countrywide data. The plot should include the Lorenz curve and the equality reference line. The plot should also include the Gini value for the model.
- Plots useful for understanding the model
    - Plots showing model performance by number of trees. The company should provide a plot showing that an error metric (deviance, negative log-likelihood, etc.) decreases after each iteration (each additional tree). If the company chooses an error metric other than deviance or log-likelihood, the company should describe why they chose a different metric and explain how it is calculated.
    - Variable Importance Plots highlighting which variables contributed most to the model. Provide commentary why variables with relatively lower importance are still included in the proposed model.
    - Interpretability plots visualizing the relationship between each predictor variable and the target variable such as partial dependence plots (PDPs), accumulated local effects (ALE) plots, or Shapley plots. There should be at least one plot for every variable used in the model. The plots should be accompanied by commentary on why the visualized relationships are reasonable.
- An Excel file containing correlation matrices in this format:
    - Each model's correlation matrix is a separate worksheet
    - Row 1 and Column 1 include variable names
    - The rest of the table displays the correlation metrics
- Commentary on which correlation metric (Pearson's, Cramer's V, etc.) was provided in the correlation matrix Excel file

Sometimes Needed Information

- A description of how often the model will be validated against new data in the future
- A double lift chart comparing the newly proposed model and the current model (if applicable)
- Actual vs. Expected plots by model and variable (aka "Univariate Plots") which show the closeness between actual averages and predicted averages.

Tree-based Model Implementation

Essential Information

- A description of how the models being filed are ultimately integrated into the company's final rating algorithm
- A narrative about all post modeling adjustments, such as smoothing, mapping to scores, and tempering of factors
- A narrative identifying the variables where deviations from indicated were made and commentary on the reason for the deviations
- Tree diagrams for the first tree in each model, demonstrating how the splitting works.
- A dislocation analysis accounting for all rate changes within the filing, including the following:
    - Histograms showing percentage premium change on uncapped and capped basis (if applicable), using buckets of 5%
    - Descriptions of the scenarios with the highest increases
    - Descriptions of the scenarios with the biggest decreases
- Commentary on the differences between rating new and existing policyholders
- Documentation on deviations between indicated and selected factors, if applicable. For example, a tree-based model might assign policies to different tiers. Additional analysis after the tree model may derive indicated factors by tier. Any deviations from indicated should be disclosed.
- ~~An Excel file which documents deviations between indicated and selected in this format:~~
    - ~~Each model is a separate worksheet~~
    - ~~Column A is Variable Name~~
    - ~~Column B is Variable Level Name~~
    - ~~Column C is the Current Factor (if applicable)~~
    - ~~Column D is the Indicated Factor~~
    - ~~Column E is the Proposed Factor~~
    - ~~Column F is the percentage difference between indicated and proposed. If the absolute value of the percentage difference is > 10%, the cell should be highlighted.~~
- Sample rating/scoring exhibits for 10 risks in Excel, which show risk characteristics, all intermediate adjustments, and the final algorithm output considering the company's final selections.

Sometimes Needed Information

- Description of how the results of the model will be displayed or explained to policyholders.
- Complete documentation that would allow future audits of model predictions. This could be satisfied by one of the following:
    - Comprehensive Tree diagrams for every tree
    - Comprehensive splitting rules that reproduce the tree logic
    - Tables showing every possible combination of risk characteristics and the final model prediction.

Penalized Regression Model (GAM, Elastic Net, Lasso, Ridge, Derivative Lasso, Lasso Credibility, etc.) Checklist

Penalized Regression Model Introduction

Essential Information

- A narrative discussing what the company is trying to accomplish with the model, including the following details:
  - Is this a new model or refresh? What is the prior model's SERFF number (if applicable)?
  - Does the filing impact existing renewals?
  - ~~o~~ What is the target market for the product?~~Who is the target consumer?~~
  - What is the target variable of the model? (Frequency, Severity, Loss Ratios, Pure Premium, etc.) How is it defined?
  - What is being optimized? Does the model consider anything other than differences in loss cost?
- A narrative discussing the specifications and high-level assumptions of the model, including the following details:
  - Number and Type of models (GAM, Elastic Net, Lasso, Ridge, Derivative Lasso, Lasso Credibility, etc.)
  - Split of the data into models (by coverage, by peril, etc.)
  - Split of the data into datasets (training, test, holdout)
  - How models were combined to derive the final rating algorithm

Sometimes Needed Information

- A narrative discussing the credentials of the lead modeler and actuary reviewing the model (if applicable),~~modeling team~~, including the following details:
  - Name of each individual
  - Relevant educational experience
  - Relevant credentials and designations
  - Years of experience building ~~predictive~~ models
  - Years of experience in the insurance industry
- Discuss how Actuarial Standards of Practice (ASOPs) 12, 23, 41, and 56 were considered in building the models.
- Describe the software (including packages and libraries if applicable) used to build the models.
- Provide copies of or links to academic references for their modeling techniques.
- A table listing the states where the model has been filed for review, the SERFF tracking number, and an indicator showing whether the filing has been approved.

Penalized Regression Model Data

Essential Information

- A narrative providing the description of each data source including the following:
  - Informational materials or website links for each 3rd party
  - Commentary on how the company reviewed the veracity of the data source
  - Why the company believes the data source is useful for the model's intended purpose
  - Disclosure of known data errors
  - The SERFF filing number representing the latest prior iteration of the model which contains the same proposed third-party data variables (if applicable).
  - ~~SERFF filing numbers where the use of the data was previously approved (if applicable)~~
- A description of the relevance of the data
  - The lines of business and companies included should be identified
  - Description of any considerations or adjustments made to make the data more applicable for its intended use
- A data dictionary provided as a table with the following columns:
  - Data Source (Vendor name or "Internal")
  - Variable name
  - Alternate names appearing in other filing documents
  - Data types (discrete, continuous, logical, categorical)
  - Treatment Type (Model, Control, Offset, Target)
  - Possible values (Empirical min and max for numerical variables, all categories for categorical variables)
- Tables showing summary metrics for each dataset (training, testing, holdout) by year, when applicable ~~(training, testing, holdout)~~
  - Year
  - Losses
  - Exposures (or Policy Count)
  - Claim Count (if applicable)
- A narrative on how the company determined the variables to include in the final model
- A narrative on the data accuracy and data reconciliation process
  - Description of the methods used to compile, filter, and/or merge data from different sources
  - How the data was reconciled to other sources
- A listing of the rational explanation for each modeled variable that discusses why it would plausibly impact insurance risk as discussed in the CASTF white paper.
- A guarantee that the modeling dataset will be retained for at least 7 years
- A description of any dimensionality reduction techniques (PCA, clustering, etc.) that were applied to the data.
- ~~An Excel file with 100 anonymized sample modeling records including all predictor variables and target variables.~~

Sometimes Needed Information

- A description of steps taken to meet state requirements regarding unfair discrimination (if applicable).
- A listing of variables which are subject to the fair credit reporting act (if applicable).

Formatted

- The percentage of data coming from the state where the model is filed for each dataset (training, testing, holdout).~~A table showing the data volume distribution by state for each dataset (training, testing, holdout)~~
- A listing of variables initially considered but later removed from the model.
- An Excel file with 10 anonymized sample modeling records including all predictor variables and target variables.

Formatted: Font: Bold

Penalized Regression Modeling

Essential Information

- A narrative discussing the specifications and assumptions of the model, including the following details:
  - Form of the regression equation
  - Description of the penalty term used in fitting the model
  - Distribution assumed for the error term
  - The link function (if applicable)
  - Weights used in regression (if appliable)
- A description of the following hyperparameters
  - The penalty parameter value and how it was chosen.
  - Any other hyperparameters used in model fitting if applicable (example: number of knots for a smoothed term in a GAM). Describe how they were chosen.
- A description of how the model differs from prior versions of the model (if applicable).
- A narrative on the steps taken to eliminate the effects of other rating plan variables from the model (e.g. offsets).
- A description for each control or offset variable of why it was necessary to treat them as control/offset variables.
- A description of how the variables with null or missing values will be treated, including the following:
  - A table showing the rate of null or missing values for each variable
  - A description of the scenarios which generated null or missing values
  - A description of how each null or missing value is treated (might include imputation method or simply left in as a control)
  - A description of what happens to null and/or missing values when generated in production. (Is there a rating factor applied for null/missing or is the data populated before policy issuance?)
- A description of any large loss capping applicable to the dataset
  - Identify the size of the large loss cap
  - Identify the percentile of claim severity represented by large loss cap
- A description of adjustments and modifications to the data including trending, loss development, capping at minimums or maximums, and removal of outliers.
- A description of variable transformations applied to the data. The description should include the name of each transformation technique used and an example transformation complete with a sample unadjusted value and a final transformed value.
- A description of each feature engineered variables. The description should include the rationale behind the feature engineered variable and a sample calculation including unadjusted original variable values and the final feature engineered variable value.
- A description of how binning was applied to numeric variables and how categorical variable values were grouped together.

Formatted: Indent: Left: 0.5", No bullets or

Sometimes Needed Information

- Deviance residual plots for each model demonstrating the appropriateness of the model assumptions.
- Demonstration of how the mode would differ if different hyperparameters were selected. This could take one of the following forms:

- Sensitivity showing coefficient outputs side-by-side for higher and lower complexity hyperparameters
- Plots showing coefficients by penalty value

Penalized Regression Model Validation

Essential Information

- A narrative on how the model was validated and assessed for model stability
- A narrative on how the model was assessed for improvement over the prior version of the model (if applicable)
- An Excel file containing model output in this format:
  - Each model is a separate worksheet
  - Column A is Variable Name
  - Column B is Variable Level Name
  - Column C is the coefficient
- A demonstration of parameter stability via one of the following methods
  - Confidence intervals (5^{th} to 95^{th} percentile) of coefficients based on 100+ bootstrap samples
  - Range of coefficients from 10 or 20 cross validation folds
  - Range of coefficients across at least 5 different time periods
  - P-values from a reference GLM with the same selected variables
- Ventile plots (quantile plots with at least 120 buckets) for both state specific data and countrywide data, built on data not used for model training. Each plot should include lines for both predicted averages and actual average.
- Lorenz curve for each model built on countrywide data. The plot should include the Lorenz curve and the equality reference line. The plot should also include the Gini value for the model.
- Models with a complement of credibility (example: lasso credibility) should provide plots by variable that visualize the credibility complement and the model indicated as separate lines.
- ~~An Excel file containing correlation matrices in this format:~~
  - ~~Each model's correlation matrix is a separate worksheet~~
  - ~~Row 1 and Column 1 include variable names~~
  - ~~The rest of the table displays the correlation metrics~~
- Commentary on which correlation metric (Pearson's, Cramer's V, etc.) was provided in the correlation matrix Excel file
- Tables showing concurvity metrics (applicable to GAMs)

Sometimes Needed Information

- An Excel file containing correlation matrices in this format:
  - Each model's correlation matrix is a separate worksheet
  - Row 1 and Column 1 include variable names
  - The rest of the table displays the correlation metrics
- A description of how often the model will be validated against new data in the future
- A double lift chart comparing the newly proposed model and the current model (if applicable)
- Actual vs. Expected plots by model and variable (aka "Univariate Plots") which show the closeness between actual averages and predicted averages.

Penalized Regression Model Implementation

Essential Information

- A description of how the models being filed are ultimately integrated into the company's final rating algorithm
- A narrative about all post modeling adjustments, such as smoothing, mapping to scores, and tempering of factors
- A narrative identifying the ~~variables~~ risk classes where deviations from indicated were made and commentary on the reason for the deviations
- A dislocation analysis accounting for all rate changes within the filing, including the following:
  - Histograms showing percentage premium change on uncapped and capped basis (if applicable), using buckets of 5%
  - Descriptions of the scenarios with the highest increases
  - Descriptions of the scenarios with the biggest decreases
- Commentary on the differences between rating new and existing policyholders
- An Excel file which documents deviations between indicated and selected in this format:
  - Each model is a separate worksheet
  - ~~o~~ Column A is ~~Variable Name~~
  - ~~Column B is Variable Level Name~~Risk Class
  - Column B~~C~~ is the Current Factor (if applicable)
  - Column C~~D~~ is the Indicated Factor
  - Column D~~E~~ is the Proposed Factor
  - Column E~~F~~ is the percentage difference between indicated and proposed. If the absolute value of the percentage difference is > 10%, the cell should be highlighted.
- Sample rating/scoring exhibits for 10 risks in Excel, which show risk characteristics, all intermediate adjustments, and the final algorithm output considering the company's final selections.

Sometimes Needed Information

~~None are listed at this time.~~

- Description of how the results of the model will be displayed or explained to policyholders.

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 2.25" + Indent at: 2.5"

Formatted: Font: (Default) +Headings (Calibri Light), 16 pt, Font color: Accent 1

Neural Network Checklist

Neural Network Model Introduction

Essential Information

- A narrative discussing what the company is trying to accomplish with the model, including the following details:
  - Is this a new model or refresh? What is the prior model's SERFF number (if applicable)?
  - Does the filing impact existing renewals?
  - ~~o~~ What is the target market for the product?~~Who is the target consumer?~~
  - What is the target variable of the model? How is it defined?
  - What is being optimized? Does the model consider anything other than differences in loss cost?
- A narrative discussing the specifications and high-level assumptions of the model, including the following details:
  - Number and Type of models (Neural Network, etc.)
  - Split of the data into models (by coverage, by peril, etc.)
  - Split of the data into datasets (training, test, holdout)
  - How models were combined to derive the final rating algorithm

Sometimes Needed Information

- A narrative discussing the credentials of the lead modeler and actuary reviewing the model (if applicable),~~modeling team~~, including the following details:
  - Name of each individual
  - Relevant educational experience
  - Relevant credentials and designations
  - Years of experience building ~~predictive~~ models
  - Years of experience in the insurance industry
- Discuss how Actuarial Standards of Practice (ASOPs) 12, 23, 41, and 56 were considered in building the models.
- Describe the software (including packages and libraries if applicable) used to build the models.
- Provide copies of or links to academic references for their modeling techniques.
- A table listing the states where the model has been filed for review, the SERFF tracking number, and an indicator showing whether the filing has been approved.

Neural Network Model Data

Essential Information

- A narrative providing a description of each data source including the following:
  - Informational materials or website links for each 3rd party
  - Commentary on how the company reviewed the veracity of the data source
  - Why the company believes the data source is useful for the model's intended purpose
  - Disclosure of known data errors
  - The SERFF filing number representing the latest prior iteration of the model which contains the same proposed third-party data variables (if applicable).
  - ~~SERFF filing numbers where the use of the data was previously approved (if applicable)~~
- A description of the relevance of the data
  - The lines of business and companies included should be identified
  - Description of any considerations or adjustments made to make the data more applicable for its intended use
- Tables showing summary metrics for each dataset (training, testing, holdout) by year, when applicable ~~(training, testing, holdout)~~
  - Year
  - Losses
  - Exposures (or Policy Count)
  - Claim Count (if applicable)
- A narrative on the data accuracy and data reconciliation process
  - Description of the methods used to compile, filter, and/or merge data from different sources
  - How the data was reconciled to other sources
- A guarantee that the modeling dataset will be retained for at least 7 years
- A description of any dimensionality reduction techniques (PCA, clustering, etc.) that were applied to the data.
- If the neural network is trained on image data
  - Describe the team creating the initial labels, how they determined the labels, the number of people labeling each image, and what their rate of consensus was (interrater reliability).
  - Explain what season(s) of the year the images are captured
  - Explain what percent of US properties have an image in the current database
  - Explain how the images are captured
  - Describe how frequently the images are refreshed
  - Describe what image quality criteria is placed on images
  - Provide a distribution of images by state for each dataset (training, testing, holdout).
  - Provide a histogram showing the age of the latest image for each dwelling in the database

Formatted

Sometimes Needed Information

- A description of steps taken to meet state requirements regarding unfair discrimination (if applicable).
- A listing of variables which are subject to the fair credit reporting act (if applicable).

- The percentage of data coming from the state where the model is filed for each dataset (training, testing, holdout).~~A table showing the data volume distribution by state for each dataset (training, testing, holdout)~~

Neural Network Modeling

Essential Information

- A narrative discussing the specifications and assumptions of the model, including how the hyperparameters of the neural networks were tuned.
- Provide the hyperparameters selected for the neural network, including the following:
    - Learning Rate
    - Number of Epochs
    - Batch Size
    - Activation Function
    - Number of hidden layers and units
    - Weight initialization
- A description of how the model differs from prior versions of the model (if applicable).
- Commentary on how the risk of overfitting was mitigated including whether these common methods were applied:
    - Early Stopping
    - Regularization
    - Dropout
- Provide plots that help demonstrate how the models work
    - For Artificial Neural Networks (ANN), provide Shapley plots by variable
    - For Artificial Neural Networks (ANN), provide waterfall plots for:
        - 10 records with the worst score and commentary on what is driving the score
        - 10 records of false positives (if applicable) and commentary on what is driving misclassification
        - 10 records of false negatives (if applicable) and commentary on what is driving misclassification
    - For Convolutional Neural Networks (CNN), provide Grad-CAM images for:
        - 10 images with the worst score and commentary on what is driving the score
        - 10 images of false positives (if applicable) and commentary on what is driving misclassification
        - 10 images of false negatives (if applicable) and commentary on what is driving misclassification

Sometimes Needed Information

- A description of any preprocessing (resizing, normalization, etc.) applied to the images before running the model.

Neural Network Model Validation

Essential Information

- A narrative on how the model was validated and assessed for model stability
- A narrative on how the model was assessed for improvement over the prior version of the model (if applicable)
- A confusion matrix for the Test and/or Holdout datasets arranged as follows:
    - Predicted Class in the row names
    - Actual Class in the column names
    - Test Dataset count in the table
- A summary of performance metrics (precision, recall, accuracy) on the test dataset.
- 10 sample images including model predictions and actual values.
- A description whether the model predictions were compared to an independent report (example: roof image classification versus findings from an actual roof inspection)

Neural Network Model Implementation

Essential Information

- A description of how the models being filed are ultimately utilized by the company
- An explanation regarding whether the data source used to train the model is the same data source that will be used in production. If not, what adjustments will be made to address differences between data sources.
- An explanation regarding whether the neural network prediction can be reproduced by a person using an objective criteria checklist
- A description regarding how consumers can appeal determinations made by the neural network
- A description of how often the data will be refreshed, whether scores will be updated automatically, and whether consumers can request an update to the score
- If the neural network is trained on image data
    - Explain whether an insured can personally submit an updated image if there have been updates to their property
    - ~~o~~

Formatted: Indent: Left: 1", No bullets or numbering

Sometimes Needed Information

- Description of how the results of the model will be displayed or explained to policyholders.

Unknown Risk Characteristics

The Task Force discussed ”unknown risk characteristics” in personal lines rating at the NAIC Summer National Meeting. Here is the link to the exposed summary and optional questions to answer.

https://content.naic.org/sites/default/files/inline-files/CASTF%20Unknown%20Risk%20Characteristics.pdf

Written comment was due to Kris DeFrain (kdefrain@naic.org) by Monday, Oct. 20.

October 20, 2025

Christian Citarella
Chair, Casualty Actuarial and Statistical (C) Task Force
National Association of Insurance Commissioners

Re: Request for additional comments regarding the issue of "unknown risk characteristics" in personal lines rating

Dear Chair Citarella:

On behalf of the American Academy of Actuaries'[1] Data Science and Analytics Committee (DSAC), we appreciate the opportunity to respond to the Casualty Actuarial and Statistical (C) Task Force's (CASTF) request for additional comments regarding the issue of "unknown risk characteristics" in personal lines rating. We value CASTF's work addressing the problem of rating policies with unknown risk characteristics.

Our overarching perspective is that the appropriate response to missing data is dependent upon the variable in question and the use case. A wide variety of responses are possible, as detailed below. Each response has a context where it is an appropriate balance of practicality and accuracy. Alternately, each response has a different context where it could be highly impractical or negatively impact accuracy. It is important for modelers to be deliberate about their responses and be able to defend their decisions. It is important for regulators to inquire about insurers' approaches and challenge them as needed. Mandating one response in all situations, such as contacting the consumer, would have non-optimal insurance market impacts.

It is beneficial to address the topic as much as possible within the current insurance and regulatory framework, creating new practices where there is a newly identified risk.

Background/Context

Missing data is a well-established field of study in statistics and a common challenge in many databases. It is a subtopic of larger considerations related to data quality. Insurers leverage this knowledge in statistical work related to pricing and underwriting policies, especially when data science is used to develop predictive models for these purposes. This is a challenge in all lines of business.

Insurers have always needed to make decisions about how to handle missing information. For example, determining how to proceed if a consumer refuses to answer an application question.

[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.

Insurer practices have developed to handle these situations, and regulators have also developed practices to oversee them. Examples of these practices include filing reviews, filing exhibits/questionnaires, and market conduct exams. This topic is within the scope of current regulatory authority. Regulators can, and do, challenge insurer practices for handling missing information that they find unsatisfactory.

The DSAC cannot comment directly on whether or not missing data is becoming more common. On one hand, it is plausible that increased use of third-party data could lead to an increased frequency of missing data since practical considerations can lead to databases not being fully populated (e.g., a database of car maintenance history would have gather information from a large number of maintenance shops). On the other hand, increased access to external data used for application prefill and policy data verification could decrease the frequency of missing data. The need to handle missing data responsibly is independent of whether it is becoming more common.

Responses to Questions

Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect another way? What risks or challenges might be involved with asking a consumer or agent to supply missing data?

There are some contexts in which asking a consumer about a rating characteristic is the best course of action. However, there are also situations where consumers may not be the best information source. For example, consumers may not know or be able to obtain the missing information. Consumers may be inclined to misrepresent the information to receive better treatment. The best course of action is dependent upon the nature of the missing information and the use to which it is being put.

Our comments focus on scenarios when requesting consumer input seems reasonable. The following examples identify when consumer input seems *less* reasonable. It's important to consider the broad range of variables and use cases when discussing this topic.

- A query of motor vehicle reports (MVRs) may return "missing" information about whether the consumer had a traffic violation. An insurer would reasonably assume that a lack of information would indicate that the consumer had no violations and group the "Unknown" category with the "no violation" category. However, this data may also be missing for other reasons, such as an error on the MVR. Asking the consumer to verify the accuracy of this data is unlikely to yield any benefit.

- Suppose an insurer appends vehicle safety ratings (i.e., a crash test) to their book of business. They find that 20% of their book is high risk, 20% is low risk, and the remainder have not been subject to the test and are labeled "unknown." The unknown class could be treated neutrally, providing improved risk segmentation to the remaining policies. Alternatively, an insurer could seek to estimate the safety rating (i.e., interpolate) by

identifying similar vehicle characteristics as those that underwent the test. Consumers would not be able to supply this information.

- An important note for CASTF is to keep in mind that asking consumers for direct feedback or information that results in less than ideal data is not solely an issue for property and casualty insurance products. This topic is present across all lines of business. For example, in life insurance, data is used to detect risk factors where consumers are unlikely to provide accurate information, like tobacco use or high cholesterol. That data is then used in underwriting and to determine eligibility for specific life insurance products.

A significant consideration in whether to use data in a model is the cost of that data compared to its marginal predictive value. Asking a consumer to verify data increases costs in terms of time spent sending requests, collecting responses, verifying responses, and updating policies. These costs might be significant enough that they override the value of the data, although using less data reduces the accuracy of predictions, negatively impacting the insurance market. Regulators might also incur additional costs associated with filing reviews and market conduct exams of these processes.

Does the insurer have a responsibility to notify the consumer when a risk characteristic is unknown?

This question relates to the broader concern of transparency. Considerations such as accuracy, expense, protection of trade secret business practices, and consumer experience need to be weighed against each other. There is nothing materially different between unknown risk classification and other aspects of risk classification which may or may not be of interest to consumers.

How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium?

Actuarial Standard of Practice No. 12, *Risk Classification (for All Practice Areas)* lists items actuaries should consider when designing, reviewing, or changing risk classification systems. These are included below, along with brief commentary on how each might apply to unknown risk classification:

- Relationship of Risk Characteristics and Expected Outcomes—"unknown" can be treated as its own category if it is correlated with expected losses.
- Causality—It is not necessary to determine causality. Consequently, it is not necessary for insurers to determine whether the reason data is missing is causally related to insurance risk.
- Objectivity (based on readily verifiable facts that cannot be easily manipulated)—Missing data can occur for specific, non-subjective reasons that depend on the type of data.
- Practicality (reflects the tradeoffs between practical and other relevant situations)—The cost, time, and effort to populate missing information is relevant to consider.
- Applicable Law—Laws prohibiting unknown risk classification would need to be followed.
- Industry Practice—Industry practice to address missing data should be considered. The options listed in this letter describe industry practice.

Actuarial Standard of Practice No. 23, *Data Quality* encourages actuaries to balance data limitations against the practicality of obtaining alternative data. Actuaries are prompted to use their professional judgment about the appropriateness of the data for the intended purpose. It lists the following considerations for selecting data which are relevant to this topic:

- whether the data constitute appropriate data
- whether the data are reasonable with particular attention to internal consistency
- whether the data are reasonable given relevant external information that is readily available and known to the actuary
- the degree to which the data are sufficient
- any known significant limitations of the data
- the availability of additional or alternative data and the benefit to be gained from such additional or alternative data, balanced against how practical it is to collect and compile such additional or alternative data

Actuarial Standard of Practice No. 56, *Modeling* states that actuaries should understand the model's intended purposes when determining appropriate design, data, and model risk evaluation. Treatment of unknown/missing data falls within this guidance.

Finally, actuarial standards require transparency in communication (Actuarial Standard of Practice No. 41, *Actuarial Communication*), as well as honesty, integrity, and competence (Precept 1 of the Actuarial Code of Professional Conduct).

What methods are appropriate for determining factors for "unknown" characteristics? Does this differ based on whether or not the data is missing at random?

A wide variety of responses are available, including neutral treatment, best/worst treatment, average treatment, interpolation, requesting information from the consumer, and declining/non-renewing the policy. Each option is appropriate for balancing practicality and accuracy in some contexts but not others. Alternately, each response has a context in which it could be highly impractical or inaccurate. Whether or not the data is missing at random is an example of a consideration which might lead to different responses. It is not desirable, and arguably not possible, to articulate firm standards for how to respond to all reasons why data might be missing.

If the data is frequently missing for a variable, how should the insurer decide whether or not to keep that variable in the rating algorithm? Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used?

Actuaries use their professional judgement in these scenarios, taking into consideration the credibility, predictive power, and availability of the information. Some rating variables have high proportions of missing information, such as MVRs and loss history. It is impractical and undesirable to establish a single course of action for all types of data. However, regulators could identify scenarios when they may desire a more in-depth review of insurer practices.

Additionally, the data used to create the rating plan ("development data") can either under- or overestimate the frequency of missingness in production. In an extreme case, data that is missing

in the development data might never be missing in production. The nature of the use case and the particular data need to be considered in order to assess what level of missingness is a concern.

How should insurers think about the concept of fairness when using variables for which information is missing for some consumers?

Missing data needs to be handled with care by both insurers and regulators. For rates to be as fair as possible, insurers should be able to use a wide variety of data sources, provided they do so responsibly.

Rates are not unfairly discriminatory if they are actuarially justified estimates of future loss experience. More accurate rates are fairer in that they match the premium paid for the policy with the expected services that will be obtained from the policy. More accurate rates benefit society by improving both the affordability and availability of insurance; this is because insurers can confidently offer coverage to high-risk consumers and reduce margins for uncertainty in their premiums. Also, setting premiums based on the risk profile of the insured discourages anti-selection and encourages risk-mitigation activities. When risk classifications are prohibited or discouraged, lower risk consumers pay more than necessary to fund discounts on higher risk consumers. In order to promote the fairest outcomes in the insurance market, data sources with missing data should evaluated carefully, but should not be discouraged or prohibited.

*****

We appreciate the opportunity to share this feedback and our recommendations in response to CASTF's request for additional comments. If you have any questions or would like to discuss these comments further, please contact Will Behnke, the Academy's Risk Management and Financial Reporting policy project manager (behnke@actuary.org).

Sincerely,

Kirsten Pedersen MAAA, FSA
Chairperson, Data Science and Analytics Committee
American Academy of Actuaries

October 20, 2025

Christian Citarella, Chair
Julie Lederer, Vice Chair
Casualty Actuarial and Statistical (C) Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197
Sent via email to: Kris DeFrain and Roberto Perez

RE: Personal Lines Insurers' Use of "Unknown Risk Characteristics"

Dear Chair Citarella and Vice Chair Lederer:

We appreciate the opportunity to respond to your September 18 invitation to provide comment on the treatment of "unknown risk characteristics" in personal lines rating.

Before providing answers to the specific questions in the document, we wanted to offer some comments for the record on the letter's introduction. We are not in alignment with referring to the issue described as "the problem," as the document does in two places--the second paragraph and the one preceding the list of questions. We would submit that the matter described is not a "problem" that needs fixing, but rather a "practice" that is regulated and recognized as reasonable and appropriate, as we discuss below.

We agree with the letter's observation that insurers use third-party data vendors to gather loss-predictive information in order to maximize accuracy and minimize cost. The proper balance of cost with effectiveness and accuracy is fundamental to the issue being addressed. Personal lines insurers operate in an intensely competitive marketplace and want data that is as complete and accurate as possible provided in as cost-effective a manner as possible. Most significantly, the proper balance of complete and accurate data with cost ultimately benefits consumers.

Attached to this letter are APCIA's responses to the questions.

Sincerely,

Hilary Segura
Dept. VP, State Government Relations

David Snyder
VP, International Policy & Counsel

Paul Tetrault
Sr. Director, Personal Lines & Counsel

Attachment

APCIA Comments
On
CASTF Questions on Unknown Risk Characteristics

APCIA has previously provided a report and supported the testimony of Roosevelt Mosley, managing principal at Pinnacle Actuarial Resources, before CASTF. We also appreciate the opportunity to provide these comments to the CASTF in response to questions on the issue of the use of unknown risk characteristics in rating and underwriting. The responses were drafted by Roosevelt Mosley at the request of APCIA.

CASTF QUESTION: Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect another way? What risks or challenges might be involved with asking a consumer or agent to supply missing data?

CASTF QUESTION: Does the insurer have a responsibility to notify the consumer when a risk characteristic is unknown?

APCIA RESPONSE: Whether an insurer has the responsibility to ask consumers about rating characteristics it was unable to collect another way may be dependent on why the rating characteristic is missing. As an example, if the company asked the consumer to provide the information as part of an application and the consumer did not provide it, the company could argue that it does not have a responsibility to ask again.

If the information is obtained from a third-party vendor, the answer may not be a simple "yes" because of the risks and challenges indicated below. These risks and challenges may ultimately result in rating that is not more accurate and may even be less accurate.

<u>Efficiency</u>

Requesting data from consumers sounds easy in theory, but there are practical limitations to satisfying this requirement. Section 3.3.2(c) of ASOP 12 on Risk Classification describes an actuarial consideration related to practicality.

> *"The actuary should use professional judgment in balancing the potentially conflicting objectives of accuracy and efficiency, as well as in minimizing the potential effects of adverse selections."*

Theoretically, if a risk classification is missing or unknown, asking the policyholder for accurate information would make the rating more accurate. However, reaching out to every policyholder or every applicant about each missing or unknown risk characteristic would not be practical, depending on how many applicants or current policyholders have missing factors, and the number of missing characteristics. Additionally, depending on the factor that is unknown or missing, it may be unlikely that the policyholder is able to provide accurate information. One example is related to vehicle characteristics that are provided by third parties. If, for example, it is unknown if a particular vehicle has a specific safety feature, the policyholder may not know the accurate answer to the question. **Therefore, introducing this requirement will make balancing the accuracy and efficiency of rating factor determination more challenging.**

It also is not a given that the rating of policies will be more accurate. It also may not be beneficial to the consumer. It is likely that the cost of collecting and reviewing all missing data is so large that all policies will have a higher premium to reflect the increased expense, and that higher premium may still not

completely offset the insurer's cost for this additional data collection. In this case, the proposed rule would leave every consumer in a worse position.

Accuracy

The stated purpose of addressing the missing category issue is to ensure policyholders are "being charged a rate that is commensurate with their risk." Asking policyholders to provide information does not ensure this will be the result. In some cases, the policyholder is not likely to know the answer (e.g., horsepower, vehicle weight, forward collision warning vs. active collision avoidance, and prior 5-years insurance coverage lapse/cancellation history). In some cases, the policyholder may provide the most advantageous answer (e.g., annual mileage).

In these cases, if the goal is to ensure rates are commensurate with the risk, there will need to be a requirement that the policyholder also provide documentation of the information being provided where appropriate, and the insurer should have the ability to investigate and potentially challenge the information provided if there are concerns. These additional steps will amplify the first concern – evaluation and investigation could create potentially significant additional expense.

CASTF QUESTION; How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium?

APCIA RESPONSE: The assignment of indicated or weighted neutral factors to unknown or missing data fields returned from third-party vendors is a reasonable actuarial practice. There are at least two actuarial standards of practice (ASOP) that apply to the use of unknown risk characteristics.

ASOP 12 – Risk Classification

ASOP 12 – Risk Classification provides guidance to actuaries when performing professional services with respect to designing, reviewing, or changing risk classification systems. This includes classification of individuals or entities into groups intended to reflect the relative likelihood of expected outcomes. Section 3.2.7 – Business Practices of ASOP 12 states that:

> *"When selecting risk characteristics, the actuary should consider limitations created by business practices related to the financial or personal security system as known to the actuary and consider whether such limitations are likely to have a significant impact on the risk classification system."*

When considering data obtained from third-party sources, the business practices of the data providers are such that data is likely not to be returned for 100% of the policies of an insurance company for the reasons described earlier. In this case, the actuary is to consider these limitations and determine whether they are likely to have a significant impact on the risk classification system. The outcome of these considerations may be that the business practice does not have a significant impact on the risk classification system. If this is the case, this means it is reasonable for the actuary to analyze the experience of the policies assigned to the unknown category and assign rating factors based on the results of this analysis.

This is underscored by Section 3.4.4(c)., which encourages the actuary to consider quantitative analysis of the impact of "significant limitations created by business practices of the financial or personal security system." Again, this shows that it is reasonable for the actuary to base rates for the missing category on a quantitative analysis of the missing category.

ASOP 23 – Data Quality

ASOP 23 – Data Quality provides guidance to the actuary when performing actuarial services involving data. Section 3.5 addresses reliance on data provided by others.

"In most situations, the data are provided to the actuary by others. The accuracy and completeness of data supplied by others are the responsibility of those who supply the data. The actuary may rely on data supplied by others, subject to the guidance in section 3.3 and 3.4. The actuary should disclose reliance on data supplied by others in an appropriate actuarial communication, in accordance with section 4.1 (h)."

Section 3.3 indicates the actuary should conduct a review of the data. Section 3.4 relates to the professional determination by the actuary of the appropriateness of the data for use in an analysis. This actuarial guidance allows for the reliance on data provided by third parties as long as the actuary conducts a review of the data and determines that the use of the data is appropriate. Therefore, the use of a missing or unknown data classification is reasonable if the actuary reviews the data and determines it is appropriate.

CASTF QUESTION: What methods are appropriate for determining factors for" unknown" characteristics? Does this differ based on whether or not the data is missing at random?

APCIA RESPONSE: There are three typical approaches for setting rating factors, and it is important to understand the motivation for each.

Weighted average of non-missing category

- This is more appropriate in cases when the cause of the missing or unknown is more of a random occurrence. Using a weighted average is akin to neutralizing the impact of this rating factor.
- The weighted average approach balances the use of the characteristic for those for which it is known (accuracy) and attempts to associate the fairest outcome for those for which the characteristic is not known.

Distinct category

- The rating factor is selected based on the indication from the model for the unknown category.
- This can be appropriate in situations when the cause of the missing category is not random. As an example, if there are vehicle characteristics that are more likely to be unknown for older vehicles, this is not a random occurrence and therefore assigning a weighted average may not be appropriate.
- **Actuarial models often incorporate missing or unknown categories explicitly, allowing for their distinct risk profile to be measured rather than assumed or not included altogether.**

Judgment-Based Approach

- This allows for acknowledgment of special circumstances.
- An example of this could be the case where the unknown or missing category is most like a known level or category.

While regulators have expressed valid concerns that missing or unknown values may not be randomly distributed and could correlate with certain subpopulations (e.g., demographic, or socioeconomic factors), the actuarial use of such data remains appropriate when supported by sound methodology and analysis. Actuarial models often incorporate missing or unknown categories explicitly, allowing for their distinct risk profile to be measured rather than assumed or not included altogether.

When missingness is non-systematic or its impact is controlled through modeling techniques (e.g., indicator variables), the resulting rates can remain both actuarially sound and equitable. Moreover, excluding or discarding missing data may substantially reduce the sample size and weaken predictive

power – all of which must be balanced in the context of the ASOP's and CASTF regulatory standards. The use of a modeled unknown category enables actuaries to preserve the full dataset, reducing the risk of selection bias that may arise from excluding observations with missing fields.

Additionally, in predictive modeling contexts (ASOP 56), missingness can be informative and itself carry predictive information, and modeling it as a distinct category allows actuaries to empirically assess its relationship to expected outcomes. This is more likely to be the case if the unknown category is not random but caused by some systematic reason. This facilitates out-of-sample generalizability, as new observations encountered at the time of rating may also lack the variable in question. Furthermore, treating inherently incomplete data as distinct risk segments allows for transparent and consistent treatment aligned with ASOP 12 principles of practicality, objectivity, and actuarial credibility.

CASTF QUESTION: If the data is frequently missing for a variable, how should the insurer decide whether or not to keep that variable in the rating algorithm? Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used?

APCIA RESPONSE: An insurer should decide whether to keep a variable with missing data based on sound actuarial analysis. There is not a hard threshold that applies in this case; the evaluation of how to assign rates to the unknown or missing category should still be based on an actuarial consideration and quantitative analysis of the limitations of the use of the unknown or missing category regardless of the percentage of missing values.

In cases where the percentage of missing or unknown data is high, it does not necessarily change the reasonability of assigning an indicated or weighted factor, but the reasonability of using the factor at all may be brought into question. All else being equal, a priori expectations would be that a the larger the percentage of missing or unknown data, the less likely it may be that the use of the factor would be determined reasonable by a sound actuarial analysis. However, simply because the percentage of missing or unknown data is high does not automatically mean the use of a variable is not appropriate.

In the CASTF white paper "Regulatory Review of Predictive Models," the CASTF indicates that state insurance departments should request the percentage of exposures for a given rating variable that is missing. There is no indication in the white paper that a particular percentage of missing exposures would result in rejecting a rating variable. Therefore, the CASTF did not determine that there was a specific threshold that would be acceptable for an unknown or missing category.

CASTF QUESTION: How should insurers think about the concept of fairness when using variables for which information is missing for some consumers?

APCIA RESPONSE: We believe it is fair to use variables for which information is missing for some consumers. In fact, we believe fairness would be negatively impacted if using variables for which information is missing for some consumers is not allowed. If a company is unable to comply with a requirement to ask consumers for missing variables, the rating factor will not be able to be used. If this is the case, the accuracy of the rating of the entire book is negatively impacted in a significant way. If a company is obtaining data from a third-party vendor and this results in some policyholders being assigned to a missing or unknown category, these policyholders will be rated either in a neutral category or according to their experience. The policyholders that are not in the missing or unknown category will also be rated associated with the loss experience of the risk group to which they belong, and the rates for these policyholders could be higher and/or lower than the rates for the missing/unknown category.

If the company were not able to use the rating factor, then all of the policyholders would be rated at an average level as no differentiation in risk would be allowed. In the case where the missing or unknown category was being rated at a weighted average level, not using the factor means that 100% of the policies would be rated at the average level instead of just the policies in the missing or unknown category. This would result in a significant percentage of policyholders whose rates would be

inadequate, excessive, or unfairly discriminatory. **In the case where the unknown or missing category was being rated based on the indication, every policyholder would move from their indicated rate to an average rate, which again would result in a significant percentage of policyholders whose rates would be inadequate, excessive, or unfairly discriminatory. If this is the case, the accuracy of the rating of the entire book is negatively impacted in a significant way**

Consider the example in the table below.

Base Rate	100				
Rating Factor 1	**Distribution**	**Rating Factor**	**Premium with Rating Factor 1**	**Premium without Rating Factor 1**	**Percent Difference**
Good	25%	0.75	75.00	101.25	35.0%
Neutral	25%	1.00	100.00	101.25	1.3%
Bad	25%	1.25	125.00	101.25	-19.0%
Missing	25%	1.05	105.00	101.25	-3.6%
Total	100%		101.25		

Assume there is only one rating factor in this rating plan, and the rating factor has three levels and a missing category. There is equal exposure distribution in each category, including 25% in the missing category. We have also assumed the rating factors in column three are based on an actuarial analysis and thus reflect the indicated rates. These rating factors produce the premiums in column four. Assuming the missing category is a mix of risks from the three non-missing categories, less than 25% of policyholders would have rates considered excessive or inadequate individually.

What would happen if the company pulled the rating factor? The rate for each level goes back to the average rate (column 5), and the percentage of policyholders whose rates became inadequate or excessive would immediately increase by 50% (as rates for both the Good and Bad categories would be significantly higher or lower than indicated). Therefore, this proposed solution would result in a significant increase in number of policyholders with rates that are not commensurate with their risk.

Conclusion

The key conclusions related to the use of missing/unknown data are as follows.

1. The assignment of indicated, weighted or neutral factors to unknown or missing data fields returned from third-party vendors is a reasonable actuarial practice if supported by a sound actuarial analysis.

2. The reasonability of the assignment of indicated, weighted or neutral factors to unknown or missing data fields generally does not depend on whether the unknown or missing percentage fluctuates. The evaluation of how to assign rates to the unknown or missing category should still be based on an actuarial consideration of the limitations of the use of the unknown or missing category regardless of the percentage of missing values. In fact, actuarial models often incorporate missing or unknown categories explicitly.

3. Introducing the requirement that insurers must request unknown/missing data from consumers will make balancing the accuracy and efficiency of rating factor determination more challenging.

Even assuming considerable sacrifices in efficiency, it is not certain that the rating of policies will be more accurate.

4. If regulatory requirements resulted in restricting the use of a significant rating factor, it would increase the number of policyholders whose rates would not be commensurate with their risk.

We appreciate the opportunity to provide these comments and would be happy to answer any additional questions or provide additional information if needed.

Phil Vigliaturo (MN) responses to Kris D. e-mail 9/18 on CASTF Unknown Risk Characteristics

- Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect another way? It probably should. However, I am very doubtful that our agency would want to take on the responsibility of enforcing that this is done. Also, this would seem to bring into question the integrity of the model from which the rating factors were built, that is if the characteristic is say only on 60% on the dataset that the model was built, yet the department would be obtaining the characteristic for 90% of the insureds, could the model be incorrect for this larger grouping. (The reverse could happen as well.)
- What risks or challenges might be involved with asking a consumer or agent to supply missing data? As correctly stated, if the effect of the data variable is known, there could be an opportunity to manipulate answers in order to achieve a less costly premium. Insurers may resist as it is an additional task (and additional cost) for them to obtain the information and rerate the policyholder. Also, if a policyholder's premium goes up with the information, there is a risk that they may go to a competitor.
- Does the insurer have a responsibility to notify the consumer when a risk charactistic is unknown? My initial reaction is that they should, but again, enforcing this may be beyond the work that regulatory agencies are equipped to handle.
- How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium? I struggled finding anything dealing with missing data and classification ratemaking. I looked at the CAS Ratemaking principles, and ASOPs 12, 23, 25, 53 and 58. Maybe it is the Friday afternoon syndrome. Sidenote, this is what AI Overview said about the CAS Ratemaking principles, as they got this completely backwards: The Casualty Actuarial Society (CAS) Statement of Principles Regarding Property and Casualty Insurance Ratemaking identifies and describes principles for determining property and casualty insurance rates, focusing on the cost of risk transfer. Although the CAS initially rescinded the statement in 2020, it was reinstated in 2021 for reference in U.S.-regulated ratemaking, despite criticism from consumer groups and regulators who viewed the principles as essential for fair pricing.
- What methods are appropriate for determining factors for "unknown" characteristics? Possibly the average of the knowns, if "unknown" vs. "known" is random.
- Does this differ based on whether or not the data is missing at random? Yes, I believe so. This was covered well in the text of the letter of the request, and I agree with what the authors laid out.
- If the data is frequently missing for a variable, how should the insurer decide whether or not to keep that variable in the rating algorithm? It would seem that if a variable is mostly missing that it may still have significant value, and should probably be allowed for the insurer to use it. Let's say that policyholders with DUIs are shown to have twice

as bad of loss experience when compared to the rest of drivers. However, most drivers do not have DUIs, so the variable is missing. Regulators would probably allow this variable to be used.

- Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used? In my opinion, if regulators come up with a threshold it would be seen as arbitrary and capricious.
- How should insurers think about the concept of fairness when using variables for which information is missing for some consumers? Insurers are entities that are trying to make a profit. Fairness would only be a concern when dealing with regulators (as I could not find anything in the ASOPs or CAS statement of principles). So I suspect that they will be trying to find an edge on their competitors (while not violating anything that concerns the regulators, so they would not be too concerned with missing or unavailable values.

NAMIC
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

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

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

October 20, 2025

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

Re: CASTF Discussions on the Use of Unknown Risk Classes and Missing Data

Chair Citarella (NH), Vice-Chair Lederer (MO), and Members of the Task Force:

On behalf of the National Association of Mutual Insurance Companies (NAMIC)[1], we thank the Casualty Actuarial and Statistical (C) Task Force (CASTF) for engaging in a robust discussion and requesting feedback on the issue of "unknown risk characteristics" and "missing data." At the outset, insurance companies are continuously making reasonable efforts to reduce the amount of unknown information in data. An insurer's incentive is to calculate rates that match risks and the expected claim costs as accurately as possible. Current carrier approaches coupled with existing regulatory authority are already adequately addressing the perceived issues addressed in CASTF's letter soliciting interested party feedback.

In this vein, NAMIC posits that the missing issue is comprised of three distinct, nuanced issues that have been conflated. We view those issues as: 1) The use of unknown risk classes as part of the premium determination when data elements are missing; 2) The use of missing data in model development or model build; and 3) A broader concern over third-party data and model vendors and transparency. As explained in greater detail below, the first two issues are ones in which CASTF is attempting to create solutions disjointed from the needs of consumer protection and of the market, as existing regulatory authority is sufficient to provide oversight of insurer practices in these regards. Separately, the references to concern over use and transparency into data and models that carriers may use from third parties are concerns and issues more appropriately addressed in the Third-Party Data and Models (H) Working Group than by CASTF.

Substantive Comments

[1] Use of Unknown Risk Classes

The use of unknown risk classes has proven to be an actuarially sound practice, carriers are incentivized to accurately match rates to risk and expected claim costs, and regulators already have the tools to review and oversee this practice.

[1] The National Association of Mutual Insurance Companies consists of over 1,300 member companies, including six of the top 10 property/casualty insurers in the United States. The association supports local and regional mutual insurance companies on main streets across America as well as many of the country's largest national insurers. NAMIC member companies write $383 billion in annual premiums and represent 61 percent of homeowners, 48 percent of automobile, and 25 percent of the business insurance markets. Through its advocacy programs NAMIC promotes public policy solutions that benefit member companies and the policyholders they serve and fosters greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

Carriers want as accurate and comprehensive data as possible to match rate with the risk of loss. At times, data may be unavailable or missing in pricing for a variety of reasons, including: information requested by the company not provided by the applicant, the insurance company obtains data from a third-party data provider and data is not able to be returned on a specific policy or individual, or that data element may simply not exist. When there is data missing, insurers will either be unable to rate the policy due to the information being necessary to bind coverage (like missing age or a missing VIN number, for example), or the company may assign an "unknown" risk class if the carrier is comfortable determining coverage and pricing without it. Carriers must decide which course of action is warranted based on the type of data. It is also important to remember that the inclusion of "unknown" as a risk class in a rate filing does not mean that unknown risk class will ultimately be used.

Moreover, while there has been much talk of consumers in this debate, there has been less talk of the consumer experience. It has been the experience of carriers that consumers do not like completing lengthy applications nor do they like being asked or instructed to answer follow-up questions from financial service providers. In fact, when given the opportunity, customers rarely provide the unknown data. Nevertheless, some have continued to suggest that if a data point remains unknown after a consumer's application and supplementation with additional third-party data, insurers should nonetheless ask the consumer for this data. As noted above, certain bedrock data elements are indeed essential for underwriting and policy issuance. However, in other cases, asking the consumer directly could be impractical or result in less accurate pricing. Examples include when the data element does not exist, the consumer is not able to accurately provide the information, the consumer is likely to provide inaccurate information, or the cost of collecting and validating information is high. As noted in a recent report by Pinnacle: "It is possible the cost of collecting and reviewing all missing data is so large that all policies will have a higher premium and that higher premium will still not completely offset the insurer's cost for this additional data collection. In this case, the proposed rule would leave every participant in a worse position."[2] In short, the reasonable option of allowing for unknown risk classifications balances the cost of obtaining that information with the desire to have the most accurate data for most customers. Pursuing regulatory approaches that would require 100% complete information could result in a large number of policies unable to be written.

Given the drawbacks of asking consumers directly for the missing data fields, another proposal that has occasionally been discussed is requiring insurers to assign these consumers the most favorable rating factor for the missing field, rather than the neutral or average approach that is currently used. However, requiring unknown class consumers to be assigned a non-indicated factor would erode the pricing segmentation for that variable. While unknown class consumers might receive a better price, many or all known class customers would receive a higher price in order to offset the lower (and non-indicated) price of the unknown class customers. It is worth remembering that the parent committee of this Task Force is actively investigating policy approaches to improve insurance affordability. Prohibiting the use of unknown risk classes or forcing insurers to ask consumers for unknown data would not accomplish this objective. Ultimately, assigning the unknown class a neutral or average factor is fairest and overall best approach.

[2] *Actuarial Opinion on the Use of Missing Data in Actuarial Analyses*, Pinnacle Actuarial Resources (Commissioned by American Property & Casualty Insurance Association), July 17, 2025, p. 9.

As illustrated above, this effort is attempting to create a solution disjointed from the needs of consumer protection and of the market. Because the practice of using unknown risk classes is already regulated within unfair practices law, we do not see a need to continue discussion through a charge or any other vehicle.

[2] Missing Data in Model Build and Development

Using missing or unknown data in model development is not the same as assigning for missing or unknown in a rating plan for premium determination. Insurers apply safeguards during model development to ensure consumers are treated fairly and that the models do not result in rates that are unfairly discriminatory, and regulators already have the tools to review and oversee this practice.

As referenced in several presentations by NAIC's Kevin Burke, the second distinct issue within the broader "missing data" discussion is that of using missing data in model build. It is important to note that, when focusing on the model build aspect of the discussion, models are developed and used by carriers to identify predictive patterns and develop rating factors across large populations, that the models use aggregated, de-identified data across broad portfolios, and that the data used to build these models are not used to quote or bill a specific customer. These models are also subject to regulatory review via regulatory filings for use in the state marketplace.

In its presentations on the issue, the NAIC has posited that buying third party data that has missing data and merging it with company data to develop a model is a decision made by the company to incorporate uncertainty into models. Insurers have no incentive to introduce uncertainty into their models, as it benefits insurers to make their rates match the risk and expected claim costs as accurately as possible. In actuality, there are several actuarially supported options for dealing with missing data in model development, and the selected method depends on how the variable with missing data will be used. Controlling for the missing data allows for the information in the data that is populated to be appropriately used. There is no guarantee that asking a customer to fill in missing information would produce a better or more accurate model, as that data could be more prone to inaccuracies, thereby diluting any true signal that may be gained from data from verifiable sources (even if incomplete). Removing records with missing information is problematic as well, as the records with missing data may be correlated with other variables.

As we noted in the previous section, carriers prefer and benefit from using the best data and developing accurate models to accurately segment risks across the entire book and avoid adverse selection.

Given the foregoing, we similarly do not see a need to continue discussion on this aspect of the missing data issue through a charge or any other vehicle.

Conclusion

As the world of technology and data continue to evolve, our data-driven insurance industry increasingly looks towards ways to leverage that data and technology to optimize performance, mitigate risk, and meet the rising expectations of consumers. Modern insurance relies on vast datasets, statistical models, and predictive analytics to enhance underwriting precision and ensure rate, and the premiums developed using them, are not inaccurate, inadequate, or unfairly discriminatory. Further, regulators already have a robust statutory framework and tools to oversee the use of unknown risk classes and missing data in model development. As such, we do not see a need for any charges or other vehicles in CASTF on these topics.

We close by again thanking CASTF for providing the opportunity to engage in this discussion.

Sincerely,

Lindsey Klarkowski
Policy Vice President
Data Science, AI, and Cybersecurity
NAMIC

Erica Weyhenmeyer, CPCU, AIE, MCM, WCP
Policy Vice President
Market Regulation and Workers' Compensation
NAMIC

OREGON COMMENTS

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Sept. 18, 2025

To the Casualty Actuarial and Statistical (C) Task Force, Interested Regulators, and Interested Parties:

After a discussion at the recent open CASTF meeting, we are asking for additonal comments regarding the issue of "unknown risk characteristics" in personal lines rating. Below is a summary of our understanding of the problem. **Please provide written comment by Monday, Oct. 20.**

An insurer's rating plan for property and casualty insurers (e.g., personal auto insurers, homeowners' insurers) includes many risk categories or "classes" that are assigned rating factors. The purpose of these rating factors is to charge premium that correlates with risk. Risk classes are often based on characteristics such as house location, telematics scores, insurance scores, vehicle insured (with VIN), age of house, number of years of driving experience, annual estimated mileage, number of driving convictions, and many more.

Commented [DDF1]: Rate classifications often incorporate more than one rating variable.

In the past, insurers asked consumers for the information that would be used to rate them. This was the purpose of the insurance application. Consumers were asked questions like

- How long have you owned your car?
- Does it have anti-lock brakes?
- How many bathrooms are in your home?

Today, insurers are increasingly using third-party data vendors to gather this and other information about consumers. There are advantages to using third-party vendors for this information in that consumers or agents can miscode or even intentionally attempt to lower rates with false information. In addition, using third-party vendors can lead to expense savings for the insurer due to the cost of communicating with the consumer or agent, sending mailings, properly coding the information once received, etc.

Insurers (or third-party data vendors) may not have all the specific classification information for every consumer. When the insurer does not have or obtain the information, the consumer is typically rated as "unknown" for the particular risk category. Sometimes the consumer would be able to supply the needed information, but the insurer does not always contact the consumer to ask. For example, if "number of bathrooms" is a variable in a home insurance

Deleted: using

Washington, DC 1101 K Street NW, Suite 650, Washington, DC 20005-7032 p | 202 471 3990
Kansas City 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197 p | 816 842 3600
New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000

rating algorithm and the insurer and third party do not know the number of bathrooms, "number of bathrooms" for that consumer might be treated as "unknown."

Sometimes the "unknown" category will be assigned a rating factor of 1.00, which means that the premium is the same before and after the associated variable is considered in the premium algorithm. The insurer may contend that assigning 1.00 removes the characteristic from consideration for that particular insured and does not penalize them. However, in the case of a discount with two options – say, a .90 factor for a type 1 discount and a .70 for a type 2 discount – assigning the "unknown" classification a factor of 1.00 means the consumer does not qualify for any discount and gets the highest rates compared to everyone whose data is not missing.

Other times an "unknown" risk may be slotted in a distinct category or be assigned a weighted average of the factors for the non-missing categories. Using a distinct category may be appropriate if missingness is not random. For example, a lack of credit information likely means that the consumer does not use credit. When such is the case, it makes sense that a "no hit" score would be assigned a distinct factor selected judgmentally by the insurer or as required by state law. By contrast, using a weighted average of the factors for the non-missing categories may be appropriate if missingness is random.

Commented [DDF2]: Oregon has statutory requirements for no hit credit histories, ORS 746.661 and OAR 836-080-436.

In an attempt to summarize the change occurring through theory, perhaps we could describe that as changing our regulatory view of risk-based pricing from "two consumers with the same risks transferred to the insurer receive the same rate" to "two consumers with the same *identified* risks transferred to the insurer receive the same rate." In reality, the latter statement has always been the theory. Companies have never had 100% of information to conduct rating and have had to make judgmental choices about the rates or further investigate. Although it certainly affects the individual policyholders, the treatment of "unknown" characteristics does not have a significant impact on the book of business if only a small percentage of consumers have missing information. But what if the information for a variable is missing for a larger percentage of consumers, say 10-50%? Some regulators believe rating variables should not be used if there are a large number of policies are rated as unknown. Some insurers believe using rating variables with a large number of policies rated as unknown still obtains a more accurate rate for a majority of thier consumers.

Deleted: s

Deleted: s

Some regulators are concerned that the treatment of "unknown" data means that consumers are not being charged a rate conmensurate with their risk. Regulators contend that insurers could sometimes obtain the information and thereby charge fairer rates if they asked the consumer or agent to provide the missing information, or re-queried the third-party vendor.

Not having data is one issue; not receiving data due to system error is another. Consumers might have retrievable data for a risk characteristic, but the insurer or the third party may have a system error that keeps the data from being retrieved at that moment. This likely causes the consumer to be slotted into the "unknown" category.

Adding to the issue, the variables used are often part of a confidential rating model, so consumers do not know what those categories are and would not know whether the data used is correct or not. If the consumer knew that "number of bathrooms in the home" was a rating variable and that the value of this variable is rated as "unknown", the consumer might be able to correct this information by providing the insurer information about the number of bathrooms. Insurers would be allowed to require proof; this is especially important in situations in which there might be an advantageous answer that would lower the consumer's rate.

To be clear, we are seeking input on the problem of rating policies with risk characteristics classified as unknown. This is distinct from the concerns regulators have regarding missing data in the risk modeling process. There is some overlap to be sure, but for the purposes of this letter, we ask that comments be limited to the scenario of determining appropriate premium for an individual applicant where some of the rating characteristics are classified as unknown.

We would appreciate hearing your comments on this issue. Questions you might consider include:

- Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect in its regular course of opertion? What risks or challenges might be involved with asking a consumer or agent to supply missing data?
- Does the insurer have a responsibility to notify the consumer when a risk charactistic is classified as unknown?
- How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium?
- What methods are appropriate for determining rating factors for characteristics classified as "unknown"? Does this differ based on whether or not the data is missing at random?
- If the data is frequently missing for a variable, how should the insurer decide whether to keep that variable in the rating algorithm? Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used?
- How should insurers think about the concept of fairness when using variables for which information is missing for some consumers?

Thank you for your input.

Christian Citarella, CASTF Chair
Julie Lederer, CASTF Vice Chair

Cc: Kris DeFrain and Roberto Perez (NAIC)

Deleted: was treated

Deleted: for the consumer

Deleted: with

Deleted: ask for

Deleted: unknown

Deleted: another way

Deleted: "unknown"

Deleted: or not

TO: Kris DeFrain, FCAS, MAAA, CPCU
Director, Research and Actuarial Services
National Association of Insurance Commissioners

FROM: Mike McKenney, Director of Property and Casualty Rate and Form Review
Pennsylvania Insurance Department

CC: Christian Citarella, ACAS, MAAA; CASTF Chair
Julie Lederer, FCAS, MAAA; CASTF Vice Chair

DATE: October 10, 2025

SUBJECT: CASTF's September 18, 2025 Request for Comments on Unknown Risk Characteristics

---

"*The Task Force recommends that two insurance customers having the same risk profile should be charged the same premium for the same coverage.*"

The above statement, found in paragraph 45 of the NAIC's Price Optimization White Paper ("White Paper"), is a cornerstone of insurance rate regulation. For more than 75 years, state insurance regulators have been ensuring that, to the greatest extent possible, differences in rates are based only on differences in risk. The widespread use of unknown characteristics is directly antithetical to that goal.

It seems like every five years state insurance regulators are called upon to stand up for fairness in property and casualty insurance rates. In the mid-2010s, it was price optimization. In 2020, it was the CAS Board of Directors rescinding the Statement of Principles Regarding Property and Casualty Insurance Ratemaking ("Principles"). Today, it is unknown risk classifications.

In response to price optimization, the NAIC commissioned a task force that drafted the White Paper which also included a model bulletin that more than twenty states have issued in some form. The model bulletin in the White Paper included:

- *"Insurers should group individual policyholders into justifiable, supportable, risk-based classifications and treat similarly situated policyholders the same with respect to insurance pricing."*

- *"Both base rates and rating classes must be based on policyholder characteristics specifically related to an insurer's expected losses, expenses or policyholders' risk."*

In response to the CAS Board of Directors rescinding the Principles, CASTF wrote a letter urging their reinstatement, which ultimately occurred. That letter, adopted unanimously by the members of CASTF, included:

- *"The rescindment of the Ratemaking SOP provides the impression that the principles are no longer viewed as valid by the actuarial profession. We find this especially troubling in an environment in which characteristics used by insurers in pricing are being challenged, quite publicly, for their perceived lack of a relationship to risk."*

We're dealing with the same core issue again today with unknown risk classifications – as state insurance regulators, do we or do we not believe that insurance rates must be tied to risk?

Principles

One of the reasons the Principles are so vitally important is that they remind us rates matter even at the individual risk level:

- *"Ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained."*
- *"A rate provides for the costs associated with an individual risk transfer."*
- *"A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer."*

Unknown risk classifications do not adhere to the above quoted principles. When a risk is assigned to the unknown risk classification instead of a higher or lower rated risk classification associated with its actual characteristics, the rate: (1) does not provide for the costs associated with an individual risk transfer; (2) is not an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer; and (3) equity among insureds is not maintained.

ASOP 12

ASOP No. 12: Risk Classification (for All Practice Areas) repeatedly states that the assignment of a risk to a classification should be based on objective, measurable and observable characteristics:

- *"2.8 Risk Characteristics—Measurable or observable factors or characteristics that are used to assign each risk to one of the risk classes of a risk classification system."*
- *"3.2.3 Objectivity—The actuary should select risk characteristics that are capable of being objectively determined."*
- *"3.3 Considerations in Establishing Risk Classes—A risk classification system assigns each risk to a risk class based on the results of measuring or observing its risk characteristics.*

In contrast, a risk assigned to the unknown risk classification had nothing observed, measured or objectively determined about it.

ASOP 12 also stresses the importance of risk classifications being homogeneous and related to expected outcomes. But there is nothing homogeneous about the unknown risk classification; it will contain risks with the full gamut of expected outcomes – the literal opposite of homogeneity. And except in rare circumstances where the lack of information relates to an expected outcome, not observing or measuring a risk's characteristics cannot tell you anything about an expected outcome.

Further, ASOP 12 discusses the issue of practicality in evaluating risk characteristics. In 3.2.4, ASOP 12 discusses the "*cost, time, and effort needed to evaluate the risk characteristic*" and "*the ongoing cost of administration*". Similarly, in 3.3.2.c, ASOP 12 states "*The cost, time, and effort needed to assign risks to appropriate risk classes will increase with the number of risk classes.*" Finally, equitable or fair rates are contemplated in 3.2.1: "*Rates within a risk classification system would be considered equitable if differences in rates reflect material differences in expected cost for risk characteristics. In the context of rates, the word fair is often used in place of the word equitable.*"

Some insurers' solution to the time, effort and cost problem of assigning risks to their appropriate classes is to: (1) query an unregulated third-party vendor; and (2) if the information is not instantaneously returned for any reason (e.g., no-hit, blurry or obstructed photo, internet is down, intranet is down, incorrect address, incorrect VIN, misspelled name, etc.) to otherwise not even try to obtain it. That's not a good, fair or appropriate solution and it does not maintain equitable or fair rates within the risk classification system.

Law

An analysis of how to respond to insurers' use of unknown risk classifications that considers only actuarial principles and standard of practice is incomplete; one must also review applicable insurance laws and regulations.

The NAIC Property and Casualty Model Rating Law (File and Use Version) defines "*classification system*" as "*the process of grouping risks with similar risk characteristics so that differences in costs may be recognized*" and further states that "*unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses.*" By contrast, the unknown risk classification is a group of risks with dissimilar characteristics, and its use will result in price differentials that fail to reflect equitably the differences in expected losses and expenses.

Recommendations

1. Create a maximum threshold above which the use of an unknown risk classification is not permitted and makes the variable as a whole invalid for inclusion in the rating algorithm. The Pennsylvania Insurance Department recommends this threshold be 10%. In other words, if less than 90% of risks can be assigned to a known risk class, then the rating variable is invalid and cannot be used.

2. Create a minimum threshold beneath which the use of an unknown risk classification can be tolerated. The Pennsylvania Insurance Department recommends this threshold be no higher than 2.5%. If less than 2.5% of risks will be assigned to the unknown risk classification, then it can be tolerated under the premise that perfection is not achievable (as well as the desire to meet industry as far as we can on the issue).

3. Create a requirement that for rating variables with an unknown risk classification populated between the above-mentioned thresholds, the first named insured must either be: (1) asked to supply the information that is missing; or (2) provided a clear disclosure of those characteristics for which the insured was rated on as "unknown."

4. Ensure that coverage can still be bound and the policy can still be issued without delay even when the first named insured is asked for or informed of unknown or missing information.

5. Require that the unknown risk classification be rated at the weighted-average rating value for the variable, with a recalculation made each year.

6. Create a list of variables for which the lack of information (e.g., a "no-hit") properly defines a valid risk classification and is therefore acceptable and exempt from requirements 1-5.

7. Create a list of variables for which assignment to the unknown risk classification can never be tolerated. We commonly see unknown risk classes proposed for rating territory, as one example. Rating territory should always be assignable.

8. Exempt rates for policies issued to large commercial risks (i.e., businesses that can be considered sophisticated insurance buyers) from these requirements.

Additional Discussion Points

1. One of the questions for which the CASTF letter requested comments was: "*What risks or challenges might be involved with asking a consumer or agent to supply missing data?*" It is important to fully understand the operational challenges that may be presented by putting parameters around the use of unknown characteristics. However, we believe that these efforts should be balanced with the desired outcome of two insurance customers having the same risk profile being charged the same premium for the same coverage. And, the discussion should include consideration of whether an insurer should use a rating variable for which they cannot properly classify risks in the first instance.

2. Although we have heard from insurers that some rating variables are too difficult for the first named insured to provide, we believe that option should be left to the insured. Additionally, the safe harbor would likely address that issue in many instances.

3. Some insurers may claim that asking their applicants and policyholders for the unknown characteristics will result in incorrect answers and gaming of the system. We believe that existing insurance laws recognize material misrepresentation as something that voids the insurance contract and should mitigate that concern.

4. As a reminder of what is being filed every day, we have seen unknown / missing risk classifications filed for everything imaginable, from the age of the named insured (including in a filing pending in review with us right now), to the number of bathrooms in the insured home, and even how many doors are on the insured car. The following is one example of what we see filed regularly:

Initial Length of Ownership Factor

Length	ABI	APD	ILB	PDB	FNB	UNB	UBS	UIB	UIS	AMP	EMB	CMB	CMP	COL
1-60	1.113	1.089	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.059	1.104
61-180	1.116	1.103	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.990	1.049
181-364	1.152	1.070	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.147	1.052
365-729	0.960	0.993	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.024	0.955
730-1094	0.967	0.958	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.008	0.952
1095-1825	0.879	0.915	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.860	0.922
1826-99997	0.879	0.915	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.860	0.922
Not registered in my name	1.113	1.089	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.059	1.104
Unknown	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

In the above filed rate table, if you've owned your car for at least three years when you apply for insurance, but the third-party data vendor doesn't know this, you'll pay 13.8% more than you should for BI, 9.3% more than you should for PD, 16.3% more than you should for Comp and 8.5% more than you should for Collision. It is difficult to conceive why an insurer does not simply ask a consumer how long they owned their car on the application.

Conclusion

Given the increased reliance on the use of third-party vendors and other emerging technologies, we believe it is more important than ever to work toward a solution that will protect consumers and ensure they are charged fair rates. In closing, the Pennsylvania Insurance Department urges the members of CASTF and state insurance regulators everywhere to continue to ensure that differences in insurance rates are related to differences in insurance risk by establishing parameters as outlined above.

Memo

To:	Kris DeFrain, Director, Research and Actuarial Services at NAIC Christian Citarella, CASTF Chair Julie Lederer, CASTF Vice Chair
From:	Lauren Cavanaugh, FCAS, MAAA, Partner, RRC Scott Merkord, FCAS, MAAA, CPCU, Senior Manager, RRC Taylor Davis, FCAS, MAAA, CERA, Senior Manager, RRC
Date:	October 20, 2025
Subject:	Comments regarding Unknown Risk Characteristics

Background

The Casualty Actuarial and Statistical Task Force discussed unknown risk characteristics at the NAIC Summer National Meeting and submitted a memorandum dated September 20, 2025 for comments related to rating policies with unknown risk characteristics.

Risk and Regulatory Consulting (RRC) regularly supports regulators in reviewing rate filing reviews across the country. As such, we have reviewed many filings that include rating plans that treat unknown risk characteristics in a variety of ways.

RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and Task Force members.

Direct Responses to questions in the Memorandum

- **Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect another way?**

We believe that insurers have the responsibility to obtain accurate information for all risk characteristics, to the extent practicable.

If two identical risks are charged different rates solely because the risk characteristic is not available for one risk but it is available, for another risk then the insurer should have a process to make reasonable efforts to collect that information.

- **What risks or challenges might be involved with asking a consumer or agent to supply missing data?**

Considerations include additional expense, moral hazard, and lack of access to the information by the consumer/agent. Consumers may not remember exact details, and agents may guess or enter placeholder values to complete a quote. Further, the consumer or agent may not fully understand what data is needed and why.

- **Does the insurer have a responsibility to notify the consumer when a risk characteristic is unknown?**

We believe that transparency is an important part of insurance regulation. This is especially the case when missing information could impact the consumer's premium or eligibility for coverage. Notifying the consumer of missing information during the application process can give the consumer an opportunity to provide additional information to the insurer.

- **How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium?**

It is common for actuaries to produce the Rate and Rule pages which define how unknown rating characteristics are rated, thus relevant considerations are located primarily within Actuarial Standard of Practice No. 12 *Risk Classification* and Actuarial Standard of Practice No. 53 *Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention*. While not an Actuarial Standard of Practice, the CAS Principles on Ratemaking also provide helpful guidance.

Actuarial Standard of Practice No. 12 *Risk Classification* states in Section 3.1.2: "Rates within a risk classification system would be considered equitable if differences in rates reflect material differences in expected cost for risk characteristics. In the context of rates, the word fair is often used in place of the word equitable." The CAS Principles on Ratemaking state that "A rate provides for all costs associated with the transfer of risk." The CAS Principles on Ratemaking further specify that ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained. This guidance would appear to suggest that either:

1. Rates should not include risk characteristics that are unknown for certain insureds; or
2. A rate with an unknown risk characteristic should be set at an indicated level for the cohort of policyholders with unknown data for that risk characteristic. The insurer may further consider the homogeneity of the data such that it subdivides experience appropriately within the unknown assignment.

Ratemaking is not solely a cost-based exercise. Actuaries must follow Actuarial Standard of Practice No. 1 *Introductory Actuarial Standard of Practice* which states that "there are situations where applicable law (statutes, regulations, and other legally binding authority) may require the actuary to deviate from the guidance of an ASOP. Where requirements of law conflict with the guidance of an ASOP, the requirements of law shall govern." In the context of unknown risk characteristics, there may be statutes and regulations currently in place that insurers need to adhere to.

- **What methods are appropriate for determining factors for "unknown" characteristics? Does this differ based on whether or not the data is missing at random?**

We believe the methods to determine factors for "unknown" characteristics should consider whether or not the missing data is random. The most common methods that we have observed for determining a factor would be the exposure weighted average factor -or- an indicated factor using the actual experience of the unknown risk characteristic bucket, which may be based on a univariate or multivariate analysis. Depending on the cause of the missing data (e.g., if it is not under the consumer's control to provide the missing data), the regulatory body or insurer may consider assigning the best available rating factor to unknown risk characteristics.

If the missing data is not randomly distributed, the Company should consider an analysis of the distribution when selecting the most appropriate rating factors. As an example, consider two property

insurers, Insurer ABC and XYZ, which rate on both roof age and roof condition. In this example, assume that roof condition is not randomly distributed and roof condition correlates with roof age. If the insurer has information for roof age, that information may be helpful for assigning a rating factor for roof condition if the information for roof condition is unavailable. If Insurer ABC assigns the average rating factor for roof condition when the roof condition is unavailable, Insurer ABC rating may not as accurately match risk to rating compared to Insurer XYZ, which assigns a roof condition rating factor that considers the roof age.

- **If the data is frequently missing for a variable, how should the insurer decide whether or not to keep that variable in the rating algorithm? Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used?**

If an insurer is using the variable with a multivariate model such as a GLM, the insurer may use the model diagnostics and variable significance measures to evaluate and decide how to address variables with missing data. Such analyses include:

1. An exclusion analysis with a measure such as Akaike Information Criterion[1] ("AIC") may allow the insurer to rank order the importance of variables;
2. Modeling the missing level separately and reviewing its results;
3. Consistency tests by year to determine if the missing variable has the same relationship across years; and
4. An evaluation of whether the missing data has an indicated factor near another level to determine whether there is intuitive rationale for the indicated factor given the characteristics of the missing data.

If the variable with a significant amount of missing data is highly predictive, then it may justify efforts for the insurer to improve data collection. If the data collection is inconsistent or costly, it may not be practical for the insurer to include the variable.

- **How should insurers think about the concept of fairness when using variables for which information is missing for some consumers?**

When considering fairness in rates, we first suggest consideration of ASOPs and the CAS Principles on Ratemaking, highlighted on the prior page. Further, we suggest that insurers and regulators consider the following:

1. Whether variables with a large volume of missing data should be utilized in the rating plan, given potential differences in treatment for consumers of equivalent risk.
2. The extent to which the consumer should be made aware of and have the ability to correct and update the risk characteristics used in rating.

Additional Comments for Consideration

We wanted to highlight a specific case of unknown risk characteristics which is emerging. Aerial Imagery models are being utilized for risk classification within property insurance. A new property may not yet have an image available, and these properties are more likely to not have an image available thus they are assigned an Unknown Risk Characteristic classification. In this situation, a new roof is commonly accepted to be superior and result in a lower rate. The task force members may consider this scenario as it evaluates appropriate responses to the concerns and questions.

[1] A statistical measured used to compare models by balancing goodness of fit and model complexity

We want to emphasize that insurers may need to analyze and confirm whether unavailable risk characteristics are disproportionately concentrated within specific segments, as this could lead to affordability/accessibility challenges for certain populations.

Thank you for the opportunity to provide comments on this important topic. We can be reached at 609-255-9778/lauren.cavanaugh@riskreg.com, 865-789-9970/scott.merkord@riskreg.com, or 774-258-8030/taylor.davis@riskreg.com if you or other members have any questions.

From: Tomasz Serbinowski <tserbinowski@utah.gov>
Date: October 20, 2025 at 11:25:49 AM EDT
To: "DeFrain, Kris" <kdefrain@naic.org>
Cc: "Klausmeier, Tracy" <tklausmeier@utah.gov>, "Stringham, Reed" <rmstringham@utah.gov>
Subject: Re: CASTF Unknown Risk Characteristics - Exposed Until Oct. 20

Christian Citarella, CASTF Chair

Julie Lederer, CASTF Vice Chair

I would like to offer the following comments on the issue of "unknown risk characteristics" in personal lines rating. My comments are limited to the question: Does the insurer have a responsibility to notify the consumer when a risk characteristic is unknown?

In the past, consumers were the primary source of information used to rate them. Today, insurers are increasingly using third-party data vendors for information about consumers.

The use of third-party vendors creates two issues. First, third-party vendors might lack some information about a consumer, resulting in an "unknown" value for a risk characteristic. Second, third-party vendors might have incorrect information about a consumer.

It would seem appropriate not only to notify the consumer when a risk characteristic is unknown but also to disclose to the consumer all information used to rate them that was obtained from sources other than the consumer themselves. Doing so would give the consumer an opportunity to provide missing information and would also allow the consumer to challenge any information gathered from third parties.

A homeowner policy may use the age of the roof as a rating variable, and the insurer may be using a third-party vendor for that information. If the insured recently replaced the roof, but the vendor information does not reflect that, the insured is charged an incorrect rate and is oblivious to the fact that the insurer is using outdated information.

Requiring disclosure to the consumer of the information used to rate them would likely come at a very low cost. This information is readily available and could be provided with the policy, renewal notice, or as part of other already required communications.

Tomasz Serbinowski

, Actuary

Utah Insurance Department

4315 S. 2700 West, Ste. 2300 | Salt Lake City, UT 84129

P: 801-957-9324 | tserbinowski@utah.gov

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Wilder (WA)

Sept. 18, 2025

To the Casualty Actuarial and Statistical (C) Task Force, Interested Regulators, and Interested Parties:

After a discussion at the recent open CASTF meeting, we are asking for additonal comments regarding the issue of "unknown risk characteristics" in personal lines rating. Below is a summary of our understanding of the problem. **Please provide written comment by Monday, Oct. 20.**

An insurer's rating plan for property and casualty insurers (e.g., personal auto insurers, homeowners' insurers) includes many risk categories or "classes" that are assigned rating factors. The purpose of these rating factors is to charge premium that correlates with risk. Risk classes are characteristics such as house location, telematics scores, insurance scores, vehicle insured (with VIN), age of house, number of years of driving experience, annual estimated mileage, number of driving convictions, and many more.

In the past, insurers asked consumers for the information that would be used to rate them. This was the purpose of the insurance application. Consumers were asked questions like

- How long have you owned your car?
- Does it have anti-lock brakes?
- How many bathrooms are in your home?

Today, insurers are increasingly using third-party data vendors to gather this and other information about consumers. There are advantages to using third-party vendors for this information in that consumers or agents can miscode or even intentionally attempt to lower rates with false information. In addition, using third-party vendors can lead to expense savings for the insurer due to the cost of communicating with the consumer or agent, sending mailings, properly coding the information once received, etc.

Insurers (or third-party data vendors) may not have all the specific class information for every consumer. When the insurer does not have or obtain the information, the consumer is typically rated using "unknown" for the particular risk category. Sometimes the consumer would be able to supply the needed information, but the insurer does not always contact the

Washington, DC 1101 K Street NW, Suite 650, Washington, DC 20005-7032 p | 202 471 3990
Kansas City 1100 Walnut Street, Suite 1000, Kansas City, MO 64106-2197 p | 816 842 3600
New York One New York Plaza, Suite 4210, New York, NY 10004 p | 212 398 9000

consumer to ask. For example, if "number of bathrooms" is a variable in a home insurance rating algorithm and the insurer and third party do not know the number of bathrooms, "number of bathrooms" for that consumer might be treated as "unknown."

Sometimes the "unknown" category will be assigned a rating factor of 1.00, which means that the premium is the same before and after the associated variable is considered in the premium algorithm. The insurer may contend that assigning 1.00 removes the characteristic from consideration for that particular insured and does not penalize them. However, in the case of a discount with two options – say, a .90 factor for a type 1 discount and a .70 for a type 2 discount – assigning the "unknown" a factor of 1.00 means the consumer does not qualify for a discount and gets the highest rates compared to everyone whose data is not missing.

Other times an "unknown" risk may be slotted in a distinct category or be assigned a weighted average of the factors for the non-missing categories. Using a distinct category may be appropriate if missingness is not random. For example, a lack of credit information likely means that the consumer does not use credit. When such is the case, it makes sense that a "no hit" score would be assigned a distinct factor based on the model output. By contrast, using a weighted average of the factors for the non-missing categories may be appropriate if missingness is random, although regulators may require that this randomness be demonstrated and/or explained in order to be satisfied that there is no unfair discrimination.

Deleted: selected judgmentally by the insurer

In an attempt to summarize the change occurring through theory, perhaps we could describe that as changing our regulatory view of risk-based pricing from "two consumers with the same risks transferred to the insurer receive the same rate" to "two consumers with the same *identified* risks transferred to the insurer receive the same rate." In reality, the latter statement has always been the theory. Companies have never had 100% of information to conduct rating and have had to make judgmental choices about the rates or further investigate. On the other hand, regulators need to hold companies accountable to select their variables considering availability and accuracy at point of sale, not just predictive power observed on a groomed and enhanced modeling dataset. Although it certainly affects the individual policyholders, the treatment of "unknown" characteristics does not have a significant impact on the book of business if only a small percentage of consumers have missing information. But what if the information for a variable is missing for a larger percentage of consumers, say 10-50%? Some regulators believe rating variables should not be used if there are a large number of unknowns and some believe that discrimination is still "unfair" when it affects only a minority of insureds and/or apply this standard at the individual risk level rather than the portfolio level. Some insurers believe using rating variables with a large number of unknowns still obtains a more accurate rate for a majority of consumers.

Some regulators are concerned that the treatment of "unknown" data means that consumers are not being charged a rate commensurate with their risk. Regulators contend that insurers could sometimes obtain the information and thereby charge fairer rates if they asked the consumer or agent to provide the missing information, or re-queried the third-party vendor.

Not having data is one issue; not receiving data due to system error is another. Consumers might have retrievable data for a risk characteristic, but the insurer or the third party may have a system error that keeps the data from being retrieved at that moment. This likely causes the consumer to be slotted into the "unknown" category.

Adding to the issue, the variables used are often part of a confidential rating model, so consumers do not know what those categories are and would not know whether the data used is correct or not. If the consumer knew that "number of bathrooms in the home" was a rating variable and that the value of this variable was treated as "unknown" for the consumer, the consumer might be able to correct this information by providing the insurer with information about the number of bathrooms. Insurers would be allowed to ask for proof; this is especially important in situations in which there might be an advantageous answer that would lower the consumer's rate.

To be clear, we are seeking input on the problem of rating policies with unknown risk characteristics. This is distinct from the concerns regulators have regarding missing data in the risk modeling process. There is some overlap to be sure, but for the purposes of this letter, we ask that comments be limited to the scenario of determining appropriate premium for an individual applicant where some of the rating characteristics are unknown.

We would appreciate hearing your comments on this issue. Questions you might consider include:

- Does an insurer have a responsibility to ask the consumer about rating characteristics it was unable to collect another way? What risks or challenges might be involved with asking a consumer or agent to supply missing data?
- Does the insurer have a responsibility to notify the consumer when a risk charactistic is unknown?
- How do the Actuarial Standards of Practice apply when insurers are dealing with unknown rating characteristics in calculating an insured's premium?
- What methods are appropriate for determining factors for "unknown" characteristics? Does this differ based on whether or not the data is missing at random?
- If the data is frequently missing for a variable, how should the insurer decide whether or not to keep that variable in the rating algorithm? Are there thresholds that should apply – e.g., if data is missing for more than X% of consumers, that variable should not be used?
- How should insurers think about the concept of fairness when using variables for which information is missing for some consumers?

Thank you for your input.

Christian Citarella, CASTF Chair
Julie Lederer, CASTF Vice Chair

Cc: Kris DeFrain and Roberto Perez (NAIC)

Draft: 10/31/25

Casualty Actuarial and Statistical (C) Task Force
E-Vote
October 23, 2025

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Oct. 23, 2025. 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 Sian Ng-Ashcraft (AK); Ricardo Lara represented by Tina Shaw (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima W. 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 J. Temple represented by Nichole Torblaa (LA); Marie Grant represented by Aaron Levine (MD); Robert L. Carey represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Phil Vigliaturo (MN); 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 David Dahl (OR); Michael Humphreys represented by Michael McKenney (PA); Suzette M. Del Valle (PR); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Elizabeth Byckovski (TX); Kaj Samsom represented by Rosemary Raszka (VT); Patty Kuderer represented by William Wilder (WA); and Allan L. McVey (WV).

1. Adopted its 2026 Proposed Charges

The Task Force conducted an e-vote to consider adoption of its 2026 proposed charges (Attachment Two-A). The motion passed unanimously.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Summer/CASTF/102325 Minutes evote 2026 Proposed Charges.docx

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

2026 Proposed Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

2. The **Actuarial Opinion (C) Working Group** will:

Propose revisions to the following as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:

i. *Financial Analysis Handbook.*
ii. *Financial Condition Examiners Handbook.*
iii. *Annual Statement Instructions—Property/Casualty.*
iv. Regulatory guidance to appointed actuaries and companies.
v. Other financial blanks and instructions, as needed.

3. The **Statistical Data (C) Working Group** will:

A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators* to improve data quality and reporting standards.

B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically, evaluate the demand and utility versus the costs of production of each product.

i. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance* (Homeowners Report).
ii. *Auto Insurance Database Report* (Auto Report).
iii. *Competition Database Report* (Competition Report).
iv. *Report on Profitability by Line by State Report* (Profitability Report).
v. *Auto Insurance Average Premium Supplement.*

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

MemberMeetings/CCMTE/2025 Fall/CASTF/2026 CASTF Adopted Charges.Docx

Draft: 11/4/25

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
October 14, 2025

The Casualty Actuarial and Statistical (C) Task Force met Oct. 14, 2025. 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 Patrick Lennon (MO); Heather Carpenter represented by Austin Childs (AK); Mark Fowler represented by Kyle Ogden (AL); Ricardo Lara represented by Mitra Sanandajifar (CA); Andrew N. Mais represented by George Bradner (CT); Michael Yaworsky represented by Peshala Disanayaka (FL); Doug Ommen represented by Travis Grassel (IA); Holly W. Lambert represented by Larry 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); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Stewart Trego (OH); Glen Mulready represented by Andy Schallhorn (OK); TK Keen represented by Ying Liu (OR); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Elizabeth Byckovski and Miriam Fisk (TX); Kaj Samson represented by Rosemary Raszka (VT), and Patty Kuderer represented by William Wilder (WA).

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

Fisk reported that the Actuarial Opinion (C) Working Group met Sept. 30 to continue refining the 2025 Regulatory Guidance Document and the *2026 Property/Casualty (P/C) Statement of Actuarial Opinion (SAO) Instructions*. No comments were received during the 30-day public comment period that ended Sept. 26. Following adoption by the Working Group, the P/C SAO instructions move to the Blanks (E) Working Group. The Regulatory Guidance document will be sent for final edits and then published as a guidance document.

Fisk made a motion, seconded by McKenney, 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 Sept. 24 to continue reviewing updates to the *Statistical Handbook of Data Available to Insurance Regulators*, focusing on the private passenger auto (PPA) section. The Working Group's next meeting is scheduled for Oct. 29. Industry involvement and feedback are welcome at all meetings.

The homeowners, auto, and profitability reports will be considered for adoption once the Working Group completes its review of the forthcoming finalized data.

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

3. Received a Report on GLM Regulator Training

Kris DeFrain (NAIC) reported that the generalized linear model (GLM) regulator training course, which consists of 23 modules covering various GLM filing topics, was developed by the NAIC Rate Model Review team and moved

to the NAIC's learning platform, NAIC Compass, by the Education and Training team. DeFrain said this course expands on the best practices outlined in the NAIC *Model Review Manual* and provides advanced training for non-actuaries and experienced rate filing reviewers with the goal of making them more comfortable reviewing GLM filings.

Melissa Griffin (NAIC) and Brandon Smith (NAIC) said course modules can be taken at any time and repeated as needed. A short snippet of a module was played, and the regulators' feedback was positive.

DeFrain reported that the GLM regulator training course will be rolled out in early November.

4. Discussed its 2026 Proposed Charges

Citarella introduced edits to the Task Force's 2025 charges to be considered for adoption as its 2026 proposed charges. Some additional edits were made during the meeting. Citarella said comments will be incorporated into the document for review, and an e-vote will follow.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/101425 min.docx

Draft: 9/9/25

Casualty Actuarial and Statistical (C) Task Force
Virtual Meeting
September 9, 2025

The Casualty Actuarial and Statistical (C) Task Force met Sept. 9, 2025. 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 Patrick Lennon (MO); Mark Fowler represented by Charles Hale and Ken Williamson (AL); Ricardo Lara represented by Mitra Sanandajifar, and Sarah Ye (CA); Andrew N. Mais represented by Qing He (CT); Karima M. Woods represented by David A. Christhilf (DC); Doug Ommen represented by Jordan Esbrook (IA); Holly W. Lambert represented by Larry Steinert (IN); Vicki Schmidt represented by Nicole Boyd (KS); Timothy J. Temple represented by Nichole Torblaa and Arthur Schwartz (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 and Connie Van Slyke (NE); Ned Gaines represented by Gennady Stolyarov (NV); Judith L. French represented by Stewart Trego and Thomas Botsko (OH); Glen Mulready represented by Andy Schallhorn (OK); Michael Humphreys represented by Michael McKenney (PA); Michael Wise represented by Will Davis (SC); Cassie Brown represented by J'ne Elizabeth Byckovski, Miriam Fisk, Rebecca Armon, and Nicole Elliott (TX); 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 convened on August 20 to continue refining the 2025 Regulatory Guidance Document and the 2026 P&C Statement of Actuarial Opinion (SAO) Instructions. Subsequent edits were made based on that discussion and the revised documents were released for a 30-day public comment period with comments due Sept. 26. A follow-up meeting is scheduled for Sept. 30 to review submitted comments and potentially adopt the updated guidance and instructions.

Fisk highlighted the proposed removal of a long-standing disclosure item from Exhibit B of the SAO Instructions. This item pertains to net reserves for losses and LAE related to voluntary and involuntary underwriting pools and associations. She explained that the item is no longer deemed necessary by regulators due to its declining materiality and inconsistent reporting across companies. Miriam encouraged stakeholders to provide feedback during the comment period if they believe the item remains important.

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 met Aug. 20 to continue reviewing updates to the *Statistical Handbook of Data Available to Insurance Regulators*, focusing on the homeowners and dwelling fire and allied lines sections and incorporating feedback from statistical agents. The group has now opened the private passenger auto section for discussion, which will continue in the upcoming meeting on Sept. 24. Additionally, NAIC staff are finalizing data for the homeowners, auto, and profitability reports for the group's review this month.

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

3. Provided Feedback on Catastrophe Model Training

Tim Barnett (CIPR) presented a new catastrophe model training initiative and asked for feedback. He said this training, designed for insurance regulators, builds on the existing Catastrophe 101 course and focuses on how catastrophe models are used in rate filings. Scheduled to pilot in person on Nov. 11, ahead of the All-Perils Conference, the training will cover model selection, validation, and applications in filings, including provisions for retained risk, reinsurance, and geographic segmentation. It will include interactive modules and real-world examples. Plans are to eventually offer an online version. He said feedback is welcomed to refine the course.

Regulators provided some immediate feedback, including the following: 1) The proposed date of Nov. 11 coincides with Veterans Day and may be a holiday for some attendees; 2) A checklist for reviewing catastrophe models in rate filings was requested with some discussion whether the checklist should be peril-specific or general, with consensus leaning toward a mostly general checklist with some peril-specific elements. 3) Training was requested for other lines beyond home insurance, such as personal and commercial auto. Barnett acknowledged the feedback and indicated openness to refining the training accordingly.

Jeff Czajkowski (CIPR) reiterated that step one is to get the pilot up and running so feedback can be received from regulators to evolve the curriculum further.

4. Heard Reports from Liaisons

The liaison reports highlighted several key activities across other NAIC committees and working groups:

- **Risk-Based Capital Investment Risk and Evaluation (E) Working Group of the Capital Adequacy (E) Working Group**: Botsko shared that the group is holding a call in October, focusing on items relevant to P&C RBC. Input from stakeholders is welcomed to enhance the process.
- **SERFF Modernization Project**: Citarella and Darby reported on progress of the SERFF Modernization Project. Updates were provided on the phased rollout of the new SERFF platform, with about 10 states involved in phase one. While most are not yet using it for P&C filings, Maine is among the few that are. Darby said there are enhanced intake capabilities that affect form filings, mostly. She said AI features will affect rules.
- **Big Data and AI (E) Working Group**: Citarella said discussions are ongoing about whether to draft an AI Model Law. The group is also working on developing an evaluation tool for AI models.
- **Homeowners Market Data Call Task Force**: Sandra Darby reported that the task force has sent out an updated data collection template for industry comment, with feedback due mid-Sept. Tools are under development to help states analyze their own data, which could significantly impact rate review and underwriting practices.

5. Discussed a Trade's Podcast about Unknown Rating Characteristics

McKenney raised concerns about inaccuracies in a recent NAMIC podcast about unknown rating characteristics, particularly the claim that insurers consistently collect the age of the insured but never use it as a rating factor. McKinney clarified that Pennsylvania has received multiple filings this year where insurers proposed using age as a rating variable, directly contradicting the podcast's assertion. He emphasized the importance of basing discussions on actual filings and rating characteristics, and reaffirmed Pennsylvania's commitment to a fair and consistent approach grounded in regulatory standards. He welcomed continued dialogue on the issue and offered to provide supporting examples if needed.

Citarella said he expects there to be many more conversations going forward on this issue about an unknown or missing rating characteristics and the most appropriate way to manage that within the scope of our laws that include unfair discrimination and charging proper premiums.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/090925 min.docx

Draft: 10/10/25

Actuarial Opinion (C) Working Group
Virtual Meeting
September 30, 2025

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Sep. 30, 2025. 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 Jim Di Santo (PA). Also participating was: Arthur Schwartz (MD).

1. Discussed comments received and adopted the 2025 Regulatory Guidance and the 2026 P/C Statement of Actuarial Opinion instructions documents

The proposed 2025 Regulatory Guidance and the 2026 P/C Statement of Actuarial Opinion (SAO) instructions were exposed for a 30-day public comment period ending Sep. 21. Fisk said that no comments were received for the 2025 regulatory guidance document. The group proceeded to discuss the 2026 P/C SAO Instructions. The following edits and considerations were reviewed: 1) A minor edit to clarify that exceptions for exams completed under earlier syllabi apply to both CAS and SOA; 2) Additional minor edits to revise references to items in Exhibit B which are renumbered due to the proposed removal of item 10 from Exhibit B.

Lederer made a motion, seconded by Darby, to adopt both the 2026 P/C SAO Instructions 2025 (Attachment Five-A) and the 2025 Regulatory Guidance (Attachment Five-B). The motion passed unanimously. Having no further business, the Actuarial Opinion (C) Working Group adjourned.

ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled "Statement of Actuarial Opinion" (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the *Annual Statement Instructions – Property and Casualty*.

   Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

   a. Name and title (and, in the case of a consulting actuary, the name of the firm).

   b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

   c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

   Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

   If subject to the *U.S. Qualification Standards*, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the *U.S. Qualification Standards* for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the *U.S. Qualification Standards* and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

   The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their initial appointment directly or through company management. The documentation should include brief biographical information and a description of how the definition of "Qualified Actuary" is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary's responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document their review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. It is generally expected that the review of the Appointed Actuary's qualification documentation should take place at the level within a holding company structure that is responsible for overseeing insurance operations. If a statutory entity is a subsidiary or a non-lead pool member with an Appointed Actuary whose qualifications were reviewed by the pool lead or principal's Board, the statutory entity's Board can satisfy the review requirement by acknowledging the parent Board's review. This can be done by noting in the meeting minutes the name of the principal or lead entity and the date the parent Board reviewed the qualification documentation, or by attaching a copy of the parent Board's meeting minutes reflecting their review of the qualification documentation. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.

If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former Appointed Actuary's satisfaction and those not resolved to the former Appointed Actuary's satisfaction. The letter should include a description of each disagreement and the nature of its resolution (or that it was not resolved). Within this same ten (10) business days, the Insurer shall in writing also request such former Appointed Actuary to furnish a letter addressed to the Insurer stating whether the Appointed Actuary agrees with the statements contained in the Insurer's letter and, if not, stating the reasons for which he or she does not agree. The former Appointed Actuary shall provide a written response to the insurer within ten (10) business days of such request, and the Insurer shall furnish such responsive letter from the former Appointed Actuary to the domiciliary commissioner together with its own responses.

The Appointed Actuary must report to the Board of Directors each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors and identify the manner of presentation (e.g., webinar, in-person presentation, written). A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

The Actuarial Opinion and the supporting Actuarial Report and workpapers should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including, but not limited to, ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.

1A. Definitions

"Appointed Actuary" is a Qualified Actuary (or individual otherwise approved by the domiciliary commissioner) appointed by the Board of Directors in accordance with Section 1 of these instructions.

"Board of Directors" can include the designated Board of Directors, its equivalent or an appropriate committee directly reporting to the Board of Directors.

"Qualified Actuary" is a person who:

(i) Meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualifications Standards)*, promulgated by the American Academy of Actuaries (Academy);

(ii) Has obtained and maintains an Accepted Actuarial Designation; and

(iii) Is a member of a professional actuarial association that requires adherence to the same *Code of Professional Conduct* promulgated by the Academy, requires adherence to the *U.S. Qualification Standards*, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.

An exception to parts (i) and (ii) of this definition would be an actuary evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary for particular lines of business and business activities.

"Accepted Actuarial Designation" in item (ii) of the definition of a Qualified Actuary, is an actuarial designation accepted as meeting or exceeding the NAIC's Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (published on the NAIC website). The following actuarial designations, with any noted conditions, are accepted as meeting or exceeding basic education minimum standards:

(i) Fellow of the CAS (FCAS) – Condition: basic education must include Exam 6 – Regulation and Financial Reporting (United States);

(ii) Associate of the CAS (ACAS) – Conditions: basic education must include Exam 6 – Regulation and Financial Reporting (United States) and Exam 7 – Advanced Estimation of ~~Policy~~ Claims Liabilities~~, Insurance Company Valuation, and Enterprise Risk Management~~;

(iii) Fellow of the SOA (FSA) – Conditions: basic education must include completion of the following courses: GI 101 Ratemaking and Reserving; GI 201 Operational, Financial, Regulatory, and Legal; GI 301 Further Topics in General Insurance; and GI 302 General Insurance in the U.S.~~general insurance track, including the following optional exams: the United States' version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.~~

The table below provides some allowable exam substitutions for (i), (ii) and (iii) in the definition of "Accepted Actuarial Designation:" ~~Noting that~~Since CAS exams have changed over time, exceptions are granted for exams completed under earlier syllabi.~~for (i) and (ii) provide for FCAS/ACAS designations achieved before an exam was created (e.g. CAS Exam 6-US) or with an earlier version of an exam or exam topic (e.g., 2010 CAS Exam 6 instead of the current CAS Exam 7 Section A). FCAS/ACAS qualified under the 2018 and prior Statement of Actuarial Opinion instructions can use the noted substitution rules to achieve qualification under the new instructions by demonstrating basic and/or continuing education of the required topics including material in CAS Exam 6 (US) and section A of CAS Exam 7 (in the May 2019 CAS syllabus). Exceptions for (iii) for an FSA are also included in the table. The SOA exams completed in the general insurance track in 2019 and prior should be supplemented with continuing education and experience to meet basic education requirements in the *U.S. Qualification Standards*. For purpose of these instructions only, the table also includes specific exams from other organizations that are accepted as substitutes.~~

Exception for (i), (ii), or (iii)	Exam:	Exam Substitution Allowed*
(i) and (ii)	CAS Exam 6 (US)	1. Any CAS version of a U.S. P/C statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 (US) in 2011. 2. An FCAS or ACAS earned prior to 2021 who did not pass CAS Exam 6 (US) or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 6 (US) provided the Appointed Actuary explains in his/her qualification documentation how knowledge of U.S. financial reporting and regulation was obtained. ~~3. SOA FREU (US) Exam~~
(ii)	CAS Exam 7	1. Any CAS version of an exam including advanced P/C reserving administered prior to creation of Exam 7 in 2011. ~~1.~~2. Any version of CAS Exam 7 administered since 2011. ~~2.~~3. An ACAS earned prior to 2021 who did not pass CAS Exam 7 or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 7 provided the Appointed Actuary explains in his/her qualification documentation how knowledge of the additional reserving topics in CAS Exam 7 (Section A) in the May 2019 syllabus was obtained. ~~3. SOA Advanced Topics Exam (Note: The ERM portion of Exam 7 is not needed to meet NAIC educational standards, therefore SOA ERM Exam is not needed for the substitution for this purpose.)~~
(iii)	SOA GI 101	SOA General Insurance Ratemaking and Reserving Exam administered after 2019

(iii)	SOA GI 201	SOA Introduction to General Insurance Exam administered after 2019 and SOA Financial Economics, Regulation and Law Module completed prior to 2026
(iii)	SOA GI 301	1. SOA Advanced Topics in General Insurance Exam administered after 2019 and SOA General Insurance Applications Module completed prior to 2026 2. CAS Exam 7 and SOA General Insurance Applications Module completed prior to 2026
(iii)	SOA GI 302	1. United States' version of the SOA Financial and Regulatory Environment Exam administered after 2019 2. CAS Exam 6 (US)
~~(iii)~~	~~SOA FREU (US) Exam~~	~~1. CAS Exam 6 (US)~~ ~~2. Any CAS version of a U.S. statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 in 2011.~~
~~(iii)~~	~~SOA Advanced Topics Exam~~	~~1. CAS Exam 7~~ ~~2. Any CAS version of an exam containing the advanced techniques to estimate policy liabilities (i.e., advanced reserving).~~
*Note: These exam substitutions only apply to these instructions and are not applicable for CAS or SOA exam waivers.		

"Insurer" or "Company" means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

"Actuarial Report" means a document or other presentation prepared as a formal means of conveying to the state regulatory authority and the Board of Directors the Appointed Actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the Appointed Actuary's opinion or findings, and of documenting the analysis underlying the opinion. The required content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

"Property and Casualty (P&C) Long Duration Contracts" refers to contracts (excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts) that fulfill both of the following conditions: (1) the contract term is greater than or equal to 13 months; and (2) the insurer can neither cancel the contract nor increase the premium during the contract term. These contracts are subject to the three tests of *SSAP No. 65—Property and Casualty Contracts* of the NAIC *Accounting Practices and Procedures Manual*.

"Accident and Health (A&H) Long Duration Contracts" refers to A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required. See Schedule H instructions for a description of categories of contract reserves, as well as policy features that give rise to contract reserves. Two specific examples of contracts that typically require contract reserves are long-term care and disability income insurance.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.

Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent (1%) of the insurer's capital and surplus reflected in the insurer's latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer's direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer's latest quarterly statements filed with its domiciliary commissioner.

1C. Reporting Requirements for Pooled Companies

For each company in the pool, the Appointed Actuary shall include a description of the pool, identification of the lead company and a listing of all companies in the pool, their state of domicile and their respective pooling percentages.

Exhibits A and B for each company in the pool should represent the company's share of the pool and should reconcile to the financial statement for that company.

The following paragraph applies to companies that have a 0% share of the pool (no reported Schedule P data). The company shall submit an Actuarial Opinion that reads similar to that provided for the lead company. For example, the IRIS ratio and risk of material adverse deviation discussions, and other relevant comments shall relate to the risks of the lead company in the pool. The Exhibit B responses to question 5 should be $0 and to question 6 should be "not applicable." Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the 0% companies in their data capture).

2. The Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary's work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary's relationship to the Company, qualifications for acting as Appointed Actuary and date of appointment and specify that the appointment was made by the Board of Directors.

If the Appointed Actuary was approved by the Academy to be a "Qualified Actuary," with or without limitation, or if the Appointed Actuary is not a Qualified Actuary but was approved by the domiciliary commissioner, the company must attach, each year, the approval letter and reference such in the identification paragraph.

4. The SCOPE paragraph should contain a sentence such as the following:

"I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date."

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

As required by SSAP No. 65, Exhibit A should also include the reserve for Direct and Assumed Unearned Premiums for P&C Long Duration Contracts and the reserve for Net Unearned Premiums for P&C Long Duration Contracts, regardless of whether the amounts are material.

The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.

The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

"In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by _____ (~~officer~~ individual's name and title at the Company). I evaluated that data for reasonableness and consistency. I also reconciled ~~that~~ the data used in my analysis to Schedule P, Part 1 of the Company's current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary."

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration: "In my opinion, the amounts carried in Exhibit A on account of the items identified:

   A. Meet the requirements of the insurance laws of (state of domicile).

   B. Are computed in accordance with accepted actuarial standards.

   C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements."

If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts, ~~or~~ Other Loss Reserve items, or Other Premium Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:

   D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or <insert Other ~~Loss~~ Reserve item on which the Appointed Actuary is expressing an Opinion> of the Company under the terms of its contracts and agreements.

If the Unearned Premium Reserves for P&C Long Duration Contracts reported on lines 7 or 8 of Exhibit A are non-zero but the Appointed Actuary deems the amounts immaterial and is not issuing an opinion on these amounts, the Appointed Actuary should include clarifying comments in the SCOPE, OPINION, and/or RELEVANT COMMENTS sections of the opinion.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards.

If the Appointed Actuary has ~~made~~ used ~~of the analysis of~~ another actuary's analysis that was not produced ~~under not within~~ the Appointed Actuary's ~~control~~ direction (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name, credential and affiliation within the OPINION paragraph. If the Appointed Actuary has ~~made~~ used ~~of~~ the work of a non-actuary (such as for modeling) for a material portion of the reserves, that individual must be identified by name and affiliation and a description of the type of analysis performed must be provided.

A Statement of Actuarial Opinion should be made in accordance with one of the following sections (1 through 5). The Appointed Actuary must explicitly identify in Exhibit B which type applies.

1. Determination of Reasonable Provision. When the carried reserve amount is within the Appointed Actuary's range of reasonable reserve estimates, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

2. Determination of Deficient or Inadequate Provision. When the carried reserve amount is less than the minimum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the minimum amount that the Appointed Actuary believes is reasonable.

3. Determination of Redundant or Excessive Provision. When the carried reserve amount is greater than the maximum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the maximum amount that the Appointed Actuary believes is reasonable.

4. Qualified Opinion. When, in the Appointed Actuary's opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items, the Appointed Actuary should issue a qualified Statement of Actuarial Opinion. The Appointed Actuary should disclose the item (or items) to which the qualification relates, the reason(s) for the qualification and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, *except for* the item (or items) to which the qualification relates. The Appointed Actuary is not required to issue a qualified opinion if the Appointed Actuary reasonably believes that the item (or items) in question are not likely to be material.

5. No Opinion. The Appointed Actuary's ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the Appointed Actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

   A. Company-Specific Risk Factors

   The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the Appointed Actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to

economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

B. Risk of Material Adverse Deviation

The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.

C. Other Disclosures in Exhibit B

RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

Disclosure item 11 in Exhibit B requests amounts for the extended reporting endorsement policy reserve associated with claims-made contracts. This policy reserve is required by SSAP No. 65 if a claims-made policy provides extended reporting coverage at no additional charge in the event of death, disability, or retirement of a natural person insured. In such instance, the company must accrue a policy reserve before the triggering event (the death, disability, or retirement of the insured) to assure that premiums are not earned prematurely. The amount of the reserve should be adequate to pay for all future claims arising from these coverage features after recognition of future premiums to be paid by current insureds for these benefits. SSAP No. 65 states that this reserve shall be classified as a component part of the unearned premium reserve, but some companies instead report the reserves as part of the loss and loss adjustment expense reserves. The reserve amount reported on Exhibit B, item 11 should be greater than or equal to the amount reported in Item 1.2 of the Schedule P Interrogatories. The Schedule P Interrogatory only asks for the policy reserve associated with medical professional liability policies, but item 11 on Exhibit B should include policy reserves for all P&C lines of business, not just medical professional liability; this extended reporting coverage is also available for other lines, such as legal professional liability, architect professional liability, etc.

D. Reinsurance

RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.

The Appointed Actuary's comments on reinsurance collectability should address any uncertainty associated with including potentially uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the Appointed Actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary's comments do not imply an opinion on the financial condition of any reinsurer.

Retroactive reinsurance refers to agreements referenced in *SSAP No. 62—Property and Casualty Reinsurance* of the NAIC *Accounting Practices and Procedures Manual*.

Financial reinsurance refers to contracts referenced in SSAP No. 62 in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the

reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

E. IRIS Ratios

If the Company's reserves will create exceptional values under the NAIC IRIS Tests for One-Year Reserve Development to Policyholders' Surplus, Two-Year Reserve Development to Policyholders' Surplus or Estimated Current Reserve Deficiency to Policyholders' Surplus, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

F. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for regulatory examination for seven (7) years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Actuarial Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to Company management, the Board of Directors, the regulator or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.

Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in the NAIC *Accounting Practices and Procedures Manual* requires a company with over 10,000 in force lives covered by long-term care (LTC) insurance contracts as of the valuation date to perform a stand-alone asset adequacy analysis for its in force long-term care (LTC) contracts. The Actuarial Report and workpapers summarizing the results, assumptions and testing procedures for the asset adequacy testing of LTC business must be in compliance with AG 51 requirements. When referring to AG 51, the term "Actuarial Memorandum" is synonymous with Actuarial Report and workpapers.

The Actuarial Report should contain disclosure of all reserve amounts associated with A&H Long Duration Contracts reported by the Company; the reserve amounts in the Actuarial Report should tie to the Annual Statement.

The Actuarial Report must also include:

A. A description of the Appointed Actuary's relationship to the Company, with clear presentation of the Appointed Actuary's role in advising the Board of Directors and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board of Directors and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

B. An exhibit that ties to the Annual Statement and compares the Appointed Actuary's conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed

Actuary's conclusions include the Appointed Actuary's point estimate(s), range(s) of reasonable estimates or both.

C. An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary's analysis, to the Annual Statement Schedule P line of business reporting. An explanation should be provided for any material differences.
   i. The reconciliation should compare the data **used by the Appointed Actuary** in the analysis to Schedule P. It is not sufficient to reconcile the data **provided by the Company** to the Appointed Actuary to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary's analysis exhibits to the actuarial data shown in the Schedule P reconciliation.
   ii. If the reconciliation was not produced under the Appointed Actuary's direction, the Appointed Actuary should identify who performed the reconciliation and confirm that the Appointed Actuary reviewed the reconciliation for reasonableness.

D. An exhibit or appendix showing the change in the Appointed Actuary's estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. The exhibit or appendix should illustrate the changes on a net basis but should also include the changes on a gross basis, if relevant. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

E. Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

F. Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Policyholders' Surplus, Two-Year Reserve Development to Policyholders' Surplus or Estimated Current Reserve Deficiency to Policyholders' Surplus, and how these factors were addressed in prior and current analyses.

G. If the Appointed Actuary has used an analysis or opinion not produced under the Appointed Actuary's direction for a material portion of the reserves:
   i. The dollar amount of the reserves covered by the other's analysis or opinion and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.
   ii. Whether and to what extent the Appointed Actuary reviewed the other's underlying analysis, including items such as methods and assumptions used and underlying arithmetic calculations.
   iii. If the Appointed Actuary reviewed the other's underlying analysis, the Appointed Actuary's conclusions from the review.

8. The Actuarial Opinion should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the date when the Actuarial Opinion was rendered. The signature and date should appear in the following format:

_____
Signature of Appointed Actuary
Printed name of Appointed Actuary
Employer's name
Address of Appointed Actuary
Telephone number of Appointed Actuary
Email address of Appointed Actuary
Date opinion was rendered

The same information should be reproduced within the Actuarial Report, along with the date the Actuarial Report was finalized.

9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Actuarial Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Actuarial Opinion shall be considered to be in error if the Actuarial Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Actuarial Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification is required when discovery is made between the issuance of the Actuarial Opinion and Dec. 31 of that year. Notification should include a summary of such findings.

   If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

   An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended Actuarial Opinion submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended Actuarial Opinion has been finalized.

   No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

Exhibit A: SCOPE

DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

Loss and Loss Adjustment Expense Reserves:		Amount
1.	Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)	$ _____
2.	Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)	$ _____
3.	Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)	$ _____
4.	Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)	$ _____
5.	The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$ _____
6.	Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)	$ _____
Premium Reserves:		
7.	Reserve for Direct and Assumed Unearned Premiums for P&C Long Duration Contracts	$ _____
8.	Reserve for Net Unearned Premiums for P&C Long Duration Contracts	$ _____
9.	Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)	$ _____

Exhibit B: DISCLOSURES

DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

1. Name of the Appointed Actuary — Last _____ First _____ Mid _____

2. The Appointed Actuary's relationship to the Company

   Enter E or C based upon the following:

   E if an Employee of the Company or Group

   C if a Consultant _____

3. The Appointed Actuary's Accepted Actuarial Designation (indicated by the letter code):

   F if a Fellow of the Casualty Actuarial Society (FCAS)

   A if an Associate of the Casualty Actuarial Society (ACAS)

   S if a Fellow of the Society of Actuaries (FSA) ~~through the General Insurance track~~

   M if the actuary does not have an Accepted Actuarial Designation but is approved by the Academy's Casualty Practice Council.

   O for Other _____

4. Type of Opinion, as identified in the OPINION paragraph. Enter R, I, E, Q, or N based upon the following:

   R if Reasonable

   I if Inadequate or Deficient Provision

   E if Excessive or Redundant Provision

   Q if Qualified. Use Q when part of the OPINION is Qualified.

   N if No Opinion _____

5. Materiality Standard expressed in U.S. dollars (used to Answer Question #6) $ _____

6. Are there significant risks that could result in Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]

7. Statutory Surplus (Liabilities, Surplus and Other Funds page, Col 1, Line 37) $ _____

8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $ _____

9. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P

   9.1 Nontabular Discount [Notes, Line 32B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 1, 2, 3, & 4 $ _____

   9.2 Tabular Discount [Notes, Line 32A23, (Amounts 1 & 2)], Electronic Filing Col 1 & 2 $ _____

~~10. The net reserves for losses and loss adjustment expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and loss adjustment expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines~~ ~~$ _____~~

~~11~~10. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines *

~~11~~10.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 33A03D, ending net asbestos reserves for current year) Electronic Filing Col 5 $ _____

~~11~~10.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 33D03D, ending net environmental reserves for current year), Electronic Filing Col 5 $ _____

~~12~~11. ~~The total claims made extended loss and loss adjustment expense, and unearned premium reserves~~Extended reporting endorsement policy reserve associated with claims-made contracts (Greater than or equal to Schedule P Interrogatories, Line 1.2)

~~12~~11.1 Amount reported as loss and loss adjustment expense reserves $ _____

~~12~~11.2 Amount reported as unearned premium reserves $ _____

~~13~~12. The net reserves for the A&H Long Duration Contracts that the Company carries on the following lines on the Liabilities, Surplus and Other Funds page:

~~13~~12.1 Losses $ _____

~~13~~12.2 Loss Adjustment Expenses $ _____

~~13~~12.3 Unearned Premium $ _____

~~13~~12.4 Write-In (list separately, adding additional lines as needed, and identify (e.g., "Premium Deficiency Reserves", "Contract Reserves other than Premium Deficiency Reserves" or "AG 51 Reserves")) $ _____

~~14~~13. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ _____

* The reserves disclosed in item ~~11~~10 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor's Pollution Liability, Consultant's Environmental Liability, and Pollution and Remediation Legal Liability.

REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year ~~2024~~2025

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

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

An Appointed Actuary has a responsibility to know and understand both the Instructions and the expectations of state insurance regulators. One expectation of regulators clearly presented in the Instructions is that the SAO, AOS, and supporting Actuarial Report and work papers be consistent with relevant Actuarial Standards of Practice (ASOPs). Although it is the responsibility of the Appointed Actuary to identify the applicable ASOPs, the Appointed Actuary may find it useful to review the *Applicability Guidelines for Actuarial Standards of Practice* published by the Actuarial Standards Board (ASB).

The 2024 Instructions ~~have been~~were modified to require the Appointed Actuary provide qualification documentation to the Board of Directors only at initial appointment and not annually thereafter. The only change to the 2025 Instructions is the inclusion of an editorial note clarifying that the FSA designation is considered an "Accepted Actuarial Designation" only if it was earned under the requirements through May 2025.

The Actuarial Opinion Working Group anticipates changes to the definition of "Accepted Actuarial Designation" in the 2026 Instructions. The changes were prompted by changes to the FSA educational pathway effective in fall 2025 and the Working Group's routine assessment of the SOA and CAS's educational materials in 2024-25. The objective of this periodic assessment, last performed in 2018-19, was to determine which actuarial designations, and under what conditions, meet the NAIC's Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (also known as the "NAIC knowledge statements")[1]. Subject matter experts proposed by the SOA, CAS, and Academy reviewed the SOA and CAS's educational materials to assess whether they appropriately addressed each NAIC knowledge statement. The SOA and CAS were asked to make certain changes to their educational material as a result of this review. The Working Group reviewed the findings of the subject matter experts and the subsequent changes to the organizations' educational material and made the final assessment of the conditions under which a member of the SOA or CAS is considered qualified to sign a P/C statement of actuarial opinion.

The changes to the "Accepted Actuarial Designation" definition proposed for the 2026 Instructions include:

a. Specifying the four courses that an FSA must complete under the new educational pathway,
b. Editing the exam substitution table to account for situations in which an FSA completed courses under the prior pathway, and
c. Updating the title of the CAS's Exam 7.

Other significant anticipated changes to the 2026 Instructions include:

a. Specifying that the Unearned Premium Reserves for P&C Long Duration Contracts should be disclosed in Exhibit A regardless of whether the amounts are material.
b. Specifying that the SAO should include clarifying comments if the Unearned Premium Reserves for P&C Long Duration Contracts reported in Exhibit A are non-zero but the Appointed Actuary deems the amounts immaterial.
c. Explicitly stating that the Schedule P reconciliation required to be documented in the Actuarial Report should compare the data used by the Appointed Actuary to Schedule P and clarifying the Appointed Actuary's responsibilities if the reconciliation was not produced under the Appointed Actuary's direction.
d. Adding disclosures required to be included in the Actuarial Report if the Appointed Actuary has used an analysis or opinion not produced under the Appointed Actuary's direction for a material portion of the reserves.
e. Removing the disclosure of the net reserves for losses and loss adjustment expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and loss adjustment expenses. (Exhibit B, Line 10)
f. Clarifying what should be disclosed in Exhibit B, Line 12 (or Line 11, if Line 10 is removed) by revising the description on Exhibit B and adding explanation to section 6.C. of the Instructions.

[1] https://content.naic.org/sites/default/files/committee_related_documents/Final%2520Knowledge%2520Statements%2520053119.xlsx

Table of Contents

I. General Comments 4
A. Reconciliation Between Documents 4
B. Role of Illustrative Language in the Instructions 4
C. Qualification Documentation 4
D. Replacement of an Appointed Actuary 4
E. Reporting to the Board of Directors 5
F. Requirements for Pooled Companies 5
G. Explanation of Adverse Development 5
1. Comments on Unusual Insurance Regulatory Information System Ratios in the Statement of Actuarial Opinion 5
2. Comments on Persistent Adverse Development in the Actuarial Opinion Summary 6
H. Revisions 6
II. Comments on the Statement of Actuarial Opinion and Actuarial Report 6
A. Review Date 6
B. Reconciliation 6
C. Making Use of Another's Work 7
D. Points A and B of the Opinion Paragraph When Opinion Type Is Other Than "Reasonable" 7
E. Conclusions on a Net Versus a Direct and Assumed Basis 7
F. Unearned Premium for Property/Casualty Long-Duration Contracts 7
G. Other Premium Reserve Items 8
H. The Importance of Relevant Comments Paragraphs 8
I. Risk of Material Adverse Deviation 8
1. No Company-Specific Risk Factors 8
2. Mitigating Factors 8
3. Consideration of Carried Reserves, Materiality Standard, and Reserve Range When Making Risk of Material Adverse Deviation Conclusion 8
4. Materiality Standards for Intercompany Pool Members 8
J. State Insurance Regulators' Use of the Actuarial Report 9
1. Schedule P Reconciliation 9
2. Change in Estimates 10
3. Narrative 10
4. Support for Assumptions 10
5. Support for Roll-Forward Analyses 10
K. Exhibits A and B 10

1. Data Capture Format....10
2. Scope of Exhibit B, Item 12....11
3. Exhibit B, Item 13....11

III. Comments on the Actuarial Opinion Summary....12
A. Confidentiality....12
B. Different Requirements by State....12
C. Format....12

IV. Guidance on Qualification Documentation....12
A. Brief Biographical Information....12
B. "Qualified Actuary" Definition....13

I. General Comments

A. Reconciliation Between Documents

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

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

B. Role of Illustrative Language in the Instructions

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

C. Qualification Documentation

Starting with the 2019 Instructions, the Appointed Actuary was required to provide qualification documentation to the Board of Directors upon initial appointment and annually thereafter. The 2024 Instructions ~~have been~~were amended to require the Appointed Actuary to provide qualification documentation to the Board of Directors only upon initial appointment and eliminate the requirement to provide the documentation annually thereafter.

The documentation provided to the Board of Directors must be available to the state insurance regulator upon request and during a financial examination. Guidance on qualification documentation is in Section IV of this document.

D. Replacement of an Appointed Actuary

The Instructions require two letters when the Board of Directors replaces an Appointed Actuary: 1) one addressed from the insurer to the domiciliary commissioner and 2) one addressed from the former Appointed Actuary to the insurer. The insurer must provide both letters to the domiciliary commissioner.

The detailed steps are as follows:

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

Regarding the disagreements referenced in step 2, state insurance regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary's analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary's analysis may go through several iterations, and an insurer's comments on the Appointed Actuary's draft Actuarial Report may prompt the Appointed

Actuary to make changes to the report. While state insurance regulators are interested in material disagreements regarding differences between the former Appointed Actuary's final estimates and the insurer's carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary's work.

E. Reporting to the Board of Directors

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

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

F. Requirements for Pooled Companies

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

For all intercompany pooling members:

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

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

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

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

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

G. Explanation of Adverse Development

1. Comments on Unusual Insurance Regulatory Information System Ratios in the Statement of Actuarial Opinion

   The Appointed Actuary is required to provide comments in the SAO on factors that led to unusual values for Insurance Regulatory Information System (IRIS) ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to "reserve strengthening" or "adverse development," and it expects the

Appointed Actuary to provide insight into the company-specific factors that caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the SAO.

2. Comments on Persistent Adverse Development in the Actuarial Opinion Summary

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

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

H. Revisions

The Instructions contain a detailed definition of what it means for the SAO or AOS to be "in error," along with a description of steps the company and Appointed Actuary should take in that situation.

Even if the SAO or AOS does not meet the Instructions' specific definition of "in error," submitting a revised SAO or AOS might be appropriate or recommended in other situations. It would be prudent for the company to contact the state insurance regulator if mistakes or problems are discovered but do not meet the specific definition of "in error."

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

II. Comments on the Statement of Actuarial Opinion and Actuarial Report

A. Review Date

The illustrative language for the Scope paragraph includes "… and reviewed information provided to me through XXX date." This is intended to capture the *Actuarial Standard of Practice (ASOP) No. 36*, *Statements of Actuarial Opinion Regarding Property/Casualty Loss, Loss Adjustment Expense, or Other Reserves*, requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion, i.e., the review date.

B. Reconciliation

The Instructions state that the Scope paragraph of the SAO should include statements regarding the data used by the Appointed Actuary in forming the opinion. The illustrative language includes "I also reconciled that data to Schedule P, Part 1 of the Company's current Annual Statement."

Regulators understand that the reconciliation of data to Schedule P may be produced by others not ~~within~~under the Appointed Actuary's ~~control~~ direction~~may perform the reconciliation of data to Schedule P~~. In these cases, the Working Group encourages the Appointed Actuary to identify who performed the reconciliation and confirm that the Appointed Actuary reviewed the reconciliation for reasonableness. The Working Group is planning to propose adding this to the 2026 Instructions as an Actuarial Report requirement.

Guidance on the substance of the Schedule P reconciliation is included in Section II.J.1 of this document.

C. Making Use of Another's Work

If the Appointed Actuary ~~makes~~ uses ~~of the work of another~~ an analysis that was not produced ~~within~~under the Appointed Actuary's ~~control~~direction for a material portion of the reserves, the Instructions note that the Appointed Actuary must provide the following information in the SAO:

- The person's name.

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

The Working Group encourages the Appointed Actuary to disclose whether they reviewed the other's underlying analysis and, if so, the extent of the review (i.e., the methods and assumptions used and the underlying arithmetic calculations) and their conclusions from the review.

Section 3.4.4 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to use another party's analysis or opinion. One of these items is the amount of the reserves covered by the other's analysis or opinion in comparison to the total reserves subject to the actuary's opinion. The Working Group encourages the Appointed Actuary to disclose these items in the SAO by providing the dollar amount of the reserves covered by the other's analysis or opinion and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.

The Working Group is planning to propose adding these to the 2026 Instructions as required disclosures in an Actuarial Report.

D. Points A and B of the Opinion Paragraph When Opinion Type Is Other Than "Reasonable"

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

E. Conclusions on a Net Versus a Direct and Assumed Basis

As noted on Exhibit B in the Instructions, Exhibit B should be completed for net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

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

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

F. Unearned Premium for Property~~/~~ and Casualty Long-Duration Contracts

Exhibit A, Items 7 and 8, require disclosure of the unearned premium reserve for property~~/~~ & casualty (P~~/~~&C) long-duration contracts. These amounts should be disclosed regardless of whether the Appointed Actuary deems the amounts immaterial. The Instructions require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material.

The Working Group expects that the Appointed Actuary will include documentation in the Actuarial Report to support a conclusion on reasonableness whenever point D is included in the SAO. This documentation may include the three tests of *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts* or other methods deemed appropriate by the Appointed Actuary to support their conclusion.

If the P~~/~~&C Long Duration Unearned Premium Reserves on lines 7 or 8 of Exhibit A are non-zero, but the Appointed Actuary deems the amounts immaterial and is not issuing an opinion on these amounts, the Appointed Actuary should consider making this clear by including comments in the SCOPE, OPINION, and/or RELEVANT COMMENTS sections of the opinion. For example, if the Appointed Actuary is only opining on loss and loss adjustment expense reserves, the Appointed Actuary might use the following language in the SCOPE paragraph: "I have examined the actuarial assumptions

and methods used in determining loss and loss adjustment expense reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date." The Appointed Actuary might also use the following language in the OPINION paragraph: "In my opinion, the loss and loss adjustment expense reserves carried in Exhibit A: […]" In a RELEVANT COMMENT paragraph, the Appointed Actuary might say something like the following: "The P~~/~~&C Long Duration Unearned Premium Reserves are not material. I therefore relied on the Company for its representation of the reasonableness of the P&C Long Duration Unearned Premium Reserves."

G. Other Premium Reserve Items

Regarding "Other Premium Reserve Items" in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial. If the amounts are material and the Appointed Actuary states that the amounts are reasonable in an Opinion paragraph, state insurance regulators would expect the actuarial documentation to support this conclusion in the Actuarial Report.

Typical items state insurance regulators see listed as other premium reserve items are medical professional liability death, disability, and retirement (DD&R) unearned premium reserves (UPRs) and other liability claims. Depending on the nature of these exposures, these items may be also listed on Exhibit B, Line 12.2, as claims made extended UPRs.

H. The Importance of Relevant Comments Paragraphs

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

I. Risk of Material Adverse Deviation

The Relevant Comments paragraphs on the RMAD are particularly useful to state insurance regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to state insurance regulators. The second two stem from state insurance regulators' reviews of SAOs.

1. No Company-Specific Risk Factors—The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe there are any company-specific risk factors, the Appointed Actuary should state that.

2. Mitigating Factors—State insurance regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company's application of controls or use of mitigation techniques. The company's risk management behaviors may, however, affect the Appointed Actuary's RMAD conclusion.

3. Consideration of Carried Reserves, Materiality Standard, and Reserve Range When Making Risk of Material Adverse Deviation Conclusion—When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.

4. Materiality Standards for Intercompany Pool Members—With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate SAO with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

J. State Insurance Regulators' Use of the Actuarial Report

State insurance regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with *ASOP No. 41, Actuarial Communications*, can provide a foundation for efficient reserve evaluation during a statutory financial examination. This

expedites the examination process and may provide cost savings for the company.

1. Schedule P Reconciliation

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

The Working Group believes:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity, and the methods used by the Appointed Actuary. While it is important that the Appointed Actuary is provided with complete and accurate data, reconciling the data **provided** to the Appointed Actuary to Schedule P is not sufficient to demonstrate that the data **used** by the Appointed Actuary reconciles to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary's analysis exhibits to the actuarial data shown in the Schedule P reconciliation.
- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis, and there is often not a direct correspondence between analysis segments and Schedule P lines of business.
- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate. If the Appointed Actuary chooses not to reconcile certain data elements used in the analysis, such as claim counts, a brief explanation should be included in the Actuarial Report to make it clear that these elements were not inadvertently overlooked.
- Schedule P reconciliations are expected to be performed on both a direct and assumed basis and a net of reinsurance basis. If circumstances specific to the company lead the Appointed Actuary to perform the reconciliation on only one basis, the rationale for this decision should be explained in the Actuarial Report. Similarly, while the reconciliation of the loss-related elements, such as defense and cost containment and adjusting and other expenses, is generally expected to be on the same level as used in the analysis underlying the SAO, the Appointed Actuary has the discretion to deviate as long as the rationale is explained in the Actuarial Report.
- The Instructions require that the Appointed Actuary include an explanation for any material differences in the Schedule P reconciliation. When differences appear in the reconciliation but are viewed as immaterial by the Appointed Actuary, the Appointed Actuary should acknowledge the immateriality of the differences in the Actuarial Report in order to assure state insurance regulators that the Appointed Actuary is aware of the differences and has considered the potential impact of the differences on the analysis underlying the SAO.

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

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

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

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

2. Change in Estimates

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

3. Narrative

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

4. Support for Assumptions

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

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have little value if items, such as rate actions, tort reform, schedule rating adjustments, or program revisions, have materially affected premium adequacy.

5. Support for Roll-Forward Analyses

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

K. Exhibits A and B

1. Data Capture Format

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

2. Scope of Exhibit B, Item 12

Exhibit B, Item 12, requests ~~information on~~on the total claims made extended loss and unearned premium reserves for all P~~/~~&C lines of business, not just medical professional liability. The Schedule P Interrogatories referenced in the parenthetical only address reserves associated with yet-to-be-issued extended reporting endorsements offered in the case of DD&R of an individual insured under a medical professional liability claims-made policy.

The Working Group is planning to propose that the 2026 Instructions include a revised description of this item and additional explanation in section 6.C. As currently worded in the Instructions through 2025, this item could be interpreted broadly, to include reserves for all claims made extended reporting coverage. The Working Group's proposed revisions will specify that the amount disclosed for this item should be the extended reporting endorsement **policy reserve** associated with claims-made contracts, which is required by SSAP No. 65 if a claims-made policy provides extended reporting coverage at no additional charge in the event of death, disability, or retirement of a natural person insured.

3. Exhibit B, Item 13

The Working Group added disclosure item Exhibit B, Item 13, in 2018. This item requests information on reserves associated with accident and health (A&H) long-duration contracts, defined in the Instructions as "A&H contracts in

which the contract term is greater than or equal to 13 months, and contract reserves are required."

This disclosure item was added for several reasons:

- **A desire by state insurance regulators to gain a greater understanding of P~~/~~&C insurers' exposure to A&H long-duration contracts.**
  - This guidance does not specify how P~~/~~&C insurers should report the liabilities associated with A&H long- duration contracts on the annual statement. Through work performed on financial examinations, state insurance regulators have found that P~~/~~&C insurers may include the liabilities in various line items of the Liabilities, Surplus and Other Funds page. *SSAP No. 54—Individual and Group Accident and Health Contracts* provides accounting guidance for insurers.
  - Regardless of where the amounts are reported on the annual statement, the materiality of the amounts, and whether the insurer is subject to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), the Appointed Actuary should disclose the amounts associated with A&H long-duration contracts on Exhibit B, Item 13. The Appointed Actuary should provide commentary in a relevant comments paragraph in accordance with paragraph 6.C of the Instructions. The Appointed Actuary should also disclose all reserve amounts associated with A&H long-duration contracts in the Actuarial Report.

- **The adoption of AG 51 in 2017.** On Aug. 9, 2017, the NAIC's Executive (EX) Committee and Plenary adopted AG 51 requiring stand-alone asset adequacy analysis of long-term care (LTC) business. The text of AG 51 is included in the March 2019 edition of the NAIC's *Accounting Practices and Procedures Manual* (AP&P Manual). The effective date of AG 51 was Dec. 31, 2017, and it applies to companies with over 10,000 in-force lives covered by long-term care insurance (LTCI) contracts as of the valuation date. The Instructions state that the Actuarial Report and workpapers summarizing the asset adequacy testing (AAT) of LTC business must comply with AG 51 requirements.

- **Recent adverse reserve development in LTC business.** State insurance regulators expect Appointed Actuaries to disclose company-specific risk factors in the SAO. Given the recent adverse experience for LTC business, Appointed Actuaries should consider whether exposure to A&H long-duration contracts poses a risk factor for the company.

The Appointed Actuary is not asked to opine on the reasonableness of the reserves associated with A&H long-duration contracts except to the extent that the reserves are included within the amounts reported on Exhibit A of the SAO. For this reason, the Working Group intentionally excluded Items 13.3 and 13.4 from this sentence in paragraph 4 of the Instructions: "The Appointed Actuary should state that the items in the SCOPE, on which they is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B." Exhibit B, Item 13.1, asks the Appointed Actuary to disclose the reserves for A&H long-duration contracts that the company carries on the Losses line of the Liabilities, Surplus, and Other Funds page. The Appointed Actuary is not asked to opine on the reasonableness of the reserves disclosed on Exhibit B, Item 13.1, in isolation, but these reserves are a subset of the amount included on Exhibit A, Item 1, and Exhibit A lists amounts with respect to which the Appointed Actuary is expressing an opinion. The same is true for Exhibit B, Item 13.2, whose reserves are a subset of the amount included on Exhibit A, Item 2.

A&H long-duration contracts are distinct from P~~/~~&C long-duration contracts. There were no changes to the opinion requirements in 2018 regarding P~~/~~&C long-duration contracts, but the Working Group added a reference to SSAP No. 65 in the definition of P~~/~~&C long-duration contracts to clarify the difference between A&H long-duration contracts and P~~/~~&C long-duration contracts. The newly-added mention of SSAP No. 65 in the Instructions is not intended to change the Appointed Actuary's treatment of P~~/~~&C long-duration contracts in the SAO or the underlying analysis, but insurers and Appointed Actuaries may refer to SSAP No. 65, paragraphs 21 through 33, for a description of the three tests, a description of the types of P~~/~~&C contracts to which the tests apply, guidance on the minimum required reserves, and instructions on the SAO and Actuarial Report.

III. Comments on the Actuarial Opinion Summary

A. Confidentiality

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

B. Different Requirements by State

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

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

C. Format

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

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

IV. Guidance on Qualification Documentation

The Instructions were modified for 2019 to require the Appointed Actuary to document qualifications in what is called "qualification documentation." Beginning with year-end 2024 Opinions, the Appointed Actuary's qualification documentation is required to be provided to the Board of Directors at initial appointment, whereas in previous years it was also required to be provided annually thereafter.

The following provides guidance Appointed Actuaries may find useful in drafting qualification documentation. Appointed Actuaries should use professional judgment when preparing the documentation, and they do not need to use the sample wording or format provided below. As a general principle, Appointed Actuaries should provide enough detail within the documentation to demonstrate that they satisfy each component of the Qualified Actuary definition. In crafting the qualification documentation, it may be helpful to think about what is important for the Board of Directors to know about their Appointed Actuary's qualifications and remember that documentation should be relevant to the subject of the Actuarial Opinion being issued.

A. Brief Biographical Information

- The Appointed Actuary may provide resume-type information.
- Information may include the following:
  - Professional actuarial designation(s) and year(s) first attained.
  - Insurance or actuarial coursework or degrees.
  - Actuarial employment history: company names, position title, years of employment, and relevant information regarding the type of work (e.g., reserving, ratemaking, enterprise risk management [ERM]).

B. "Qualified Actuary" Definition

The Appointed Actuary should provide a description of how the definition of Qualified Actuary in the Instructions is met or expected to be met—in the case of continuing education (CE)—for that year. The Appointed Actuary should provide information similar to the following. Items 1 through 3 below correspond with items (i) through (iii) in the Qualified Actuary definition.

1. I meet the basic education, experience, and CE requirements of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy). The following describes how I meet

these requirements:

a. Basic education:

- [Option 1] met through relevant examinations administered by the Casualty Actuarial Society (CAS).
- [Option 2] met through alternative basic education. The Appointed Actuary should further review documentation necessary per Section 3.1.2 of the U.S. Qualification Standards.

b. Experience requirements: met through relevant experience as described below.

- To describe the Appointed Actuary's responsible experience relevant to the subject of the SAO, information may include specific actuarial experiences relevant to the company's structure (e.g., insurer, reinsurer, risk retention group [RRG]), lines of business, or special circumstances.
- Experiences may include education (through organized activities or readings) about specific types of company structures, lines of business, or special circumstances.

c. CE: met (or expected to be met) through a combination of industry conferences, seminars (both in-person and virtual), online courses, committee work, self-study, etc., on topics including _____ (provide a brief overview of the CE topics. For example, "trends in workers' compensation" or "standards of actuarial practice on reserving"). A detailed log of my CE credit hours is available upon request.

- Section 3.3 of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement requires the Appointed Actuary to earn 15 hours of CE on topics mentioned in Section 3.1.1.2.

2. I have obtained and maintain an Accepted Actuarial Designation. One of the following statements may be made, depending on the Appointed Actuary's exam track:

- I am a Fellow of the CAS (FCAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.).
- I am an Associate of the CAS (ACAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.) and Exam 7—Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management.[2]
- I am a Fellow of the SOA (FSA), and my basic education includes completion of the general insurance track, including the following optional exams: the U.S. version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.[3]

Alternatively, if the actuary was evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary, the Appointed Actuary may note such and identify any restrictions or limitations, including those for lines of business and business activities.

3. I am a member of [professional actuarial association] that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline (ABCD) when its members are practicing in the U.S.

[2] Under the changes proposed to the 2026 Instructions, this bullet point will change to "I am an Associate of the CAS (ACAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.) and Exam 7—Advanced Estimation of Claims Liabilities."

[3] Under the changes proposed to the 2026 Instructions, this bullet point will change to "I am a Fellow of the SOA (FSA), and my basic education includes completion of the following courses: GI 101 Ratemaking and Reserving; GI 201 Operational, Financial, Regulatory, and Legal; GI 301 Further Topics in General Insurance; and GI 302 General Insurance in the U.S."

Draft: 9/8/25

Actuarial Opinion (C) Working Group
Virtual Meeting
August 20, 2025

The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Aug. 20, 2025. The following Working Group members participated: Miriam Fisk, Chair (TX); Julie Lederer, Vice Chair (MO); Amy Waldhauer (CT); Chantel Long (IL); Sandra Darby (ME); Tom Botsko (OH); Andy Schallhorn (OK); and Kevin Clark and Jim Di Santo (PA). Also participating was: Arthur Schwartz (MD).

1. Discussed Proposed Edits to the 2025 Regulatory Guidance Document

Fisk said she received proposed edits to the 2025 regulatory guidance document from Lederer and Long. Fisk said she replaced some placeholders and removed remaining questions to prepare the document for exposure. Significant changes from the prior draft include the description of changes planned in the 2026 Statement of Actuarial Opinion (SAO) instructions, some additional wording about conclusions and amounts on a net versus direct and assumed basis, and improvement to the qualification documentation section.

Michelle Iarkowski (American Academy of Actuaries' Committee on Property and Liability Financial Reporting—COPLFR) said it would help Appointed Actuaries to know how regulators use the Risk of Material Adverse Deviation (RMAD) on a gross basis. Fisk responded that when a company has a 100% quota share or otherwise cedes all its business, actuaries will often choose a net materiality standard of $0 or $1. The reason provided is that there should be no development because everything is ceded. Fisk said they then establish more than $1 for a gross material adverse deviation. Iarkowski said it would be helpful to know whether RMAD should be related to reserves or solvency. Fisk said there is no time to tackle that issue right now.

Fisk concluded by noting that an updated draft of the guidance document should be ready for exposure soon.

2. Discussed Proposed Edits to the 2026 P/C SAO Instructions and Regulatory Guidance Documents

Fisk continued the discussion of proposed edits to the 2026 SAO instructions as listed in the Working Group's July 23 minutes. Schwartz suggested removing the requirement to list an "officer" when the actuary states who was relied upon to prepare the company data. He said he has seen a variety of people listed, and those people are often not officers. Fisk agreed, saying non-officers are often identified. Lederer proposed some revised wording about the Schedule P reconciliation to add context, like the wording used in the regulatory guidance. Schwartz proposed rewording the requirements about relying on someone not within the appointed actuary's control. Standards have been revised from "not within the actuary's control" to "not produced under the actuary's direction" and from "claims reliance on" to "makes use of" to now "uses" the work of others. Fisk will research and make changes to be consistent with standards.

Lederer proposed changing "the total claims-made extended loss and loss adjustment, expense and unearned premium reserves" on Exhibit B to "extended reporting endorsement policy reserve associated with claims-made contracts." Lederer said no company should report this as loss and loss adjustment expense reserves because *Statement of Statutory Accounting Principle (SSAP) No. 65—Property and Casualty Contracts* says it should be a component of unearned premium reserve. She said item one would be retained because, while it is a policy reserve, some companies report the amount as loss and loss adjustment expense (LAE) reserves. Lederer also proposed some language that describes what regulators are looking for with this line item. Fisk suggested discussing this topic at the Working Group's next meeting.

Fisk said she will redraft the guidance based on the Working Group's discussion and expose the documents (Attachment Six-A and Attachment Six-B) for a 30-day public comment period ending Sept. 26.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/AOWG/AOWG 08_20_2025 min.docx

ACTUARIAL OPINION

1. There is to be included with or attached to Page 1 of the Annual Statement the statement of the Appointed Actuary, entitled "Statement of Actuarial Opinion" (Actuarial Opinion), setting forth his or her opinion relating to reserves specified in the SCOPE paragraph. The Actuarial Opinion, both the narrative and required Exhibits, shall be in the format of and contain the information required by this section of the *Annual Statement Instructions – Property and Casualty*.

   Upon initial engagement, the Appointed Actuary must be appointed by the Board of Directors by Dec. 31 of the calendar year for which the opinion is rendered. The Company shall notify the domiciliary commissioner within five business days of the initial appointment with the following information:

   a. Name and title (and, in the case of a consulting actuary, the name of the firm).

   b. Manner of appointment of the Appointed Actuary (e.g., who made the appointment and when).

   c. A statement that the person meets the requirements of a Qualified Actuary (or was approved by the domiciliary commissioner) and that documentation was provided to the Board of Directors.

   Once this notification is furnished, no further notice is required with respect to this person unless the Board of Directors takes action to no longer appoint or retain the actuary or the actuary no longer meets the requirements of a Qualified Actuary.

   If subject to the *U.S. Qualification Standards*, the Appointed Actuary shall annually attest to having met the continuing education requirements under Section 3 of the *U.S. Qualification Standards* for issuing Actuarial Opinions. As agreed with the actuarial organizations, the Casualty Actuarial Society (CAS) and Society of Actuaries (SOA) will determine the process for receiving the attestations for their respective members and make available the attestations to the public. An Appointed Actuary subject to the *U.S. Qualification Standards* and not a member of the CAS or SOA shall select one of the above organizations to submit their attestation.

   The Appointed Actuary shall provide to the Board of Directors qualification documentation on occasion of their initial appointment directly or through company management. The documentation should include brief biographical information and a description of how the definition of "Qualified Actuary" is met or expected to be met (in the case of continuing education) for that year. The documentation should describe the Appointed Actuary's responsible experience relevant to the subject of the Actuarial Opinion. The Board of Directors shall document their review of those materials and any other information they may deem relevant, including information that may be requested directly from the Appointed Actuary. It is generally expected that the review of the Appointed Actuary's qualification documentation should take place at the level within a holding company structure that is responsible for overseeing insurance operations. If a statutory entity is a subsidiary or a non-lead pool member with an Appointed Actuary whose qualifications were reviewed by the pool lead or principal's Board, the statutory entity's Board can satisfy the review requirement by acknowledging the parent Board's review. This can be done by noting in the meeting minutes the name of the principal or lead entity and the date the parent Board reviewed the qualification documentation, or by attaching a copy of the parent Board's meeting minutes reflecting their review of the qualification documentation. The qualification documentation shall be considered workpapers and be available for inspection upon regulator request or during a financial examination.

If an actuary who was the Appointed Actuary for the immediately preceding filed Actuarial Opinion is replaced by an action of the Board of Directors, the Insurer shall within five (5) business days notify the Insurance Department of the state of domicile of this event. The Insurer shall also furnish the domiciliary commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former Appointed Actuary regarding the content of the opinion on matters of the risk of material adverse deviation, required disclosures, scope, procedures, type of opinion issued, substantive wording of the opinion or data quality. The disagreements required to be reported in response to this paragraph include both those resolved to the former Appointed Actuary's satisfaction and those not resolved to the former Appointed Actuary's satisfaction. The letter should include a description of each disagreement and the nature of its resolution (or that it was not resolved). Within this same ten (10) business days, the Insurer shall in writing also request such former Appointed Actuary to furnish a letter addressed to the Insurer stating whether the Appointed Actuary agrees with the statements contained in the Insurer's letter and, if not, stating the reasons for which he or she does not agree. The former Appointed Actuary shall provide a written response to the insurer within ten (10) business days of such request, and the Insurer shall furnish such responsive letter from the former Appointed Actuary to the domiciliary commissioner together with its own responses.

The Appointed Actuary must report to the Board of Directors each year on the items within the scope of the Actuarial Opinion. The Actuarial Opinion and the Actuarial Report must be made available to the Board of Directors. The minutes of the Board of Directors should indicate that the Appointed Actuary has presented such information to the Board of Directors and identify the manner of presentation (e.g., webinar, in-person presentation, written). A separate Actuarial Opinion is required for each company filing an Annual Statement. When there is an affiliated company pooling arrangement, one Actuarial Report for the aggregate pool is sufficient, but there must be addendums to the Actuarial Report to cover non-pooled reserves for individual companies.

The Actuarial Opinion and the supporting Actuarial Report and workpapers should be consistent with the appropriate Actuarial Standards of Practice (ASOPs), including, but not limited to, ASOP No. 23, ASOP No. 36, ASOP No. 41 and ASOP No. 43, as promulgated by the Actuarial Standards Board.

1A. Definitions

"Appointed Actuary" is a Qualified Actuary (or individual otherwise approved by the domiciliary commissioner) appointed by the Board of Directors in accordance with Section 1 of these instructions.

"Board of Directors" can include the designated Board of Directors, its equivalent or an appropriate committee directly reporting to the Board of Directors.

"Qualified Actuary" is a person who:

(i) Meets the basic education, experience and continuing education requirements of the Specific Qualification Standard for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualifications Standards)*, promulgated by the American Academy of Actuaries (Academy);

(ii) Has obtained and maintains an Accepted Actuarial Designation; and

(iii) Is a member of a professional actuarial association that requires adherence to the same *Code of Professional Conduct* promulgated by the Academy, requires adherence to the *U.S. Qualification Standards*, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.

An exception to parts (i) and (ii) of this definition would be an actuary evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary for particular lines of business and business activities.

"Accepted Actuarial Designation" in item (ii) of the definition of a Qualified Actuary, is an actuarial designation accepted as meeting or exceeding the NAIC's Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (published on the NAIC website). The following actuarial designations, with any noted conditions, are accepted as meeting or exceeding basic education minimum standards:

(i) Fellow of the CAS (FCAS) – Condition: basic education must include Exam 6 – Regulation and Financial Reporting (United States);

(ii) Associate of the CAS (ACAS) – Conditions: basic education must include Exam 6 – Regulation and Financial Reporting (United States) and Exam 7 – Advanced Estimation of ~~Policy~~ Claims Liabilities~~, Insurance Company Valuation, and Enterprise Risk Management~~;

(iii) Fellow of the SOA (FSA) – Conditions: basic education must include completion of the following courses: GI 101 Ratemaking and Reserving; GI 201 Operational, Financial, Regulatory, and Legal; GI 301 Further Topics in General Insurance; and GI 302 General Insurance in the U.S.~~general insurance track, including the following optional exams: the United States' version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.~~

The table below provides some allowable exam substitutions for (i), (ii) and (iii) in the definition of "Accepted Actuarial Designation:" ~~Noting that~~Since CAS exams have changed over time, exceptions are granted for exams completed under earlier syllabi.~~for (i) and (ii) provide for FCAS/ACAS designations achieved before an exam was created (e.g. CAS Exam 6-US) or with an earlier version of an exam or exam topic (e.g., 2010 CAS Exam 6 instead of the current CAS Exam 7 Section A). FCAS/ACAS qualified under the 2018 and prior Statement of Actuarial Opinion instructions can use the noted substitution rules to achieve qualification under the new instructions by demonstrating basic and/or continuing education of the required topics including material in CAS Exam 6 (US) and section A of CAS Exam 7 (in the May 2019 CAS syllabus). Exceptions for (iii) for an FSA are also included in the table. The SOA exams completed in the general insurance track in 2019 and prior should be supplemented with continuing education and experience to meet basic education requirements in the *U.S. Qualification Standards*. For purpose of these instructions only, the table also includes specific exams from other organizations that are accepted as substitutes.~~

Exception for (i), (ii), or (iii)	Exam:	Exam Substitution Allowed*
(i) and (ii)	CAS Exam 6 (US)	1. Any CAS version of a U.S. P/C statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 (US) in 2011. 2. An FCAS or ACAS earned prior to 2021 who did not pass CAS Exam 6 (US) or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 6 (US) provided the Appointed Actuary explains in his/her qualification documentation how knowledge of U.S. financial reporting and regulation was obtained. ~~3. SOA FREU (US) Exam~~
(ii)	CAS Exam 7	1. Any CAS version of an exam including advanced P/C reserving administered prior to creation of Exam 7 in 2011. ~~1.~~2. Any version of CAS Exam 7 administered since 2011. ~~2.~~3. An ACAS earned prior to 2021 who did not pass CAS Exam 7 or an allowable exam substitution, may substitute experience and/or continuing education for CAS Exam 7 provided the Appointed Actuary explains in his/her qualification documentation how knowledge of the additional reserving topics in CAS Exam 7 (Section A) in the May 2019 syllabus was obtained. ~~3. SOA Advanced Topics Exam (Note: The ERM portion of Exam 7 is not needed to meet NAIC educational standards, therefore SOA ERM Exam is not needed for the substitution for this purpose.)~~
(iii)	SOA GI 101	SOA General Insurance Ratemaking and Reserving Exam administered after 2019

(iii)	SOA GI 201	SOA Introduction to General Insurance Exam administered after 2019 and SOA Financial Economics, Regulation and Law Module completed prior to 2026
(iii)	SOA GI 301	1. SOA Advanced Topics in General Insurance Exam administered after 2019 and SOA General Insurance Applications Module completed prior to 2026 2. CAS Exam 7 and SOA General Insurance Applications Module completed prior to 2026
(iii)	SOA GI 302	1. United States' version of the SOA Financial and Regulatory Environment Exam administered after 2019 2. CAS Exam 6 (US)
~~(iii)~~	~~SOA FREU (US) Exam~~	~~1. CAS Exam 6 (US)~~ ~~2. Any CAS version of a U.S. statutory accounting and regulation exam administered prior to creation of the CAS Exam 6 in 2011.~~
~~(iii)~~	~~SOA Advanced Topics Exam~~	~~1. CAS Exam 7~~ ~~2. Any CAS version of an exam containing the advanced techniques to estimate policy liabilities (i.e., advanced reserving).~~
*Note: These exam substitutions only apply to these instructions and are not applicable for CAS or SOA exam waivers.		

"Insurer" or "Company" means an insurer or reinsurer authorized to write property and/or casualty insurance under the laws of any state and who files on the Property and Casualty Blank.

"Actuarial Report" means a document or other presentation prepared as a formal means of conveying to the state regulatory authority and the Board of Directors the Appointed Actuary's professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the Appointed Actuary's opinion or findings, and of documenting the analysis underlying the opinion. The required content of the Actuarial Report is further described in paragraph 7. (Note that the inclusion of the Board of Directors as part of the intended audience for the Actuarial Report does not change the content of the Actuarial Report as described in paragraph 7. The Appointed Actuary should present findings to the Board of Directors in a manner deemed suitable for such audience.)

"Property and Casualty (P&C) Long Duration Contracts" refers to contracts (excluding financial guaranty contracts, mortgage guaranty contracts and surety contracts) that fulfill both of the following conditions: (1) the contract term is greater than or equal to 13 months; and (2) the insurer can neither cancel the contract nor increase the premium during the contract term. These contracts are subject to the three tests of *SSAP No. 65—Property and Casualty Contracts* of the NAIC *Accounting Practices and Procedures Manual*.

"Accident and Health (A&H) Long Duration Contracts" refers to A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required. See Schedule H instructions for a description of categories of contract reserves, as well as policy features that give rise to contract reserves. Two specific examples of contracts that typically require contract reserves are long-term care and disability income insurance.

1B. Exemptions

An insurer who intends to file for one of the exemptions under this Section must submit a letter of intent to its domiciliary commissioner no later than December 1 of the calendar year for which the exemption is to be claimed. The commissioner may deny the exemption prior to December 31 of the same year if he or she deems the exemption inappropriate.

A copy of the approved exemption must be filed with the Annual Statement in all jurisdictions in which the company is authorized.

Exemption for Small Companies

An insurer that has less than $1,000,000 total direct plus assumed written premiums during a calendar year, and less than $1,000,000 total direct plus assumed loss and loss adjustment expense reserves at year-end, in lieu of the Actuarial Opinion required for the calendar year, may submit an affidavit under oath of an officer of the insurer that specifies the amounts of direct plus assumed written premiums and direct plus assumed loss and loss adjustment reserves.

Exemption for Insurers under Supervision or Conservatorship

Unless ordered by the domiciliary commissioner, an insurer that is under supervision or conservatorship pursuant to statutory provision is exempt from the filing requirements contained herein.

Exemption for Nature of Business

An insurer otherwise subject to the requirement and not eligible for an exemption as enumerated above may apply to its domiciliary commissioner for an exemption based on the nature of business written.

Financial Hardship Exemption

An insurer otherwise subject to this requirement and not eligible for an exemption as enumerated above may apply to the commissioner for a financial hardship exemption. Financial hardship is presumed to exist if the projected reasonable cost of the Actuarial Opinion would exceed the lesser of:

(i) One percent (1%) of the insurer's capital and surplus reflected in the insurer's latest quarterly statement for the calendar year for which the exemption is sought; or

(ii) Three percent (3%) of the insurer's direct plus assumed premiums written during the calendar year for which the exemption is sought as projected from the insurer's latest quarterly statements filed with its domiciliary commissioner.

1C. Reporting Requirements for Pooled Companies

For each company in the pool, the Appointed Actuary shall include a description of the pool, identification of the lead company and a listing of all companies in the pool, their state of domicile and their respective pooling percentages.

Exhibits A and B for each company in the pool should represent the company's share of the pool and should reconcile to the financial statement for that company.

The following paragraph applies to companies that have a 0% share of the pool (no reported Schedule P data). The company shall submit an Actuarial Opinion that reads similar to that provided for the lead company. For example, the IRIS ratio and risk of material adverse deviation discussions, and other relevant comments shall relate to the risks of the lead company in the pool. The Exhibit B responses to question 5 should be $0 and to question 6 should be "not applicable." Exhibits A and B of the lead company should be attached as an addendum to the PDF file and/or hard copy being filed (but would not be reported by the 0% companies in their data capture).

2. The Actuarial Opinion must consist of an IDENTIFICATION paragraph identifying the Appointed Actuary; a SCOPE paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary's work; an OPINION paragraph expressing his or her opinion with respect to such subjects; and one or more additional RELEVANT COMMENTS paragraphs. These four sections must be clearly designated.

3. The IDENTIFICATION paragraph should indicate the Appointed Actuary's relationship to the Company, qualifications for acting as Appointed Actuary and date of appointment and specify that the appointment was made by the Board of Directors.

If the Appointed Actuary was approved by the Academy to be a "Qualified Actuary," with or without limitation, or if the Appointed Actuary is not a Qualified Actuary but was approved by the domiciliary commissioner, the company must attach, each year, the approval letter and reference such in the identification paragraph.

4. The SCOPE paragraph should contain a sentence such as the following:

"I have examined the actuarial assumptions and methods used in determining reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date."

Exhibit A should list those items and amounts with respect to which the Appointed Actuary is expressing an opinion.

As required by SSAP No. 65, Exhibit A should also include the reserve for Direct and Assumed Unearned Premiums for P&C Long Duration Contracts and the reserve for Net Unearned Premiums for P&C Long Duration Contracts, regardless of whether the amounts are material.

The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.

The SCOPE paragraph should include a paragraph such as the following regarding the data used by the Appointed Actuary in forming the opinion:

"In forming my opinion on the loss and loss adjustment expense reserves, I relied upon data prepared by _____ (~~officer~~ individual's name and title at the Company). I evaluated that data for reasonableness and consistency. I also reconciled ~~that~~ the data used in my analysis to Schedule P, Part 1 of the Company's current Annual Statement. In other respects, my examination included such review of the actuarial assumptions and methods used and such tests of the calculations as I considered necessary."

5. The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration: "In my opinion, the amounts carried in Exhibit A on account of the items identified:

   A. Meet the requirements of the insurance laws of (state of domicile).

   B. Are computed in accordance with accepted actuarial standards.

   C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements."

If the Scope includes material Unearned Premium Reserves for P&C Long Duration Contracts, ~~or~~ Other Loss Reserve items, or Other Premium Reserve items on which the Appointed Actuary is expressing an opinion, the Actuarial Opinion should contain language such as the following:

   D. Make a reasonable provision for the unearned premium reserves for P&C Long Duration Contracts and/or <insert Other ~~Loss~~ Reserve item on which the Appointed Actuary is expressing an Opinion> of the Company under the terms of its contracts and agreements.

If the Unearned Premium Reserves for P&C Long Duration Contracts reported on lines 7 or 8 of Exhibit A are non-zero but the Appointed Actuary deems the amounts immaterial and is not issuing an opinion on these amounts, the Appointed Actuary should include clarifying comments in the SCOPE, OPINION, and/or RELEVANT COMMENTS sections of the opinion.

If there is any aggregation or combination of items in Exhibit A, the opinion language should clearly identify the combined items.

Insurance laws and regulations shall at all times take precedence over the actuarial standards.

If the Appointed Actuary has ~~made~~ used ~~of the analysis of~~ another actuary's analysis that was not produced ~~under not within~~ the Appointed Actuary's ~~control~~ direction (such as for pools and associations, for a subsidiary or for special lines of business) for a material portion of the reserves, the other actuary must be identified by name, credential and affiliation within the OPINION paragraph. If the Appointed Actuary has ~~made~~ used ~~of~~ the work of a non-actuary (such as for modeling) for a material portion of the reserves, that individual must be identified by name and affiliation and a description of the type of analysis performed must be provided.

A Statement of Actuarial Opinion should be made in accordance with one of the following sections (1 through 5). The Appointed Actuary must explicitly identify in Exhibit B which type applies.

1. Determination of Reasonable Provision. When the carried reserve amount is within the Appointed Actuary's range of reasonable reserve estimates, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves.

2. Determination of Deficient or Inadequate Provision. When the carried reserve amount is less than the minimum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the minimum amount that the Appointed Actuary believes is reasonable.

3. Determination of Redundant or Excessive Provision. When the carried reserve amount is greater than the maximum amount that the Appointed Actuary believes is reasonable, the Appointed Actuary should issue a Statement of Actuarial Opinion that the carried reserve amount does not make a reasonable provision for the liabilities associated with the specified reserves. In addition, the Appointed Actuary should disclose the maximum amount that the Appointed Actuary believes is reasonable.

4. Qualified Opinion. When, in the Appointed Actuary's opinion, the reserves for a certain item or items are in question because they cannot be reasonably estimated or the Appointed Actuary is unable to render an opinion on those items, the Appointed Actuary should issue a qualified Statement of Actuarial Opinion. The Appointed Actuary should disclose the item (or items) to which the qualification relates, the reason(s) for the qualification and the amounts for such item(s), if disclosed by the Company. Such a qualified opinion should state whether the carried reserve amount makes a reasonable provision for the liabilities associated with the specified reserves, *except for* the item (or items) to which the qualification relates. The Appointed Actuary is not required to issue a qualified opinion if the Appointed Actuary reasonably believes that the item (or items) in question are not likely to be material.

5. No Opinion. The Appointed Actuary's ability to give an opinion is dependent upon data, analyses, assumptions, and related information that are sufficient to support a conclusion. If the Appointed Actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the Appointed Actuary may issue a statement of no opinion. A statement of no opinion should include a description of the reasons why no opinion could be given.

6. The Appointed Actuary must provide RELEVANT COMMENT paragraphs to address the following topics of regulatory importance.

   A. Company-Specific Risk Factors

   The Appointed Actuary should include an explanatory paragraph to describe the major factors, combination of factors or particular conditions underlying the risks and uncertainties the Appointed Actuary considers relevant. The explanatory paragraph should not include general, broad statements about risks and uncertainties due to

economic changes, judicial decisions, regulatory actions, political or social forces, etc., nor is the Appointed Actuary required to include an exhaustive list of all potential sources of risks and uncertainties.

B. Risk of Material Adverse Deviation

The Appointed Actuary must provide specific RELEVANT COMMENT paragraphs to address the risk of material adverse deviation. The Appointed Actuary must identify the materiality standard and the basis for establishing this standard. The materiality standard must also be disclosed in U.S. dollars in Exhibit B: Disclosures. The Appointed Actuary should explicitly state whether or not he or she reasonably believes that there are significant risks and uncertainties that could result in material adverse deviation. This determination is also to be disclosed in Exhibit B.

C. Other Disclosures in Exhibit B

RELEVANT COMMENT paragraphs should describe the significance of each of the remaining Disclosure items (8 through 14) in Exhibit B. The Appointed Actuary should address the items individually and in combination when commenting on a material impact.

Disclosure item 11 in Exhibit B requests amounts for the extended reporting endorsement policy reserve associated with claims-made contracts. This policy reserve is required by SSAP No. 65 if a claims-made policy provides extended reporting coverage at no additional charge in the event of death, disability, or retirement of a natural person insured. In such instance, the company must accrue a policy reserve before the triggering event (the death, disability, or retirement of the insured) to assure that premiums are not earned prematurely. The amount of the reserve should be adequate to pay for all future claims arising from these coverage features after recognition of future premiums to be paid by current insureds for these benefits. SSAP No. 65 states that this reserve shall be classified as a component part of the unearned premium reserve, but some companies instead report the reserves as part of the loss and loss adjustment expense reserves. The reserve amount reported on Exhibit B, item 11 should be greater than or equal to the amount reported in Item 1.2 of the Schedule P Interrogatories. The Schedule P Interrogatory only asks for the policy reserve associated with medical professional liability policies, but item 11 on Exhibit B should include policy reserves for all P&C lines of business, not just medical professional liability; this extended reporting coverage is also available for other lines, such as legal professional liability, architect professional liability, etc.

D. Reinsurance

RELEVANT COMMENT paragraphs should address reinsurance collectability, retroactive reinsurance and financial reinsurance.

The Appointed Actuary's comments on reinsurance collectability should address any uncertainty associated with including potentially uncollectable amounts in the estimate of ceded reserves. Before commenting on reinsurance collectability, the Appointed Actuary should solicit information from management on any actual collectability problems, review ratings given to reinsurers by a recognized rating service and examine Schedule F for the current year for indications of regulatory action or reinsurance recoverable on paid losses over ninety (90) days past due. The comment should also reflect any other information the Appointed Actuary has received from management or that is publicly available about the capability or willingness of reinsurers to pay claims. The Appointed Actuary's comments do not imply an opinion on the financial condition of any reinsurer.

Retroactive reinsurance refers to agreements referenced in *SSAP No. 62—Property and Casualty Reinsurance* of the NAIC *Accounting Practices and Procedures Manual*.

Financial reinsurance refers to contracts referenced in SSAP No. 62 in which credit is not allowed for the ceding insurer because the arrangements do not include a transfer of both timing and underwriting risk that the

reinsurer undertakes in fact to indemnify the ceding insurer against loss or liability by reason of the original insurance.

E. IRIS Ratios

If the Company's reserves will create exceptional values under the NAIC IRIS Tests for One-Year Reserve Development to Policyholders' Surplus, Two-Year Reserve Development to Policyholders' Surplus or Estimated Current Reserve Deficiency to Policyholders' Surplus, the Appointed Actuary must include RELEVANT COMMENT on the factors that led to the unusual value(s).

F. Methods and Assumptions

If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

7. The Actuarial Opinion must include assurance that an Actuarial Report and underlying actuarial workpapers supporting the Actuarial Opinion will be maintained at the Company and available for regulatory examination for seven (7) years. The Actuarial Report contains significant proprietary information. It is expected that the Actuarial Report be held confidential and not be intended for public inspection. The Actuarial Report must be available by May 1 of the year following the year-end for which the Actuarial Opinion was rendered or within two (2) weeks after a request from an individual state commissioner.

The Actuarial Report should be consistent with the documentation and disclosure requirements of ASOP No. 41, Actuarial Communications. The Actuarial Report must contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to Company management, the Board of Directors, the regulator or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data (e.g., loss triangles) to the conclusions.

Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) in the NAIC *Accounting Practices and Procedures Manual* requires a company with over 10,000 in force lives covered by long-term care (LTC) insurance contracts as of the valuation date to perform a stand-alone asset adequacy analysis for its in force long-term care (LTC) contracts. The Actuarial Report and workpapers summarizing the results, assumptions and testing procedures for the asset adequacy testing of LTC business must be in compliance with AG 51 requirements. When referring to AG 51, the term "Actuarial Memorandum" is synonymous with Actuarial Report and workpapers.

The Actuarial Report should contain disclosure of all reserve amounts associated with A&H Long Duration Contracts reported by the Company; the reserve amounts in the Actuarial Report should tie to the Annual Statement.

The Actuarial Report must also include:

A. A description of the Appointed Actuary's relationship to the Company, with clear presentation of the Appointed Actuary's role in advising the Board of Directors and/or management regarding the carried reserves. The Actuarial Report should identify how and when the Appointed Actuary presents the analysis to the Board of Directors and, where applicable, to the officer(s) of the Company responsible for determining the carried reserves.

B. An exhibit that ties to the Annual Statement and compares the Appointed Actuary's conclusions to the carried amounts consistent with the segmentation of exposure or liability groupings used in the analysis. The Appointed

Actuary's conclusions include the Appointed Actuary's point estimate(s), range(s) of reasonable estimates or both.

C. An exhibit that reconciles and maps the data used by the Appointed Actuary, consistent with the segmentation of exposure or liability groupings used in the Appointed Actuary's analysis, to the Annual Statement Schedule P line of business reporting. An explanation should be provided for any material differences.
   i. The reconciliation should compare the data **used by the Appointed Actuary** in the analysis to Schedule P. It is not sufficient to reconcile the data **provided by the Company** to the Appointed Actuary to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary's analysis exhibits to the actuarial data shown in the Schedule P reconciliation.
   ii. If the reconciliation was not produced under the Appointed Actuary's direction, the Appointed Actuary should identify who performed the reconciliation and confirm that the Appointed Actuary reviewed the reconciliation for reasonableness.

D. An exhibit or appendix showing the change in the Appointed Actuary's estimates from the prior Actuarial Report, including extended discussion of factors underlying any material changes. The exhibit or appendix should illustrate the changes on a net basis but should also include the changes on a gross basis, if relevant. If the Appointed Actuary is newly appointed and does not review the work of the prior Appointed Actuary, then the Appointed Actuary should disclose this.

E. Extended comments on trends that indicate the presence or absence of risks and uncertainties that could result in material adverse deviation.

F. Extended comments on factors that led to unusual IRIS ratios for One-Year Reserve Development to Policyholders' Surplus, Two-Year Reserve Development to Policyholders' Surplus or Estimated Current Reserve Deficiency to Policyholders' Surplus, and how these factors were addressed in prior and current analyses.

G. If the Appointed Actuary has used an analysis or opinion not produced under the Appointed Actuary's direction for a material portion of the reserves:
   i. The dollar amount of the reserves covered by the other's analysis or opinion and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.
   ii. Whether and to what extent the Appointed Actuary reviewed the other's underlying analysis, including items such as methods and assumptions used and underlying arithmetic calculations.
   iii. If the Appointed Actuary reviewed the other's underlying analysis, the Appointed Actuary's conclusions from the review.

8. The Actuarial Opinion should conclude with the signature of the Appointed Actuary responsible for providing the Actuarial Opinion and the date when the Actuarial Opinion was rendered. The signature and date should appear in the following format:

_____
Signature of Appointed Actuary
Printed name of Appointed Actuary
Employer's name
Address of Appointed Actuary
Telephone number of Appointed Actuary
Email address of Appointed Actuary
Date opinion was rendered

The same information should be reproduced within the Actuarial Report, along with the date the Actuarial Report was finalized.

9. The Insurer required to furnish an Actuarial Opinion shall require its Appointed Actuary to notify its Board of Directors or its audit committee in writing within five (5) business days after any determination by the Appointed Actuary that the Actuarial Opinion submitted to the domiciliary commissioner was in error as a result of reliance on data or other information (other than assumptions) that, as of the balance sheet date, was factually incorrect. The Actuarial Opinion shall be considered to be in error if the Actuarial Opinion would have not been issued or would have been materially altered had the correct data or other information been used. The Actuarial Opinion shall not be considered to be in error if it would have been materially altered or not issued solely because of data or information concerning events subsequent to the balance sheet date or because actual results differ from those projected. Notification is required when discovery is made between the issuance of the Actuarial Opinion and Dec. 31 of that year. Notification should include a summary of such findings.

   If the Appointed Actuary learns that the data or other information relied upon was factually incorrect, but cannot immediately determine what, if any, changes are needed in the Actuarial Opinion, the Appointed Actuary and the Company should quickly undertake procedures necessary for the Appointed Actuary to make such determination. If the Insurer does not provide the necessary data corrections and other support (including financial support) within ten (10) business days, the Appointed Actuary should proceed with the notification to the Board of Directors and the domiciliary commissioner.

   An Insurer who is notified pursuant to the preceding paragraphs shall forward a copy of the amended Actuarial Opinion to the domiciliary commissioner within five (5) business days of receipt of such and shall provide the Appointed Actuary making the notification with a copy of the letter and amended Actuarial Opinion submitted to the domiciliary commissioner. If the Appointed Actuary fails to receive such copy within the five (5) business day period referred to in the previous sentence, the Appointed Actuary shall notify the domiciliary commissioner within the next five (5) business days that an amended Actuarial Opinion has been finalized.

   No Appointed Actuary shall be liable in any manner to any person for any statement made in connection with the above paragraphs if such statement is made in a good faith effort to comply with the above paragraphs.

10. Data in Exhibits A and B are to be filed in both print and data capture format.

Exhibit A: SCOPE

DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

Loss and Loss Adjustment Expense Reserves:		Amount
1.	Unpaid Losses (Liabilities, Surplus and Other Funds page, Col 1, Line 1)	$ _____
2.	Unpaid Loss Adjustment Expenses (Liabilities, Surplus and Other Funds page, Col 1, Line 3)	$ _____
3.	Unpaid Losses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 13 and 15, Line 12 * 1000)	$ _____
4.	Unpaid Loss Adjustment Expenses – Direct and Assumed (Should equal Schedule P, Part 1, Summary, Totals from Cols. 17, 19 and 21, Line 12 * 1000)	$ _____
5.	The Page 3 write-in item reserve, "Retroactive Reinsurance Reserve Assumed"	$ _____
6.	Other Loss Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)	$ _____
Premium Reserves:		
7.	Reserve for Direct and Assumed Unearned Premiums for P&C Long Duration Contracts	$ _____
8.	Reserve for Net Unearned Premiums for P&C Long Duration Contracts	$ _____
9.	Other Premium Reserve items on which the Appointed Actuary is expressing an Opinion (list separately, adding additional lines as needed)	$ _____

Exhibit B: DISCLOSURES

DATA TO BE FILED IN BOTH PRINT AND DATA CAPTURE FORMATS

NOTE: Exhibit B should be completed for Net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

1. Name of the Appointed Actuary — Last _____ First _____ Mid _____

2. The Appointed Actuary's relationship to the Company

   Enter E or C based upon the following:

   E if an Employee of the Company or Group

   C if a Consultant _____

3. The Appointed Actuary's Accepted Actuarial Designation (indicated by the letter code):

   F if a Fellow of the Casualty Actuarial Society (FCAS)

   A if an Associate of the Casualty Actuarial Society (ACAS)

   S if a Fellow of the Society of Actuaries (FSA) ~~through the General Insurance track~~

   M if the actuary does not have an Accepted Actuarial Designation but is approved by the Academy's Casualty Practice Council.

   O for Other _____

4. Type of Opinion, as identified in the OPINION paragraph. Enter R, I, E, Q, or N based upon the following:

   R if Reasonable

   I if Inadequate or Deficient Provision

   E if Excessive or Redundant Provision

   Q if Qualified. Use Q when part of the OPINION is Qualified.

   N if No Opinion _____

5. Materiality Standard expressed in U.S. dollars (used to Answer Question #6) $ _____

6. Are there significant risks that could result in Material Adverse Deviation? Yes [ ] No [ ] Not Applicable [ ]

7. Statutory Surplus (Liabilities, Surplus and Other Funds page, Col 1, Line 37) $ _____

8. Anticipated net salvage and subrogation included as a reduction to loss reserves as reported in Schedule P (should equal Part 1 Summary, Col 23, Line 12 * 1000) $ _____

9. Discount included as a reduction to loss reserves and loss adjustment expense reserves as reported in Schedule P

   9.1 Nontabular Discount [Notes, Line 32B23, (Amounts 1, 2, 3 & 4)], Electronic Filing Cols 1, 2, 3, & 4 $ _____

   9.2 Tabular Discount [Notes, Line 32A23, (Amounts 1 & 2)], Electronic Filing Col 1 & 2 $ _____

~~10. The net reserves for losses and loss adjustment expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and loss adjustment expenses that are included in reserves shown on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines~~ ~~$ _____~~

~~11~~10. The net reserves for losses and loss adjustment expenses that the Company carries for the following liabilities included on the Liabilities, Surplus and Other Funds page, Losses and Loss Adjustment Expenses lines *

~~11~~10.1 Asbestos, as disclosed in the Notes to Financial Statements (Notes, Line 33A03D, ending net asbestos reserves for current year) Electronic Filing Col 5 $ _____

~~11~~10.2 Environmental, as disclosed in the Notes to Financial Statements (Notes, Line 33D03D, ending net environmental reserves for current year), Electronic Filing Col 5 $ _____

~~12~~11. ~~The total claims made extended loss and loss adjustment expense, and unearned premium reserves~~Extended reporting endorsement policy reserve associated with claims-made contracts (Greater than or equal to Schedule P Interrogatories, Line 1.2)

~~12~~11.1 Amount reported as loss and loss adjustment expense reserves $ _____

~~12~~11.2 Amount reported as unearned premium reserves $ _____

~~13~~12. The net reserves for the A&H Long Duration Contracts that the Company carries on the following lines on the Liabilities, Surplus and Other Funds page:

~~13~~12.1 Losses $ _____

~~13~~12.2 Loss Adjustment Expenses $ _____

~~13~~12.3 Unearned Premium $ _____

~~13~~12.4 Write-In (list separately, adding additional lines as needed, and identify (e.g., "Premium Deficiency Reserves", "Contract Reserves other than Premium Deficiency Reserves" or "AG 51 Reserves")) $ _____

~~14~~13. Other items on which the Appointed Actuary is providing relevant comment (list separately, adding additional lines as needed) $ _____

* The reserves disclosed in item ~~11~~10 above, should exclude amounts relating to contracts specifically written to cover asbestos and environmental exposures. Contracts specifically written to cover these exposures include Environmental Impairment Liability (post 1986), Asbestos Abatement, Pollution Legal Liability, Contractor's Pollution Liability, Consultant's Environmental Liability, and Pollution and Remediation Legal Liability.

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year ~~2024~~2025

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

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

An Appointed Actuary has a responsibility to know and understand both the Instructions and the expectations of state insurance regulators. One expectation of regulators clearly presented in the Instructions is that the SAO, AOS, and supporting Actuarial Report and work papers be consistent with relevant Actuarial Standards of Practice (ASOPs). Although it is the responsibility of the Appointed Actuary to identify the applicable ASOPs, the Appointed Actuary may find it useful to review the *Applicability Guidelines for Actuarial Standards of Practice* published by the Actuarial Standards Board (ASB).

The 2024 Instructions ~~have been~~were modified to require the Appointed Actuary provide qualification documentation to the Board of Directors only at initial appointment and not annually thereafter. The only change to the 2025 Instructions is the inclusion of an editorial note clarifying that the FSA designation is considered an "Accepted Actuarial Designation" only if it was earned under the requirements through May 2025.

The Actuarial Opinion Working Group anticipates changes to the definition of "Accepted Actuarial Designation" in the 2026 Instructions. The changes were prompted by changes to the FSA educational pathway effective in fall 2025 and the Working Group's routine assessment of the SOA and CAS's educational materials in 2024-25. The objective of this periodic assessment, last performed in 2018-19, was to determine which actuarial designations, and under what conditions, meet the NAIC's Minimum Property/Casualty (P/C) Actuarial Educational Standards for a P/C Appointed Actuary (also known as the "NAIC knowledge statements")[1]. Subject matter experts proposed by the SOA, CAS, and Academy reviewed the SOA and CAS's educational materials to assess whether they appropriately addressed each NAIC knowledge statement. The SOA and CAS were asked to make certain changes to their educational material as a result of this review. The Working Group reviewed the findings of the subject matter experts and the subsequent changes to the organizations' educational material and made the final assessment of the conditions under which a member of the SOA or CAS is considered qualified to sign a P/C statement of actuarial opinion.

The changes to the "Accepted Actuarial Designation" definition proposed for the 2026 Instructions include:

a. Specifying the four courses that an FSA must complete under the new educational pathway.
b. Editing the exam substitution table to account for situations in which an FSA completed courses under the prior pathway, and
c. Updating the title of the CAS's Exam 7.

Other significant anticipated changes to the 2026 Instructions include:

a. Specifying that the Unearned Premium Reserves for P&C Long Duration Contracts should be disclosed in Exhibit A regardless of whether the amounts are material.
b. Specifying that the SAO should include clarifying comments if the Unearned Premium Reserves for P&C Long Duration Contracts reported in Exhibit A are non-zero but the Appointed Actuary deems the amounts immaterial.
c. Explicitly stating that the Schedule P reconciliation required to be documented in the Actuarial Report should compare the data used by the Appointed Actuary to Schedule P and clarifying the Appointed Actuary's responsibilities if someone who is not within the Appointed Actuary's control performs the reconciliation.
d. Adding disclosures required to be included in the Actuarial Report if the Appointed Actuary has made use of an analysis or opinion of another not within the Appointed Actuary's control for a material portion of the reserves.
e. Removing the disclosure of the net reserves for losses and loss adjustment expenses for the Company's share of voluntary and involuntary underwriting pools' and associations' unpaid losses and loss adjustment expenses. (Exhibit B, Line 10)

[1] https://content.naic.org/sites/default/files/committee_related_documents/Final%2520Knowledge%2520Statements%2520053119.xlsx

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

Note:
Ignore the page numbers
during the drafting process

Table of Contents

I. General Comments 4
A. Reconciliation Between Documents 4
B. Role of Illustrative Language in the Instructions 4
C. Qualification Documentation 4
D. Replacement of an Appointed Actuary 4
E. Reporting to the Board of Directors 5
F. Requirements for Pooled Companies 5
G. Explanation of Adverse Development 5
1. Comments on Unusual Insurance Regulatory Information System Ratios in the Statement of Actuarial Opinion 5
2. Comments on Persistent Adverse Development in the Actuarial Opinion Summary 6
H. Revisions 6
II. Comments on the Statement of Actuarial Opinion and Actuarial Report 6
A. Review Date 6
B. Reconciliation 6
C. Making Use of Another's Work 7
D. Points A and B of the Opinion Paragraph When Opinion Type Is Other Than "Reasonable" 7
E. Conclusions on a Net Versus a Direct and Assumed Basis 7
F. Unearned Premium for Property/Casualty Long-Duration Contracts 7
G. Other Premium Reserve Items 8
H. The Importance of Relevant Comments Paragraphs 8
I. Risk of Material Adverse Deviation 8
1. No Company-Specific Risk Factors 8
2. Mitigating Factors 8
3. Consideration of Carried Reserves, Materiality Standard, and Reserve Range When Making Risk of Material Adverse Deviation Conclusion 8
4. Materiality Standards for Intercompany Pool Members 8
J. State Insurance Regulators' Use of the Actuarial Report 9
1. Schedule P Reconciliation 9
2. Change in Estimates 10
3. Narrative 10
4. Support for Assumptions 10
5. Support for Roll-Forward Analyses 10
K. Exhibits A and B 10

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

1. Data Capture Format....10
2. Scope of Exhibit B, Item 12....11
3. Exhibit B, Item 13....11
III. Comments on the Actuarial Opinion Summary....12
A. Confidentiality....12
B. Different Requirements by State....12
C. Format....12
IV. Guidance on Qualification Documentation....12
A. Brief Biographical Information....12
B. "Qualified Actuary" Definition....13

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

I. General Comments

A. Reconciliation Between Documents

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

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

B. Role of Illustrative Language in the Instructions

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

C. Qualification Documentation

Starting with the 2019 Instructions, the Appointed Actuary was required to provide qualification documentation to the Board of Directors upon initial appointment and annually thereafter. The 2024 Instructions ~~have been~~were amended to require the Appointed Actuary to provide qualification documentation to the Board of Directors only upon initial appointment and eliminate the requirement to provide the documentation annually thereafter.

The documentation provided to the Board of Directors must be available to the state insurance regulator upon request and during a financial examination. Guidance on qualification documentation is in Section IV of this document.

D. Replacement of an Appointed Actuary

The Instructions require two letters when the Board of Directors replaces an Appointed Actuary: 1) one addressed from the insurer to the domiciliary commissioner and 2) one addressed from the former Appointed Actuary to the insurer. The insurer must provide both letters to the domiciliary commissioner.

The detailed steps are as follows:

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

Regarding the disagreements referenced in step 2, state insurance regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary's analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary's analysis may go through several iterations, and an insurer's comments on the Appointed Actuary's draft Actuarial Report may prompt the Appointed

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

Actuary to make changes to the report. While state insurance regulators are interested in material disagreements regarding differences between the former Appointed Actuary's final estimates and the insurer's carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary's work.

E. Reporting to the Board of Directors

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

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

F. Requirements for Pooled Companies

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

For all intercompany pooling members:

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

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

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

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

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

G. Explanation of Adverse Development

1. Comments on Unusual Insurance Regulatory Information System Ratios in the Statement of Actuarial Opinion

   The Appointed Actuary is required to provide comments in the SAO on factors that led to unusual values for Insurance Regulatory Information System (IRIS) ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to "reserve strengthening" or "adverse development," and it expects the

Appointed Actuary to provide insight into the company-specific factors that caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the SAO.

2. Comments on Persistent Adverse Development in the Actuarial Opinion Summary

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

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

H. Revisions

The Instructions contain a detailed definition of what it means for the SAO or AOS to be "in error," along with a description of steps the company and Appointed Actuary should take in that situation.

Even if the SAO or AOS does not meet the Instructions' specific definition of "in error," submitting a revised SAO or AOS might be appropriate or recommended in other situations. It would be prudent for the company to contact the state insurance regulator if mistakes or problems are discovered but do not meet the specific definition of "in error."

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

II. Comments on the Statement of Actuarial Opinion and Actuarial Report

A. Review Date

The illustrative language for the Scope paragraph includes "… and reviewed information provided to me through XXX date." This is intended to capture the *Actuarial Standard of Practice (ASOP) No. 36*, *Statements of Actuarial Opinion Regarding Property/Casualty Loss, Loss Adjustment Expense, or Other Reserves*, requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion, i.e., the review date.

B. Reconciliation

The Instructions state that the Scope paragraph of the SAO should include statements regarding the data used by the Appointed Actuary in forming the opinion. The illustrative language includes "I also reconciled that data to Schedule P, Part 1 of the Company's current Annual Statement."

Regulators understand that others not within the Appointed Actuary's control may perform the reconciliation of data to Schedule P. In these cases, the Working Group encourages the Appointed Actuary to identify who performed the reconciliation and confirm that the Appointed Actuary reviewed the reconciliation for reasonableness. The Working Group is planning to propose adding this to the 2026 Instructions as an Actuarial Report requirement.

Commented [MF1]: See 7Cii in the draft 2026 Instructions

Guidance on the substance of the Schedule P reconciliation is included in Section II.J.1 of this document.

C. Making Use of Another's Work

If the Appointed Actuary makes use of the work of another not within the Appointed Actuary's control for a material portion of the reserves, the Instructions note that the Appointed Actuary must provide the following information in the SAO:

- The person's name.
- The person's affiliation.

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

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

The Working Group encourages the Appointed Actuary to disclose whether they reviewed the other's underlying analysis and, if so, the extent of the review (i.e., the methods and assumptions used and the underlying arithmetic calculations) and their conclusions from the review.

Section 3.4.4 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to use another party's analysis or opinion. One of these items is the amount of the reserves covered by the other's analysis or opinion in comparison to the total reserves subject to the actuary's opinion. The Working Group encourages the Appointed Actuary to disclose these items in the SAO by providing the dollar amount of the reserves covered by the other's analysis or opinion and the percentage of the total reserves subject to the Appointed Actuary's opinion that these other reserves represent.

The Working Group is planning to propose adding these to the 2026 Instructions as required disclosures in an Actuarial Report.

Commented [MF2]: See 7G in the draft 2026 Instructions

D. Points A and B of the Opinion Paragraph When Opinion Type Is Other Than "Reasonable"

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

E. Conclusions on a Net Versus a Direct and Assumed Basis

As noted on Exhibit B in the Instructions, Exhibit B should be completed for net dollar amounts included in the SCOPE. If an answer would be different for Direct and Assumed amounts, identify and discuss the difference within RELEVANT COMMENTS.

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

Similarly, the materiality standard in Exhibit B, Item 5, and the Risk of Material Adverse Deviation (RMAD) conclusion in Exhibit B, Item 6, should pertain to the net reserves. If the Appointed Actuary reaches a different conclusion on the risk of material adverse deviation in the net versus the direct and assumed reserves, the Appointed Actuary should include a Relevant Comments paragraph to address the differences. State insurance regulators understand that a net versus a direct and assumed RMAD will have different meanings and, potentially, different materiality standards. For example, the selection of a materiality standard for direct and assumed reserves may rely more on the balance of those reserves than on policyholders' surplus or metrics related to risk-based capital.

F. Unearned Premium for Property/ and Casualty Long-Duration Contracts

Commented [MF3]: See suggested additions to Instructions sections 4 and 5.

Exhibit A, Items 7 and 8, require disclosure of the unearned premium reserve for property/ & casualty (P/&C) long-duration contracts. These amounts should be disclosed regardless of whether the Appointed Actuary deems the amounts immaterial. The Instructions require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material.

Commented [MF4]: (Editorial changes for consistency with Instructions)

Commented [MF5]: This sentence was added in 2024.

The Working Group expects that the Appointed Actuary will include documentation in the Actuarial Report to support a conclusion on reasonableness whenever point D is included in the SAO. This documentation may include the three tests of *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts* or other methods deemed appropriate by the Appointed Actuary to support their conclusion.

If the P/&C Long Duration Unearned Premium Reserves on lines 7 or 8 of Exhibit A are non-zero, but the Appointed Actuary deems the amounts immaterial and is not issuing an opinion on these amounts, the Appointed Actuary should consider making this clear by including comments in the SCOPE, OPINION, and/or RELEVANT COMMENTS sections of the opinion. For example, if the Appointed Actuary is only opining on loss and loss adjustment expense reserves, the

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

Appointed Actuary might use the following language in the SCOPE paragraph: "I have examined the actuarial assumptions and methods used in determining loss and loss adjustment expense reserves listed in Exhibit A, as shown in the Annual Statement of the Company as prepared for filing with state regulatory officials, as of December 31, 20__, and reviewed information provided to me through XXX date." The Appointed Actuary might also use the following language in the OPINION paragraph: "In my opinion, the loss and loss adjustment expense reserves carried in Exhibit A: […]" In a RELEVANT COMMENT paragraph, the Appointed Actuary might say something like the following: "The P&C Long Duration Unearned Premium Reserves are not material. I therefore relied on the Company for its representation of the reasonableness of the P&C Long Duration Unearned Premium Reserves."

Commented [MF6]: This paragraph was new/improved in 2024.

G. Other Premium Reserve Items

Regarding "Other Premium Reserve Items" in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial. If the amounts are material and the Appointed Actuary states that the amounts are reasonable in an Opinion paragraph, state insurance regulators would expect the actuarial documentation to support this conclusion in the Actuarial Report.

Typical items state insurance regulators see listed as other premium reserve items are medical professional liability death, disability, and retirement (DD&R) unearned premium reserves (UPRs) and other liability claims. Depending on the nature of these exposures, these items may be also listed on Exhibit B, Line 12.2, as claims made extended UPRs.

H. The Importance of Relevant Comments Paragraphs

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

I. Risk of Material Adverse Deviation

The Relevant Comments paragraphs on the RMAD are particularly useful to state insurance regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to state insurance regulators. The second two stem from state insurance regulators' reviews of SAOs.

1. No Company-Specific Risk Factors—The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe there are any company-specific risk factors, the Appointed Actuary should state that.

2. Mitigating Factors—State insurance regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company's application of controls or use of mitigation techniques. The company's risk management behaviors may, however, affect the Appointed Actuary's RMAD conclusion.

3. Consideration of Carried Reserves, Materiality Standard, and Reserve Range When Making Risk of Material Adverse Deviation Conclusion—When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.

4. Materiality Standards for Intercompany Pool Members—With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate SAO with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

J. State Insurance Regulators' Use of the Actuarial Report

State insurance regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with *ASOP No. 41, Actuarial*

Communications, can provide a foundation for efficient reserve evaluation during a statutory financial examination. This expedites the examination process and may provide cost savings for the company.

1. Schedule P Reconciliation

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

The Working Group believes:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity, and the methods used by the Appointed Actuary. While it is important that the Appointed Actuary is provided with complete and accurate data, reconciling the data **provided** to the Appointed Actuary to Schedule P is not sufficient to demonstrate that the data **used** by the Appointed Actuary reconciles to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary's analysis exhibits to the actuarial data shown in the Schedule P reconciliation.
- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis, and there is often not a direct correspondence between analysis segments and Schedule P lines of business.
- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate. If the Appointed Actuary chooses not to reconcile certain data elements used in the analysis, such as claim counts, a brief explanation should be included in the Actuarial Report to make it clear that these elements were not inadvertently overlooked.
- Schedule P reconciliations are expected to be performed on both a direct and assumed basis and a net of reinsurance basis. If circumstances specific to the company lead the Appointed Actuary to perform the reconciliation on only one basis, the rationale for this decision should be explained in the Actuarial Report. Similarly, while the reconciliation of the loss-related elements, such as defense and cost containment and adjusting and other expenses, is generally expected to be on the same level as used in the analysis underlying the SAO, the Appointed Actuary has the discretion to deviate as long as the rationale is explained in the Actuarial Report.
- The Instructions require that the Appointed Actuary include an explanation for any material differences in the Schedule P reconciliation. When differences appear in the reconciliation but are viewed as immaterial by the Appointed Actuary, the Appointed Actuary should acknowledge the immateriality of the differences in the Actuarial Report in order to assure state insurance regulators that the Appointed Actuary is aware of the differences and has considered the potential impact of the differences on the analysis underlying the SAO.

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

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

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

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

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

2. Change in Estimates

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

3. Narrative

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

4. Support for Assumptions

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

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have little value if items, such as rate actions, tort reform, schedule rating adjustments, or program revisions, have materially affected premium adequacy.

5. Support for Roll-Forward Analyses

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

K. Exhibits A and B

1. Data Capture Format

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

2. Scope of Exhibit B, Item 12

Exhibit B, Item 12, requests information on extended loss and unearned premium reserves for all P~~/~~&C lines of business, not just medical professional liability. The Schedule P Interrogatories referenced in the parenthetical only address reserves associated with yet-to-be-issued extended reporting endorsements offered in the case of DD&R of an individual insured under a medical professional liability claims-made policy.

3. Exhibit B, Item 13

The Working Group added disclosure item Exhibit B, Item 13, in 2018. This item requests information on reserves associated with accident and health (A&H) long-duration contracts, defined in the Instructions as "A&H contracts in which the contract term is greater than or equal to 13 months, and contract reserves are required."

This disclosure item was added for several reasons:

- **A desire by state insurance regulators to gain a greater understanding of P~~/~~&C insurers' exposure to A&H long-duration contracts.**
  - This guidance does not specify how P~~/~~&C insurers should report the liabilities associated with A&H

DRAFT 2025 Regulatory Guidance Document
For discussion on 8/20/2025

long- duration contracts on the annual statement. Through work performed on financial examinations, state insurance regulators have found that P~~/~~&C insurers may include the liabilities in various line items of the Liabilities, Surplus and Other Funds page. *SSAP No. 54—Individual and Group Accident and Health Contracts* provides accounting guidance for insurers.

- Regardless of where the amounts are reported on the annual statement, the materiality of the amounts, and whether the insurer is subject to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51), the Appointed Actuary should disclose the amounts associated with A&H long-duration contracts on Exhibit B, Item 13. The Appointed Actuary should provide commentary in a relevant comments paragraph in accordance with paragraph 6.C of the Instructions. The Appointed Actuary should also disclose all reserve amounts associated with A&H long-duration contracts in the Actuarial Report.

- **The adoption of AG 51 in 2017.** On Aug. 9, 2017, the NAIC's Executive (EX) Committee and Plenary adopted AG 51 requiring stand-alone asset adequacy analysis of long-term care (LTC) business. The text of AG 51 is included in the March 2019 edition of the NAIC's *Accounting Practices and Procedures Manual* (AP&P Manual). The effective date of AG 51 was Dec. 31, 2017, and it applies to companies with over 10,000 in-force lives covered by long-term care insurance (LTCI) contracts as of the valuation date. The Instructions state that the Actuarial Report and workpapers summarizing the asset adequacy testing (AAT) of LTC business must comply with AG 51 requirements.

- **Recent adverse reserve development in LTC business.** State insurance regulators expect Appointed Actuaries to disclose company-specific risk factors in the SAO. Given the recent adverse experience for LTC business, Appointed Actuaries should consider whether exposure to A&H long-duration contracts poses a risk factor for the company.

The Appointed Actuary is not asked to opine on the reasonableness of the reserves associated with A&H long-duration contracts except to the extent that the reserves are included within the amounts reported on Exhibit A of the SAO. For this reason, the Working Group intentionally excluded Items 13.3 and 13.4 from this sentence in paragraph 4 of the Instructions: "The Appointed Actuary should state that the items in the SCOPE, on which they is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B." Exhibit B, Item 13.1, asks the Appointed Actuary to disclose the reserves for A&H long-duration contracts that the company carries on the Losses line of the Liabilities, Surplus, and Other Funds page. The Appointed Actuary is not asked to opine on the reasonableness of the reserves disclosed on Exhibit B, Item 13.1, in isolation, but these reserves are a subset of the amount included on Exhibit A, Item 1, and Exhibit A lists amounts with respect to which the Appointed Actuary is expressing an opinion. The same is true for Exhibit B, Item 13.2, whose reserves are a subset of the amount included on Exhibit A, Item 2.

A&H long-duration contracts are distinct from P~~/~~&C long-duration contracts. There were no changes to the opinion requirements in 2018 regarding P~~/~~&C long-duration contracts, but the Working Group added a reference to SSAP No. 65 in the definition of P~~/~~&C long-duration contracts to clarify the difference between A&H long-duration contracts and P~~/~~&C long-duration contracts. The newly-added mention of SSAP No. 65 in the Instructions is not intended to change the Appointed Actuary's treatment of P~~/~~&C long-duration contracts in the SAO or the underlying analysis, but insurers and Appointed Actuaries may refer to SSAP No. 65, paragraphs 21 through 33, for a description of the three tests, a description of the types of P~~/~~&C contracts to which the tests apply, guidance on the minimum required reserves, and instructions on the SAO and Actuarial Report.

III. Comments on the Actuarial Opinion Summary

A. Confidentiality

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

B. Different Requirements by State

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

Most states provide the annual statement contact person with a checklist that addresses filing requirements. The Working

Group advises the Appointed Actuary to work with the company to determine the requirements for its domiciliary state.

C. Format

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

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

IV. Guidance on Qualification Documentation

The Instructions were modified for 2019 to require the Appointed Actuary to document qualifications in what is called "qualification documentation." Beginning with year-end 2024 Opinions, the Appointed Actuary's qualification documentation is required to be provided to the Board of Directors at initial appointment, whereas in previous years it was also required to be provided annually thereafter.

The following provides guidance Appointed Actuaries may find useful in drafting qualification documentation. Appointed Actuaries should use professional judgment when preparing the documentation, and they do not need to use the sample wording or format provided below. As a general principle, Appointed Actuaries should provide enough detail within the documentation to demonstrate that they satisfy each component of the Qualified Actuary definition. In crafting the qualification documentation, it may be helpful to think about what is important for the Board of Directors to know about their Appointed Actuary's qualifications and remember that documentation should be relevant to the subject of the Actuarial Opinion being issued.

A. Brief Biographical Information

- The Appointed Actuary may provide resume-type information.
- Information may include the following:
  - Professional actuarial designation(s) and year(s) first attained.
  - Insurance or actuarial coursework or degrees.
  - Actuarial employment history: company names, position title, years of employment, and relevant information regarding the type of work (e.g., reserving, ratemaking, enterprise risk management [ERM]).

B. "Qualified Actuary" Definition

The Appointed Actuary should provide a description of how the definition of Qualified Actuary in the Instructions is met or expected to be met—in the case of continuing education (CE)—for that year. The Appointed Actuary should provide information similar to the following. Items 1 through 3 below correspond with items (i) through (iii) in the Qualified Actuary definition.

1. I meet the basic education, experience, and CE requirements of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy). The following describes how I meet these requirements:

   a. Basic education:

      - [Option 1] met through relevant examinations administered by the Casualty Actuarial Society (CAS).
      - [Option 2] met through alternative basic education. The Appointed Actuary should further review

documentation necessary per Section 3.1.2 of the U.S. Qualification Standards.

b. Experience requirements: met through relevant experience as described below.

- To describe the Appointed Actuary's responsible experience relevant to the subject of the SAO, information may include specific actuarial experiences relevant to the company's structure (e.g., insurer, reinsurer, risk retention group [RRG]), lines of business, or special circumstances.
- Experiences may include education (through organized activities or readings) about specific types of company structures, lines of business, or special circumstances.

c. CE: met (or expected to be met) through a combination of industry conferences, seminars (both in-person and virtual), online courses, committee work, self-study, etc., on topics including _____ (provide a brief overview of the CE topics. For example, "trends in workers' compensation" or "standards of actuarial practice on reserving"). A detailed log of my CE credit hours is available upon request.

- Section 3.3 of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement requires the Appointed Actuary to earn 15 hours of CE on topics mentioned in Section 3.1.1.2.

2. I have obtained and maintain an Accepted Actuarial Designation. One of the following statements may be made, depending on the Appointed Actuary's exam track:

- I am a Fellow of the CAS (FCAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.).
- I am an Associate of the CAS (ACAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.) and Exam 7—Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management.[2]
- I am a Fellow of the SOA (FSA), and my basic education includes completion of the general insurance track, including the following optional exams: the U.S. version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.[3]

Alternatively, if the actuary was evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary, the Appointed Actuary may note such and identify any restrictions or limitations, including those for lines of business and business activities.

3. I am a member of [professional actuarial association] that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline (ABCD) when its members are practicing in the U.S.

[2] Under the changes proposed to the 2026 Instructions, this bullet point will change to "I am an Associate of the CAS (ACAS), and my basic education includes credit for Exam 6—Regulation and Financial Reporting (U.S.) and Exam 7—Advanced Estimation of Claims Liabilities."

[3] Under the changes proposed to the 2026 Instructions, this bullet point will change to "I am a Fellow of the SOA (FSA), and my basic education includes completion of the following courses: GI 101 Ratemaking and Reserving; GI 201 Operational, Financial, Regulatory, and Legal; GI 301 Further Topics in General Insurance; and GI 302 General Insurance in the U.S."

Draft: 12/3/25

Statistical Data (C) Working Group
Virtual Meeting
November 19, 2025

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Nov. 19, 2025. The following Working Group members participated: Sandra Darby, Chair, and Erica Sanderson (ME); Brad Gerling, Vice Chair (MO); Ken Williamson (AL); Lori Dreaver Munn (AZ); Qing He (CT); David A. Christhilf (DC); Mike Andring (ND); Christian Citarella (NH); Tom Botsko (OH); and Landon Hubbart (OK). Also participating were: Luciano Gobbo (CA); Daniel Zhong (FL); Stephanie Clayton (ID); Julie Rachford (IL); John Sobhanian (LA); Jackie Horigan (MA); Arthur Schwartz (MD); Phillip Glasovatz and Chris Slovinski (MI); Kelsey McElroy (MN); Mari Kindberg and Ashley Perez (MT); Will Davis (SC); Kaleb Short and Eric Scott (TN); Kathy Stajduhar (UT); and William Wilder (WA).

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

NAIC committee support created a list of classifications of auto insurance data elements that could be collected and then grouped together by regulators as they look at different class groups.

Darby stated that the first data element's categories are male, female, and non-binary. Laura Panesso (Insurance Services Office—ISO) suggested adding "non-applicable" because some states do not allow rating on gender.

For the age data element, Darby stated that the previous class codes included those under 25 years, 25–29 years, and 65 years and older. Botsko said that collecting individual ages would create a very large data set. Darby asked committee support to draft potential buckets for age ranges for the Working Group to evaluate at the next meeting.

Darby said the next two elements are business use and farm use. She said these elements would collect yes or no answers. Botsko suggested adding a data element for pleasure use with a yes/no answer.

For the commuter distance data element, Panesso suggested changing it to annual mileage. Darby and Botsko agreed. Botsko said this data element should also have buckets to limit the data set.

For the marital status data element, Panesso said the ISO only collects two categories: married and all other. Andy Regis (American Association of Insurance Services—AAIS) said the AAIS only collects married and single. Darby said some carriers treat widows as married in their rating plans.

Darby suggested changing the wording of the "owner status" data element to "principal operator." There were no disagreements with this suggestion.

Darby asked if statistical agents are getting information on assigned risk policies. Panesso said the ISO does collect assigned risk information and reports it to AIPSO. Botsko suggested adding a definition to this data element for clarity.

For the miscellaneous vehicles data element, Darby suggested defining what types of vehicles would be included in this category.

Darby said NAIC drafted an outline for a potential new section of the *Statistical Handbook of Data Available to Insurance Regulators* (Statistical Handbook) on pet insurance. She asked if the outlined coverages of accident only,

Draft: 12/2/25

Statistical Data (C) Working Group
Virtual Meeting
October 29, 2025

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Oct. 29, 2025. The following Working Group members participated: Sandra Darby, Chair (ME); Brad Gerling, Vice Chair (MO); Kyle Ogden (AL); Lori Dreaver Munn (AZ); George Bradner (CT); Colton Schulz and Mike Andring (ND); Tom Botsko (OH); Andy Schallhorn and Landon Hubbart (OK); Ying Liu (OR); and Nicole Elliott (TX). Also participating were: Luciano Gobbo (CA); Bryanna Blasdel, Borwen Lee, and Daniel Zhong (FL); Julie Rachford (IL); John Sobhanian, Nichole Torblaa, and Niles Watson (LA); Arthur Schwartz (MD); Phillip Glasovatz (MI); Kelsey McElroy (MN); Mari Kindberg (MT); Nicholas Vogl (NC); Kaleb Short (TN); and William Wilder (WA).

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

Darby said NAIC committee support sent a survey to Working Group members, interested regulators, and interested parties with the following questions: 1) Are you currently using data reported by class group? If so, can you provide information on how you're using this data? How often are you using this data? 2) Do you find there's enough similarity between classification plans to adequately group them into class groups? 3) Would the current class groups in the NAIC Statistical Handbook be of value to you? and 4) Are there different class groups that would be of value to you?

Botsko stated that several years ago, the Ohio Department of Insurance (DOI) conducted a study using the auto insurance class groups. He said this information has not been used since. He said the data was delivered in groupings different from what is currently shown in the *Statistical Handbook of Data Available to Insurance Regulators* (Statistical Handbook).

Mike Puchner (American Association of Insurance Services—AAIS) stated that the AAIS collects class group details across many different fields. These fields can usually be mapped to the groupings found in the Statistical Handbook. He suggested capturing and reporting the data elements separately so that regulators can group elements together as needed. Becky Konkle (National Independent Statistical Service—NISS) stated that the NISS does not currently collect the data items separately. Laura Panesso (Insurance Services Office—ISO) stated that the ISO collects the data items separately. Mike Nagel (Independent Statistical Service—ISS) stated that the ISS collects the data items separately and can roll them up to the current class codes.

Gerling stated that Missouri does not use the current class codes. He agreed with the suggestion to collect and report the data items separately. Darby asked NAIC committee support to create a list of data elements that could be collected and reported.

Darby stated that during the Working Group's last meeting, there was a suggestion to consider adding a pet insurance section to the Statistical Handbook. Darby asked if any Working Group member was opposed to adding this section. No opposition was voiced. Schwartz said the pet insurance industry is currently a $5 billion market. He suggested that a pet insurance section of the Statistical Handbook should collect information on accident, illness, and wellness policies. Darby asked NAIC committee support to draft an outline of a new pet insurance section.

Bradner asked if the Working Group should consider adding a private flood insurance section to the Statistical Handbook. Elliott stated that the NAIC annual financial statement includes a private flood insurance supplement

that breaks out information on first-dollar versus excess, standalone policies versus endorsements, and residential policies versus commercial policies. Darby said the Working Group would look further into the information available for flood insurance before drafting an outline for a new section.

Darby suggested that the Working Group consider updating all of the personal lines sections of the Statistical Handbook and exposing and adopting those changes before beginning work on the commercial lines sections. She said this would allow statistical agents to begin implementing the changes for personal lines sooner. The Working Group, interested regulators, and interested parties agreed with this approach.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/SDWG/StatDataWGmin_1029

Draft: 11/26/25

Statistical Data (C) Working Group
Virtual Meeting
September 24, 2025

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Sept. 24, 2025. The following Working Group members participated: Sandra Darby, Chair (ME); Brad Gerling, Vice Chair (MO); Charles Hale, Kyle Ogden, and Ken Williamson (AL); Lori Dreaver Munn (AZ); Qing He (CT); David A. Christhilf (DC); Colton Schulz and Mike Andring (ND); Christian Citarella (NH); Alexander Vajda (NY); Landon Hubbart (OK); and David Dahl (OR). Also participating were: Borwen Lee (FL); Julie Rachford (IL); Nichole Torblaa (LA); Arthur Schwartz (MD); Kelsey McElroy (MN); Phillip Glasovatz (MI); Nicholas Vogl (NC); and William Wilder (WA).

1. Adopted its Aug. 20 Minutes

The Working Group met Aug. 20 to discuss comments on *Statistical Handbook* (Handbook) Sections 1, 2, 3, 5, 7, and 8.

Schulz made a motion, seconded by Gerling, to adopt the Working Group's Aug. 20 minutes (Attachment Nine-A). The motion passed unanimously.

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

Mark Schmalzer (Independent Statistical Services—ISS) said ISS suggested retaining territory collection in the Handbook in order to allow for that information to be included in reports to state insurance regulators in the future. He said in most cases, the reported ZIP codes can be rolled up to a territory with a one-to-one mapping, but there are instances in which the ZIP codes cannot be directly mapped to a territory. Darby, Gerling, and Schulz said they would not use territory information in their specific state and would prefer ZIP code-level data. Darby said that the Working Group will be addressing the reports to regulators as the review of the Handbook goes along and that there may not be a use for reporting territory to regulators if ZIP codes are collected.

Schmalzer asked if regulators want to see salvage and subrogation reported separately or reported together. Schulz and Munn said they would prefer to have that information reported separately.

Schmalzer said ISS currently allows for two methodologies of claim counting. He said the first and preferred methodology is to report the claim count upon initial payment. He said the second methodology is to report the claim count upon the closing transaction or final payment. Laura Panesso (Insurance Services Office—ISO) said ISO receives claim counts with incurred claims so as not to double count. Gerling said in Missouri, they collect data on a paid basis. He said the Handbook for the private passenger auto (PPA) section is based on incurred. Darby said they would be getting the same claim counts, but some claims may be reported at the beginning of the claim period and some at the end of the claim period. She asked participating statistical agents to think about the best way to collect and report this information before the Working Group takes up the topic again.

Schmalzer asked how the reporting would be handled for companies that cannot track claims closed without payment. Panesso said the collection of this information was a suggestion from ISO based on how often it is seeing this data element requested in special data calls. She said ISO is not currently collecting this data. Schmalzer asked if there is an indicator as to why the claim was closed without payment. Panesso said that information would more likely be found in the Market Conduct Annual Statement (MCAS).

Schmalzer asked if there are situations where an insurance carrier may not know what the cause of loss is while the claims is reserved. He said that might be the reason for the inclusion of the following language: “For no-fault outstanding losses, statistical agents may choose to collect the total of all types, or they may choose to collect them in detail.” Susan Chudwick (Travelers Insurance) said that level of detail is not collected on reserves. Panesso said there was already an option to collect the details of loss type for outstanding losses. Darby said if insurers are not collecting that detail, the option may need to remain in the handbook to collect the outstanding losses in total.

Schwartz said pet insurance is a growing line of business with $4.7 billion in premium volume in the US. He said regulators would get value from adding a pet insurance section into the Handbook to monitor the growth of this line of business. He said in addition to a section in the Handbook, he would like to see a fast-track report on pet insurance.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/SDWG/StatDataWGmin_820

Draft: 9/9/25

Statistical Data (C) Working Group
Virtual Meeting
August 20, 2025

The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Aug. 20, 2025. The following Working Group members participated: Sandra Darby, Chair (ME); Brad Gerling, Vice Chair (MO); Tom Zuppan (AZ); George Bradner (CT); Colton Schulz and Mike Andring (ND); Christian Citarella (NH); Tom Botsko (OH); Andy Schallhorn and Landon Hubbart (OK); David Dahl (OR); and Nicole Elliot (TX). Also participating were: Esteban Mendoza and Luciano Gobbo (CA); Bryanna Blasdel, Borwen Lee, and Daniel Zhong (FL); Julie Rachford (IL); John Sobhanian and Niles Watson (LA); Arthur Schwartz (MD); Phillip Glasovatz and Chris Slovinski (MI); Nicholas Vogl (NC); and Will Davis (SC).

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

Darby said the Working Group ended the previous meeting considering whether there was a need to define the terms owner-occupied, non-owner-occupied, seasonal, and other-than-seasonal. She said after reaching out to participating statistical agents, the Insurance Services Office (ISO) provided a definition for seasonal, which states that a seasonal dwelling is a dwelling with continuous unoccupancy for three or more consecutive months during any one-year period. The ISO does not explicitly define owner-occupied, non-owner-occupied, or other-than-seasonal and stated that insurance companies may define these terms differently for their homeowners and dwelling fire programs. Laura Panesso (ISO) said there may be different definitions in local and state ordinances. She said that when looking at seasonal dwelling information, it may not matter how "seasonal" is defined, but that they are rated on a seasonal basis. Other participating statistical agents did not have a specific definition for the term seasonal.

Zuppan asked the intent of defining occupancy. He said many homeowners policies have exclusions that relate to unoccupancy. Bradner said the intent is to be able to define differences between seasonal homes, secondary homes, and primary homes, and how policies are covering these homes. Bradner said a secondary home is a home the owners can visit at any point throughout the year for any length of time, and a seasonal home is only available for use during certain periods of the year. He said it may be up to the underwriter to determine the risk and how the home is classified. Zuppan said seasonal should be reported as a subset of secondary. Panesso said a primary residence can be covered by a dwelling fire policy and would be reported as other than seasonal.

Zuppan said there should be a distinction made that Section 8 is meant to only capture personal dwelling fire and allied lines policies. Panesso said the first few paragraphs of Section 8 outline the intent of capturing only personal lines policies, but some edits may be in order to clarify the intent. Zuppan asked if landlord rental policies would be reported in Section 8 or in a commercial lines section. Darby said Section 8 includes dwelling policies that provide coverage for one-family to four-family dwellings, so those landlord policies could be included in Section 8. Bradner said it depends on how many properties an insured owns and is trying to insure. He said a personal lines company is not going to cover an insured with multiple rental properties.

Darby said this conversation stemmed from statistical agents responding that they collect seasonal and other than seasonal in an additional owner-occupied and non-owner-occupied split. Gerling said he would like to see the *Statistical Handbook of Data Available to Insurance Regulators* (Statistical Handbook) include the owner-occupied and non-owner-occupied piece. Darby agreed that if the statistical agents are already collecting this information, it would be helpful for regulators to see the information.

accident and illness, and wellness were sufficient. Gerling said the Market Conduct Annual Statement (MCAS) collects information on accident-only policies, illness-only policies, accident and illness policies, and wellness-only policies. Gerling said he wanted to further look into the illness-only policies to see how prevalent they are.

Gerling said the MCAS data collection does not break down data by the type of loss. Darby asked what type of losses fall under a wellness plan. Schwartz said wellness plans include items such as vaccinations, regular veterinary visits, and dental care. Schwartz suggested inviting a representative from the North American Pet Health Insurance Association (NAPHIA) to join a future meeting and give insight into pet insurance coverages and loss types.

Gerling said the MCAS collects some information in an interrogatory format that gives insight into the current offerings in pet insurance. He said the MCAS data is available to regulators via Snowflake access. Gerling said data elements collected in the MCAS for underwriting activity include the: 1) number of covered pets; 2) number of policies in force; 3) number of applications; 4) number of company initiated cancellations; 5) number of policies returned during the right to review period; 6) number of policies cancelled at the consumers request; 7) number of policies cancelled for non-payment; 8) number of new policies issues; 9) number of renewal policies 10) direct written premium; 11) earned premium; and 12) number of policies issued that include a pre-existing condition exclusion. He said this data is collected for both individual and group policies.

Darby asked if the Working Group should consider breaking out individual and group policies as well. She also asked whether the Statistical Handbook should collect data separately by type of pet. Gerling said that information is not collected in the MCAS but would be useful.

Gerling said data elements collected in the MCAS for claims activity include the: 1) number of claims opened; 2) number of claims closed; 3) number of claims closed with full payment; 4) number of claims closed without payment; 5) number of claims closed with partial payment; 6) number of days for claims to close; 7) reasons for claims closed without payment; and 8) dollar amount of claims payments.

Darby said the Working Group would continue to look at pet insurance during the next meeting.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/SDWG/StatDataWGmin_1119

Darby asked if the Working Group is interested in seeing a similar seasonal and other-than-seasonal data element in the Homeowners section of the Statistical Handbook. Bradner said companies will usually collect primary versus secondary home data. Panesso said they generally only collect owner-occupied and non-owner-occupied data for homeowners policies. Mike Puchner (American Association of Insurance Services—AAIS) said AAIS currently only collects owner-occupied and non-owner-occupied but is considering a usage-type data element, which would distinguish between primary, secondary, and seasonal. Bradner asked if the unoccupied homes data is collected. Puchner said it is a proposed data field for future collection. Zuppan said forced place policies could be classified as unoccupied. Darby said that this much detail may not be necessary for a small number of policies it would collect.

Darby said the Working Group received comments on Section 5—Private Passenger Automobile Insurance from the ISO and Independent Statistical Service (ISS).

Panesso said the ISO has proposed removing territory and only collecting ZIP code data. She said for amount of loss, ISO added salvage and subrogation as separate types of loss. The ISO also added the number of claims closed without payment and total loss claims. The ISO suggested changing year of loss to date of loss, which is consistent with proposed changes in other sections of the Statistical Handbook. The ISO also added animal collision and towing and labor under type of loss.

Zuppan asked if the auto and homeowners sections capture data on force-placed policies. He said if a bank or loan owner places an insurance policy on a car or home that does not have insurance, it is reported as a premium under the private passenger auto and homeowners lines of business in the NAIC annual statement. Panesso said the scope of Section 5 of the Statistical Handbook does not seem to cover forced placed policies. Darby said the Working Group should further research this subject.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/C CMTE/2025_Fall/CASTF/SDWG/StatDataWGmin_820

