Long-Term Care Insurance Multistate Rate Review Framework

Draft as of December 12, 2021

NAIC Long-Term Care Insurance (EX) Task Force
PREFACE

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

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on Dec. 12, 2021, and the NAIC Executive Committee and Plenary on [insert date].
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I. INTRODUCTION

A. Purpose

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

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal1 and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team’s (MSA Team’s) recommendations when conducting their own state level reviews of in force LTCI rate increase filings.2 Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

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

This document will be maintained by NAIC staff under the oversight of the Task Force and be revised as directed by the Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

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

- “Impacted State” is defined as the domestic state, or any state for which the product associated with the insurer’s in force LTCI premium rate increase proposal is or has been issued.

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1 “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.

2 The term “rate increase filing” or “rate filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.
• “Participating State” is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

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

C. General Description of the MSA Review

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

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

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

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

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

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

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

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3 Certain processes for Impacted vs. Participating States are yet to be determined (TBD).
described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

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

D. Benefits of Participating in the MSA Review

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

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

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

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

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

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility, and/or decision making. Each state remains ultimately responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.
A Participating State’s use of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer’s obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

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

Information Sharing Between State Insurance Departments

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

Confidentiality of the Rate Proposal

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

Confidentiality of the MSA Reports

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

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The Long-Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

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

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

A. Qualifications of an MSA Team Member

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

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participates as a member of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (or an equivalent Subgroup appointed by the Long-Term Care Insurance (EX) Task Force) and the LTC Pricing (B) Subgroup.
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the Task Force or its appointed Subgroup

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

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

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

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
• Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

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

D. MSA Associate Program

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

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

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

Authority of the MSA Team

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

Disclosures and Confidentiality Obligations, as Applicable

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

Conflict of Interest Avoidance Procedures and Certifications

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

F. Required NAIC and Compact Resources

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

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

III. REQUESTING AN MSA REVIEW

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

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

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

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

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

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

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

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

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

C. Certification

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

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

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

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

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

The supporting NAIC and Compact staff will notify (Participating/Impacted States [TBD]) via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

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

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

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

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

C. Preparation and Distribution of the MSA Advisory Report

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

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

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

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

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

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

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

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

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

E. Feedback to the MSA Team

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

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.
4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

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

V. ACTUARIAL REVIEW

A. MSA Team’s Actuarial Review Considerations

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

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

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

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

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team’s recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches: or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. As the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

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

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

- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

**Consideration of Solvency Concerns**

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

**Follow-Up Proposals on the Same Block**

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

**B. Loss Ratio Approach**

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

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

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

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

4. The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.
   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead
to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.

b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.

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

C. Minnesota Approach

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

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

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

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

4. Interest rate / investment return component
   a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
      i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
      ii. In the Minnesota approach, all factors impacting the business are considered.
         1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
         2. If interest rates fall, this would tend to lead to higher rate increase approvals.

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

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

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

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

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarially justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

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

1. Past losses are assumed by the insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits, the recoupment of past losses to some extent.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

3. Data Requirements for Calculation:
   a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
      i. Present Value of Future Benefits (PVFB) under current assumptions.
      ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
      iii. Present Value of Future Premiums (PVFP) under current assumptions.
      iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
         1. Note that for all four projections above, the projection period is typically 40–50 years: although, some companies project for 60 or more years.

To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on waiver, on claim, or paid up) regardless of the reason. Projections under current actuarial assumptions must not include
policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
   a. Rate increases are commonly driven by a change to the persistency, morbidity, mortality assumption, or a combination of the three.
   b. Verification that assumption change(s) are supported by credible data.
   c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the insurer, not the policyholder.

The formula used in the Texas approach is provided in Appendix C.

E. RBOs

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

RBOs in the MSA Advisory Report

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

Future RBOs

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

F. Non-Actuarial Considerations

The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations affecting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

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

Considerations in the MSA Advisory Report

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

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

Future Non-Actuarial Considerations

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

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

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

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

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

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

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

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

B. Appendix B – Information Checklist

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

This document contains aspects of the NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation5 (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

Information Required for an MSA Review of a Rate Proposal

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews”6 as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

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

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.

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6 https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx
a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.

b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

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

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

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder’s own past premium deficiencies and/or subsidizes other policyholders’ past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

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

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

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

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

   a. Comparison with asset adequacy testing reserve assumptions.
      i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
      ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and Li—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) reserves.
   c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

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

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

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

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

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

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

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

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

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

Supplemental Information

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

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

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

3. RBOs
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

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

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

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

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

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

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

C. Appendix C—Actuarial Approach Detail

Minnesota Approach

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

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

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

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

3. If-knew premium and makeup premium aspects—sample policy-level verification.
   a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium.
         1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
         2. Apply first principles.
            a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
            b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
            c. Divide by the sum of the PV of an annuity of 1 per year.
d. Multiply \( \frac{b}{c} \) times \((1 + \text{originally assumed profit percentage})\) to attain the original premium.

e. This premium provides the basis for comparison against the makeup and if-knew premium.

3. Replace the original premium with a benchmark premium.
   a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
   b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
   c. The benchmark aspect is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

ii. Calculate an estimate of the makeup premium.
   1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
   2. Calculate an updated dollar PV of profits for the sample policy using:
      a. Actual history of premiums and claims.
      b. Expectations of future claims.
      c. “Backed into” makeup premium.
   3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
      a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.
   1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
   b. Verifying the impact on expectation changes on rates
      i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
      ii. A combination of information is relied upon to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
         1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
         2. Experience
         3. Impact on LLR of changes in expectations of morbidity.
         4. Industry information and trends (for reasonableness checks).
   c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
      i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer’s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
      ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
         1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
         2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).

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

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

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. No haircut for the first 15%.
      ii. 10% for the portion of cumulative rate increase between 15% and 50%.
      iii. 25% for the portion of cumulative rate increase between 50% and 100%.
      iv. 35% for the portion of cumulative rate increase between 100% and 150%.
      v. 50% for the portion of cumulative rate increase in excess of 150%.

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

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. The original premium is $1,000
      ii. Makeup premium is $3,000.
      iii. If-knew premium is $1,500.
iv. 60% of policyholders remain.

v. Past rate increases are 50%:

vi. Blended amount is:

1. $3,000 / $1,000 * 0.60 +
2. $1,500 / $1,000 * 0.40
3. – 1 =
4. 180% + 60% – 1 = 240% – 1 = 140%

vii. Cost sharing is:

1. 100% * 0.15 +
2. 90% * 0.35 +
3. 75% * 0.5 +
4. 65% * 0.4 =
5. 110%

viii. Deduction for past rate increases results in:

1. (1 + 1.1) / (1 + 5) – 1 =
2. 40%

Texas PPV Formula

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to active, premium-paying policyholders.

For rate stabilized policies:

\[
\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.58 + .85 C}{1 + C}\right)\Delta PV(\text{future earned premiums})}{.85 PV_{\text{current}}(\text{future earned premiums})}
\]

Where:

\(\Delta\) indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.

\(C\) is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then \(C = 0.5\).

The current subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the \(\Delta PV(\text{future incurred claims})\) term in the above formula could be multiplied by \((1 + \text{margin})\).

For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:

\[
\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{.6 + .8 C}{1 + C}\right)\Delta PV(\text{future earned premiums})}{.8 PV_{\text{current}}(\text{future earned premiums})}
\]
Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

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

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to “Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

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

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

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

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

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

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

Less Common RBOs for Potential Discussion

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

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

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

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

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

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

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

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

Filing Rate Action Letters

Insurers should consider:

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

Readability and Accessibility

Insurers should consider:

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

Identification

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

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

Communication Touch and Tone

Insurers should consider:

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

Consultation and Contact Information

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

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

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

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

Understanding Policy Options

Insurers should consider the presentation of the communication by:

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

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

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

Insurers should consider including disclosures regarding rate increase history by:

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

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

Insurers should consider personal needs decision-making by:

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

Insurers should consider the value of each option by:

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

Insurers should consider communicating the impact of options by:

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

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

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

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

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT

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

Executive Summary

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

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

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

Background

The MSA Team was formed to assist the Long-Term Care Insurance (EX) Task Force in developing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team’s actuarial analysis is provided below. The intention is that states can utilize

7 Information contained in this sample report is an example only and is not derived from any actual rate filing.
this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

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

**Insurer’s Proposal**

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

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

**Workstream-Related Review Aspects**

**Actuarial Review**

At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states’ laws and rules include:

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

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

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

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

The Texas approach results in an approvable rate increase of 29% in aggregate.

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

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

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

**Consideration of Differences in Histories of States’ Rate Increase Approvals**
According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

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

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

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

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

Non-actuarial & Valuation/Solvency Considerations

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

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

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

RBOs – Review for Reasonableness

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

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

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

Financial Impact for Insurer

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

Mix of Business

From the insurer’s actuarial memorandum:

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

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

Appendix 1

Drivers of Rate Increase Proposal – Summary

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

Details Regarding Minnesota Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:
• Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
  o This increase is equal to the increase that would result from a pure loss ratio approach.
• If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
• Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
• Blended if-knew / makeup rate cumulative rate increase since issue: 123%
  o = 0.62 * 177% + (1 - 0.62) * 36%, adjusted for rounding
• Insurer cost share based on Minnesota formula (see Appendix 3): 12%
• Recommended cumulative rate increase since issue: 109%
  o = (1 - 0.12) * 1.23, adjusted for rounding
• Past cumulative rate increases: 55%
• Actuarial recommended rate increase from current rates: 35%
  o = (1 + 1.09) / (1 + 0.55) – 1, adjusted for rounding
• Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
  o Minimum of calculated approval rate of 35% and insurer proposal of 60%.
• Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

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

Details Regarding Texas Approach

• Insurer Calculation (aggregate): 52%

PPV calculations
• Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%
LHAO Comments

- For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:

\[
\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left(0.58 + 0.85C\right)\Delta PV(\text{future earned premiums})}{0.85 PV_{\text{current}}(\text{future earned premiums})}
\]

Reconciliation of Minnesota and Texas Approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach’s recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team’s recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
  - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
  - Reasons for the rate increase, including which pricing assumptions were not realized and why.
  - Statement that policy design, underwriting, and claims handling practices were considered.
  - A demonstration that actual and projected costs exceed anticipated costs and the margin.
  - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
    - Comparison with asset adequacy testing reserve assumptions.
    - Provide actuarial assumptions from original pricing and most recent rate increase filing, and, have the original actuarial memorandum available upon request.
  - Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
  - Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
  - Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.
- Rate Comparison Statement of renewal premiums with new business premiums, if applicable.
• Policyholder notification letter – should be clear and accurate.
  o Provide a description of options for policyholders in lieu of or to reduce the increase.
  o If inflation protection is removed or reduced, is accumulated inflation protection vested?
  o Explain the comparison of value between the rate increase and policyholder options.
  o Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
  o How are partnership policies addressed?

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

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

Appendix 2

Examples of Rate Increases If an RBO is Not Selected

<table>
<thead>
<tr>
<th>ABC Company</th>
<th>Jurisdiction Example*</th>
<th>Past Cumulative Approved Increases</th>
<th>Increase to catch up</th>
<th>Recommended New</th>
<th>2021 Recommended Rate Incr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: state with average past approvals</td>
<td>55%</td>
<td>0%</td>
<td>35%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Example: state with lower than average past approvals</td>
<td>27%</td>
<td>22%</td>
<td>35%</td>
<td>65%</td>
<td></td>
</tr>
</tbody>
</table>

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

Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance
Cumulative rate increase since issue date is haircut by:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%.
- 25% for the portion of cumulative rate increase between 50% and 100%.
- 35% for the portion of cumulative rate increase between 100% and 150%.
- 50% for the portion of cumulative rate increase in excess of 150%.

Example: if the pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

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

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.
The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit www.naic.org.
Date: 4/7/22

2022 Spring National Meeting
Kansas City, Missouri

Report of the Executive (EX) Committee

The Executive (EX) Committee met April 6, 2022. During this meeting, the Committee:

1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met April 4 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Adopted its March 21, 2022; Feb. 3, 2022; Jan. 14, 2022; and Oct. 12, 2021, minutes, which included the following action:
      i. Approved an amicus brief In Re: Penn Treaty Network America Insurance Company.
      iii. Approved the establishment of a foundation to promote diversity in the insurance regulatory community.
      iv. Approved the release of the SERFF Modernization − 2022 Transition Stages Fiscal for public exposure.
      v. Appointed Director Evan G. Daniels (AZ) to the National Insurance Producer Registry (NIPR) Board of Directors.
      vi. Selected Los Angeles, CA, as the location of the 2026 Spring National Meeting.
      vii. Reappointed Commissioner Andrew N. Mais (CT) to the International Association of Insurance Supervisors (IAIS) Executive Committee.
   C. Adopted the report of the Audit Committee, which met March 30, including the 2021 Financial Audit Report.
   D. Adopted the report of the Internal Administration (EX1) Subcommittee, which met March 8, including its amended 2022 charges.
   E. Appointed Director Dean L. Cameron (ID), NAIC President, to the IAIS Executive Committee.
   F. Approved initial funding from the NAIC for the establishment of a foundation.

2. Adopted the report of the Executive (EX) Committee, which met March 21, Feb. 3, and Jan. 14 and took the following action:
   A. Approved the SERFF Modernization − 2022 Transition Stages Fiscal Impact Statement after a 10-day public comment period.
   C. Approved the appointment of Director Daniels to serve on the NIPR Board of Directors beginning in February 2022.
   D. Selected Los Angeles, CA, for the 2026 Spring National Meeting site location.
   E. Approved the NAIC filing an amicus brief in the case of In Re: Penn Treaty Network America Insurance Company (In Liquidation), In Re: American Network Insurance Company (In Liquidation).
3. Adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Long-Term Care Insurance (EX) Task Force; and 4) the Special (EX) Committee on Race and Insurance.

4. Adopted the proposal to establish a Catastrophe Modeling Center of Excellence (COE) within the NAIC’s Center for Insurance Policy and Research (CIPR).

5. Adopted the proposed redesigned NAIC Climate Risk Disclosure Survey as a voluntary tool for state use.

6. Approved disbanding the SERFF Advisory Board.

7. Received the 2021 Annual Report of the NAIC Designation Program Advisory Board activities.

8. Received a status report on the NAIC State Ahead strategic plan implementation.

9. Received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Mortgage Guaranty Insurance Model Act (#630); 3) the Nonadmitted Insurance Model Act (#870); and 4) the Pet Insurance Model Act.

10. Heard reports from the NIPR and the Interstate Insurance Product Regulation Commission (Compact).
A Proposal to Establish a Catastrophe (CAT) Modeling “Center of Excellence” (COE) within the NAIC’s Center for Insurance Policy & Research (CIPR)

September 20, 2021

Introduction

The leadership and members of the NAIC have determined natural CAT risks and resiliency to be a top priority and organized several workstreams to pursue objectives intended to help ensure homes and businesses are protected from insured perils arising from natural CATs, while keeping markets stable through financially strong insurers and reinsurers. For example, the Catastrophe Risk (E) Subgroup has spent many years working to develop risk-based capital (RBC) factors for hurricane and earthquake exposures and, more recently, grappling with how best to address wildfire, flood, and convection storm perils. Separately, the Catastrophe Insurance (C) Working Group is charged with maintaining the NAIC State Disaster Response Plan, the Disaster Assistance Program, and the Catastrophe Computer Modeling Handbook. The Working Group has also commenced work to determine ways in which the private flood market can be facilitated and monitored by the state insurance regulators. The Climate and Resiliency (EX) Task Force has taken on significant work, which will require a deeper understanding of all aspects of climate and natural CAT risks. Further, many state insurance regulators are taking on new roles in working to create risk resilient communities within their jurisdictions.

Given these increased pressures and new roles, state insurance regulators need to improve their understanding of the CAT modeling technologies used by insurers and reinsurers. This means having access to the same knowledge, insights, and tools used by insurers. In doing so, state insurance regulators can more effectively engage with insurers and state and federal policymakers when discussing how best to maintain critical insurance coverages for their states' economies and developing new regulatory policy. The NAIC can play an instrumental role fulfilling these needs.

In this regard, the Technology Workstream of the Climate and Resiliency (EX) Task Force was assigned the task of considering the potential application of technology, such as early warning systems and predictive modeling tools, to better understand and thereby evaluate insurers' climate and natural CAT
risk exposures. In particular, the Technology Workstream was tasked with determining whether technical support services were needed by state insurance departments regarding the industry’s use of CAT models.

To help facilitate the members’ consideration of such a need, NAIC/CIPR staff conducted two presentations on June 7 and Aug. 6, 2021, wherein staff laid out a range of support services for state insurance departments when encountering the use of commercial CAT models by insurers in rate making processes, solvency functions, and/or other insurance business decisions (e.g., strategic, reinsurance, claims management). NAIC/CIPR staff addressed potential support services in the areas of: 1) facilitating access to CAT modeling documentation; 2) providing technical education and training; and 3) conducting applied research to proactively address regulatory climate risk and resilience priorities. Finally, an additional related benefit highlighted is the ability to provide future support services for other modeled CAT risk beyond climate and natural CATs, including casualty/liability, cyber, terrorism, and infectious diseases such as pandemics. This additional support work could potentially influence other NAIC related committee activities, as appropriate.

Proposal

As outlined in the introduction above, the time has arrived for the NAIC to establish a permanent support group—i.e., the NAIC CAT Modeling COE—to provide the NAIC and state system of insurance regulation with the necessary technical expertise, tools, and information to effectively regulate the insurers and reinsurers exposed to catastrophic events for a secure and stable insurance marketplace. We believe this COE would be best positioned within the NAIC’s CIPR given CIPR’s: 1) existing knowledge, expertise, and recent NAIC applied research track record in this field; and 2) its ability to effectively work with modelers and state insurance regulators from a neutral perspective within the NAIC. Below is a complementary and integrated series of technical support services envisioned by the COE:

1) Facilitating insurance department access to CAT modeling documentation and assistance in the distilling of this information.
2) Providing general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures.
3) Conducting applied research analysis utilizing various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed for regulatory resilience priorities.

The first element from above provides for the CAT Modeling COE to facilitate insurance department access to CAT modeling documentation and other information, as well as centralizing accumulated knowledge and expertise to aid in the deciphering and distillation of CAT models. The COE would assist
with managing both CAT model vendor relationships and insurance department needs. As such, the
COE would be briefed on the modeling technologies and inputs in a similar fashion as insurers and
reinsurers are and have access to the same modeling documentation to develop internal expertise. This
knowledge and expertise would then be actively shared with state insurance regulators for use in
regulatory processes and other considerations. Critically, this information would be collected and stored
on an NAIC regulator-only technological platform with proper CAT modeling vendor Data Use
Agreements (DUAs) in place to allow for proprietary model information sharing, part of which has been
a stumbling block to regulatory access to date.

The second element from above provides for technical education/training materials on the mechanics
of commercial models and treatment of perils and risk exposures for state insurance regulators. Importantly, this technical training would be utilized to enhance regulatory operational activities, thereby bringing the science to operations. For example, it would allow for state insurance departments and the NAIC to reimagine the NAIC *Catastrophe Computer Modeling Handbook*, which could become the foundational authoritative literature on state insurance regulator use of CAT models. As state insurance regulators gain more practice with these models, the NAIC is also well-positioned to develop best practices on industry use, as well as state insurance regulator use. Consequently, the NAIC *Financial Condition Examiners Handbook* and the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* could be improved to account for the latest developments and best practices in CAT risk assessment. Further from a solvency perspective, both the development of related RBC CAT charges and climate stress testing would benefit greatly from such a technical foundation.

The third element from above provides for conducting applied research analysis to utilize various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed. CAT models are not limited to use by the insurance industry; they are tools for CAT risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities (e.g., how to increase the uptake and proliferation of home hardening activities related to hurricane and wildfire risk). Such mitigation activities are critical to reduce expected losses and improve the availability and affordability of coverage currently and in a future warming climate. Applied research utilizing CAT models can demonstrate the economic value of such mitigation activities, laying the proper foundation for policy discussions to address increasing property owner mitigation implementation.

Lastly, it is important to note that these identified support services will not be taking the place of
individual state department of insurance (DOI) activities involving CAT models, such as model and rate
filing reviews, nor will the CAT Modeling COE be approving vendor models. Rather, the support services
will allow the COE to engage with state insurance regulators as a trusted partner with a sufficient level
of CAT modeling expertise to enable the conduction of ongoing CAT modeling regulatory activities more effectively.

**Plan of Action**

In the past year, many of the above support services have already transpired and/or are currently underway. These include: 1) regulator-only technological platform infrastructure development and DUA executions; 2) NAIC Insurance Summit and CIPR events focused on CAT modeling education concerning wildfire and flood models, CAT model climate change incorporation and climate risk assessment, and casualty CAT modeling; 3) successful completion of a California, Colorado, and Oregon DOI [wildfire mitigation report](#) and wildfire CAT model technical documentation done in conjunction with the Insurance Institute for Business & Home Safety (IBHS) and Risk Management Solutions (RMS), which was further leveraged by the Catastrophe Risk (E) Subgroup for wildfire RBC factor development and the Catastrophe Insurance (C) Working Group *Catastrophe Computer Modeling Handbook* updates. Therefore, this proposal will not be to start such CAT modeling COE support service activities, but rather to build upon and leverage these activities for further enhancement and formalization at the NAIC.

Following the meeting of the Technology Workstream on Aug. 6, 2021, the proposal was released to the member states for further comments and questions. Comments were considered, and a revised proposal was approved for public exposure by the Technology, Solvency, and Pre-Disaster Mitigation Workstreams on Sept. 20, 2021.

Following the Sept. 20 regulator-only meeting, the proposal was released to interested parties for further comment and questions for 30 days. Comments will be considered by the Technology Workstream following this feedback and revisions may be made to the proposal, as agreed upon.

If the proposal advances through the above process steps, it will be prepared for recommendation to the Climate Risk and Resiliency (EX) Task Force at the NAIC 2021 Fall National Meeting in San Diego, CA.

We anticipate there would be no new charges associated with creation of the COE; i.e., the expenses associated with the COE resources would be effectively absorbed by the NAIC budget and have no special assessments, fee for services, etc. These resources may include: 1) recruiting a vendor/insurance department CAT modeling relationship manager and a CAT model research analyst; 2) funding for education/training development and implementation and the licensing and/or running of models for applied research to support and/or enhance regulatory operational activities; and 3) addressing regulatory resilience priorities.
Conclusion

In the face of extreme weather and the future climate significantly affecting property insurance markets, state insurance regulators need to have access to the same knowledge, insights, and CAT modeling tools used by insurers and reinsurers to assess and address climate risk and resiliency; i.e., knowledge and tools that are available for state insurance regulators to access, understand, and utilize. To accomplish this, we propose that the NAIC establish a permanent support group—i.e., the NAIC CAT Modeling COE—housed within the NAIC’s research unit; i.e., CIPR. We have laid out a proposal and plan of action that would build upon the work that the NAIC/CIPR has already been conducting around climate and CAT risks and allows the NAIC/CIPR to bring science to the operation of the DOIs in a way that is additive to the existing regulatory system, easy to access, and tailored to the needs of the state insurance regulators.

CATModelCOE Proposal
NAIC/Center for Insurance Policy and Research (CIPR) Catastrophe Model
Center of Excellence (COE)
Frequently Asked Questions (FAQ)
November 16, 2021

Governance & Oversight

Topic: Vendor and Insurer Continued Engagement with Departments of Insurance (DOIs)

Is the intent for the COE to become the primary point of contact between state insurance regulators and modelers?

No. As stated in the proposal, “identified support services will not be taking the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models.” However, we do envision the COE providing access to CAT modeling expertise to support state insurance regulator understanding, training, etc.

Will state insurance regulators continue to be open to discussions with modelers (and insurers) about models?

Yes. In fact, the COE will seek to improve communication between state insurance regulators and modelers/insurers, supplying state insurance regulators with expertise and information to help facilitate such discussions.

Topic: Transparency and Potential Bias of Modeled Results/Usage

How will the COE engage with interested stakeholders to remain transparent?

Most NAIC support resources interact with a committee for reporting and oversight. In this instance, at least for now, we propose that the catastrophe resource center will report to the Technology Workstream under the Climate and Resiliency (EX) Task Force, as well as coordinate with the Property and Casualty Insurance (C) Committee.

How will the COE work to ensure impartiality of vendor models?
The COE will make every effort to engage with all vendors willing to participate for all perils with available technical documentation. Furthermore, the COE will establish a governance structure to ensure that partiality is not provided to any model or vendor.

Would the COE be engaging to connect learnings from the CAT model to specific insurer rate-making, solvency, and/or business—i.e., strategic, reinsurance, claims management—decisions?

The COE support services will not take the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. The COE will work to understand models objectively from a general sense, not for individual rate filings or solvency assessments. We acknowledge that each insurer has their own risk profile that would need to be considered on an individual basis, which is outside the scope of the COE.

Topic: Objective Science

Would the kind of information the COE conveys be facts-based or would it include opinions or analysis?

The information provided to the state DOIs would be fact-based with relevant objective analysis, as requested. Providing this type of information to states highlights the importance of the placement of the COE within the NAIC’s independent research center, the CIPR.

Topic: Addressing Regulatory “So What” Questions Through Applied Research

What are regulatory “so what” questions in support service #3 of the proposal conducting applied research analysis?

State insurance regulators are responsible for maintaining well-functioning competitive insurance markets. Forward-looking models can be utilized to help analyze market performance, especially regarding the need for improved resilience. As stated in the proposal, CAT models are tools for catastrophe risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities. For example, models can be used to identify high-risk areas and where proliferation of home hardening activities can improve resilience to natural hazards, including hurricane, flood, severe convective storm, tornado, wildfire, and earthquake. Such mitigation activities are critical to reduce probable losses. Lower losses over time can improve the availability and affordability of coverage in the future. Applied research utilizing CAT models can demonstrate the economic value of mitigation activities. One
description provided via public comments that we considered useful is, “conducting applied research analysis that utilizes or analyzes the potential to utilize CAT models to further public and private risk mitigation and resiliency efforts; benefits and opportunities at the individual consumer or business; or public agency at the community, regional, state, or national level.”

**Regarding conducting applied research analyses utilizing CAT models, we would like to understand the research and support expectations from the COE on modelers.**

We envision working with modelers on applied research activities as applicable. We are requesting funding to allow for modeler engagement.

**Depending on the expected level of granularity for COE work, additional questions may be relevant, such as whether the COE (NAIC/CIPR) would need to be prepared to go to a hearing to testify or respond to discovery?**

It is not anticipated that the COE would maintain granular information about individual insurer use of CAT models. The level of detail would be around the actual CAT model to provide education and training to state DOIs.

**Will the COE be used to conduct research and analysis into the markets for CAT models. Will conflicts of interest or market failures distort the use of CAT models?**

No. It is not envisioned that the COE would set out to conduct this type of research and analysis.

**Implementation Considerations**

**Topic: COE Communication of Various Results, Information, and Observations to DOIs**

**Given the complexity of models and breadth of expertise required to build and maintain them, there is a risk that any third party cannot adequately communicate the nuances and justification of models. Will the COE plan to coordinate model presentations from the modelers, rather than only relaying this information second-hand?**

Yes. The COE would plan to coordinate model presentations from modelers.

**How will information, observations, and/or questions about models be conveyed to state insurance departments? What kind of output will be generated?**

We plan to hire a relationship manager responsible for communicating with the CAT model vendors and state insurance regulators. A regulator-only technology platform will help facilitate information sharing with state insurance regulators.
Research output could take multiple forms depending upon the nature of the analysis undertaken.

**What kinds of data fields will be included? Will others provide input into the design?**

The data fields selected would be contingent on the models being used and the research project under consideration. Data fields would follow from model inputs and outputs.

**Will the COE reviews and/or output be designed to be geography-specific?**

Yes. That is possible.

**Once a model has been reviewed, what renewal process is envisioned?**

Models will not be reviewed, nor would they be posted on the state insurance regulator-only website. However, model technical documentation and information will be updated as new versions of the models are released.

**Topic: Model Vendor Intellectual Property (IP) Protection**

**How will the COE safe-guard intellectual property of the participating CAT model vendors?**

All modeling documentation, access, and usage will be centralized and monitored through the COE via legally binding data use agreements. The NAIC has an extensive track record of experience in collecting and protecting proprietary information. The actual models will not be posted on the state insurance regulator website, only the model documentation will be posted.

**Topic: Interaction with Modelers and Other External Experts**

**Will modelers engage in discussions with the COE about specific models? Do you expect insurers would be involved in model-related discussions?**

Yes. The COE would be engaged with modelers on the modeling technologies and inputs in a similar fashion as insurers and reinsurers and have access to the same modeling documentation to develop internal expertise. It is possible that insurers could be involved in model-related discussions with the COE, but the COE will not review individual insurer’s use of models.

**Is the CIPR planning to license and use modeler software or engage in paid consulting studies for their research and development of processes?**
Yes, depending on COE resources and the specific research use case. The CIPR would be willing to either license modeler software and/or engage in paid consulting studies for research and educational/training purposes, as directed by the appropriate NAIC authorities.

**How will results and underlying assumptions from licensed models be communicated to state insurance regulators?**

Any use of a licensed model, including distribution of modeled results, would be subject to the model license agreement and/or model vendor negotiated research consulting contract. Underlying assumptions from the various models utilized would be collected via the model technical documentation as part of the model vendor data use agreement. Note that it is possible that the model technical documentation, including underlying model assumptions, could be collected through a COE data use agreement without an associated model-based research project. If we were to license a model, the actual model would not be posted on the state insurance regulator-only website.

**Will modelers be involved in establishing workflows, best practices, agendas, and expectations of the COE, including timing?**

We anticipate that modelers will be actively engaged with the COE staff, advising on these items as appropriate.

**How many vendors is the COE considering supporting?**

The COE will not be “supporting” vendors, but rather the COE will collect model documentation and engage with model vendors. The COE will engage with any model vendor serving insurance markets where the information is relevant to state insurance regulators.

**Does the COE anticipate looking to external experts for some of the implementation or ongoing work?**

Yes. External collaboration would be welcome, whether that be with industry experts, public agencies, or the academic community.

**Topic: Resources - Staffing and Funding**

**How many states do you expect to be interfacing with the COE?**

The COE will be a resource of the NAIC potentially interfacing with all 56 jurisdictions.
Beyond recruiting for the identified new roles of CAT modeling relationship manager and CAT model research analyst, how many people at the NAIC/CIPR will be contributing to COE activities? Do you expect that to change over time?

The CIPR director, the NAIC solvency enterprise risk management (ERM) advisor, and potentially Property and Casualty Insurance (C) Committee staff support will have a role in supporting the work of the COE. We anticipate that additional technical and administrative support resources may be necessary as the workload and demand for services evolve with demonstrated success.

Will the staffing level proposed by the NAIC be able to provide meaningful analysis in the broad category of catastrophe modeling?

Prior to the creation of the COE, CIPR and NAIC staff have provided meaningful analysis on wildfire CAT modeling and applied wildfire resilience research. We aim to build off this success and need to start somewhere. Every little bit helps for the states, as stated by one industry commenter, “[t]he staffing issues mentioned above regarding experts at the NAIC are even larger for state insurance departments. Most states are not going to have enough or the right staff to review these models. They will have to rely on others to evaluate catastrophe model validity, and most likely will have to rely heavily on the decisions and evaluations made by others.”

Have long-term plans been prepared? Are there budget implications?

No long-term plan has been developed for the COE. The expenses associated with the COE would be subject to the NAIC budget process and have no special assessments or fees for service.
PROPOSED REDESIGNED NAIC CLIMATE RISK DISCLOSURE SURVEY

INTENT AND PURPOSE

The Climate Risk Disclosure Survey is a voluntary risk management tool for state insurance regulators to request from insurers on an annual basis a non-confidential disclosure of the insurers’ assessment and management of their climate-related risks.

The purpose of the Climate Risk Disclosure Survey is to:

- Enhance transparency about how insurers manage climate-related risks and opportunities.
- Identify good practices and vulnerabilities.
- Provide a baseline supervisory tool to assess how climate-related risks may affect the insurance industry.
- Promote insurer strategic management and encourage shared learning for continual improvement.
- Enable better-informed collaboration and engagement on climate-related issues among regulators and interested parties.
- Align with international climate risk disclosure frameworks to reduce redundancy in reporting requirements.

BACKGROUND

The NAIC adopted the original Climate Risk Disclosure Survey in 2010 and it has since been administered by the California Department of Insurance. In 2021, fifteen states participated in the climate risk disclosure survey initiative, up from six states in prior years. Because any insurer writing business in a participating state is required to submit their survey response annually, adding nine states in 2021, increased the market coverage from approximately 70% in 2020 to nearly 80% of the market in 2021 based on direct premium written.

In 2021, the Financial Stability Oversight Council (FSOC) produced a series of recommendations for financial regulators to enhance supervision, data analysis, staff resources, and regulatory cooperation related to climate risk. This included a recommendation to consider enhancing public reporting requirements for climate-related risks in a manner that builds on the four core elements of the Task Force on Climate-Related Financial Disclosure (TCFD), to the extent consistent with the U.S. regulatory framework and the needs of U.S. regulators and market participants.

This revised survey responds to FSOC’s recommendations and incorporates international best practices in adopting a TCFD aligned framework for US insurers to report on climate risks when requested by their state regulator.

The TCFD framework is structured around four thematic areas that are core elements...
for how insurers operate—governance, strategy, risk management, and metrics and targets. The four thematic areas are supported by key climate-related financial disclosures—referred to as recommended disclosures—that build out the framework with information that will help regulators and others understand how reporting organizations assess and approach climate-related issues.

**INTRODUCTORY GUIDANCE**

**Timeline and expectation for reporting**

We expect that every company who will be asked to complete the survey in 2022 will have already completed the existing NAIC survey or filed a TCFD report; nearly all companies having participated for several prior years. The table below outlines the timing and other expectations for reporting in 2022 and 2023 as the new survey is phased in. If a company has not previously responded to the NAIC survey, it should be given until 2023 to first respond.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Expectation Regarding Content</th>
<th>Deadline for Completion</th>
</tr>
</thead>
</table>
| 2022           | - If the insurer has already completed a TCFD for this reporting year, they can submit it as is.  
- If the insurer has not already completed a TCFD for this reporting year, they should make their best effort to complete the survey below or include such information in their TCFD filing, as is requested below.  
- Closed-ended questions are voluntary for 2022, and states may opt out of requesting responses to closed-ended questions. | To allow additional time for insurers to move to the new reporting structure, submission deadlines should be moved from Aug. 31 to Nov. 30. Extensions may be granted by the state that initiated the request to the company or the lead state for the group filing. |
| 2023           | Insurers are expected to address the content of the entire TCFD aligned survey below, to the best of their ability. | In accordance with prior years, submissions are due from insurers by Aug. 31st. Extensions may be granted by the state that initiated the request to the company. |

**Threshold and voluntary state participation**

The reporting threshold remains consistent with the threshold implemented each year since 2013. All insurers with countrywide premium written of at least $100 million, licensed to write in any of the participating states/territories, are required to complete and submit their survey on an annual basis. As of 2021, the following states/territories participate: California,

**Confidentiality and best effort basis**
While the existing NAIC survey and TCFD contain sufficient overlap in the analysis required to answer, we recognize that many insurers will be moving to a new reporting framework in the TCFD. Insurers should make their best effort to answer each question honestly and completely, keeping in mind that the information contained in the filing will be made public. During the transition to the TCFD aligned survey, state insurance regulators should work closely with insurers to provide as much flexibility as possible in terms of responding to the survey and deadlines. Confidential information should not be included in this public disclosure unless it is intended to be made public. If additional detail is requested by a state insurance regulator, that request will be handled directly between the regulator and insurer.

**Materiality**
There is no requirement to provide information that is immaterial to an assessment of financial soundness (insurers may choose to disclose such information voluntarily, with no implication that such information is in fact material). Insurers should justify their materiality assessment. For the definition of materiality, refer to the Financial Condition Examiners Handbook and/or the U.S. Securities and Exchange Commissioner Accounting Bulletin: No. 99, if applicable.

Consistent with TCFD guidance, the Strategy and Metrics and Targets Sections involve an assessment of materiality, except for the question on Scope 1 and Scope 2 greenhouse gas emissions within the Metrics and Targets Section. Disclosures related to Governance and Risk Management Sections do not involve an assessment of materiality.

**Assessing financial impact of climate-related risks and opportunities**
The financial impacts of climate-related issues on an insurer are driven by the specific climate-related risks and opportunities to which the insurer is exposed and its strategic and risk management decisions on seizing those opportunities and managing those risks (i.e., accept, avoid, pursue, reduce, or share/transfer). Once an insurer assesses its climate-related issues and determines its response to those issues, it can then consider actual and potential financial impacts on revenues, expenditures, assets and liabilities, and capital and financing.1

Consistent with the TCFD Guidelines, determining whether an individual organization is or may be affected financially by climate-related issues usually depends on:

- the organization’s exposure to, and anticipated effects of, specific climate-related risks and opportunities;
- the organization’s planned responses to manage (i.e., accept, avoid, pursue, reduce, or share/transfer) its risks or seize opportunities; and

• the implications of the organization’s planned responses on its income statement, cash flow statement, and balance sheet.\(^2\)

Importantly, an organization should assess its climate-related risks and opportunities within the context of its businesses, operations, and physical locations in order to determine potential financial implications. In making such an assessment, an organization should consider (1) current and anticipated policy constraints and incentives in relevant jurisdictions, technology changes and availability, and market changes and (2) whether an organization’s physical locations or suppliers are particularly vulnerable to physical impacts from climate change.\(^3\)


**ADDITIONAL SPECIFIC GUIDANCE**

One of the several benefits of aligning with the TCFD is that it allows insurers to benefit from years of guidance and supporting material developed and being regularly updated by the TCFD and other organizations.

For those insurers new to TCFD reporting, the [Implementation Recommendation Report](https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf) provides a useful guide. It contains guidance for all sectors on each of the four thematic areas of governance, strategy, risk management and metrics and targets. For example, in relation to the risk management disclosure to describe the insurers’ processes for identifying and assessing climate-related risks, it provides the following guidance:

<table>
<thead>
<tr>
<th>Organizations should describe their risk management processes for identifying and assessing climate-related risks. An important aspect of this description is how organizations determine the relative significance of climate-related risks in relation to other risks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations should describe whether they consider existing and emerging regulatory requirements related to climate change (e.g., limits on emissions) as well as other relevant factors considered.</td>
</tr>
<tr>
<td>Organizations should also consider disclosing the following:</td>
</tr>
<tr>
<td>- processes for assessing the potential size and scope of identified climate-related risks and</td>
</tr>
<tr>
<td>- definitions of risk terminology used or references to existing risk classification frameworks used.(^4)</td>
</tr>
</tbody>
</table>

\(^2\) [https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf](https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf), pg.10

\(^3\) [https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf](https://assets.bbhub.io/company/sites/60/2021/07/2021-TCFD-Implementing_Guidance.pdf), pg. 11

The same document also provides supplemental insurance-sector specific guidance. For example, for the same disclosure question, it provides:

<table>
<thead>
<tr>
<th>Insurance companies should describe the processes for identifying and assessing climate-related risks on re-/insurance portfolios by geography, business division, or product segments, including the following risks:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- physical risks from changing frequencies and intensities of weather-related perils;</td>
</tr>
<tr>
<td>- transition risks resulting from a reduction in insurable interest due to a decline in value, changing energy costs, or implementation of carbon regulation; and</td>
</tr>
<tr>
<td>- liability risks that could intensify due to a possible increase in litigation.5</td>
</tr>
</tbody>
</table>

Notably, this general and supplemental guidance is not required to be included in a TCFD report. Rather, it is designed to support an insurer in developing climate-related financial disclosures consistent with the TCFD framework, including by providing context and suggestions for implementing the recommended disclosures.

The disclosures identified in bullet points in this survey are intended to be supplemental, insurance-sector specific guidance. They have been developed by the NAIC to respond to the TCFD and FSOC recommendations that regulators enhance public reporting requirements for climate-related risks in a manner that builds on the TCFD’s four core elements. They are designed to further support insurers’ in developing their disclosures by providing context and suggestions for the information a regulator may expect.

Additional guidance published by the TCFD includes:

**The Use of Scenario Analysis in Disclosure of Climate-Related Risks and Opportunities** (2017) provides information on types of climate-related scenarios, the application of scenario analysis, and the key challenges in implementing scenario analysis to support an organization’s disclosure of the resilience of its strategy, taking into consideration different climate-related scenarios.

**Guidance on Risk Management Integration and Disclosure** (2020) describes considerations for organizations interested in integrating climate-related risks into their existing risk management processes and disclosing information on their risk management processes in alignment with the Task Force’s recommendations.

**Guidance on Metrics, Targets, and Transition Plans** (2021) describes recent developments around climate-related metrics and users’ increasing focus on information describing organizations’ plans for transitioning to a low-carbon economy. The guidance also describes a set of cross-industry, climate related metric categories (described in Appendix 2: Cross-Industry, 5

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Climate-Related Metric Categories) that the Task Force believes are applicable to all organizations.

The FSB frequently produces content to assist companies in creating TCFD reports, the knowledge hub with related content is accessible at [https://www.tcfdhub.org/](https://www.tcfdhub.org/).

**SURVEY QUESTIONS**

To provide clear direction for achieving a robust, insurance-sector specific TCFD report, narrative and closed ended questions follow, grouped into the TCFD’s four topics: governance, strategy, risk management and metrics and targets.

The statements listed next to numbers and letters are directly taken from the TCFD Framework and should be fully addressed in the insurer’s response. As discussed in detail above, insurers should consider including the bulleted items in their response to the TCFD statement above it. For additional guidance on sector specific content to consider including, refer to the [Implementation Recommendation Report](https://www.tcfdhub.org/).

**Governance**

1. **Disclose the insurer’s governance around climate-related risks and opportunities.**

   In disclosing the insurer’s governance around climate-related risks and opportunities insurers should consider including the following:
   - Identify and include any publicly stated goals on climate-related risks and opportunities.
   - Describe where climate-related disclosure is handled within the insurer’s structure, e.g., at a group level, entity level, or a combination. If handled at the group level, describe what activities are undertaken at the company level.
     A. **Describe the board and/or committee responsible for the oversight of climate-related risks and opportunities.**

   In describing the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks, insurers should consider including the following:
   - Describe the position on the board and/or committee responsible for the oversight of managing the climate-related financial risks.

2. **Describe management’s role in assessing and managing climate-related risks and opportunities.**

   In disclosing the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy, and financial planning where such information is material.

   In disclosing the actual and potential impacts of climate-related risks and opportunities on the insurer’s businesses, strategy and financial planning, insurers should consider including the following:
   - Describe the steps the insurer has taken to engage key constituencies on the topic of climate risk and resiliency.*
Describe the insurer's plan to assess, reduce, or mitigate its greenhouse gas emissions in its operations or organizations.*

A. Describe the climate-related risks and opportunities the insurer has identified over the short, medium, and long term.

In describing the climate-related risks and opportunities the insurer has identified over the short, medium, and longer term, insurers should consider including the following:

- Define short, medium, and long-term, if different than 1-5 years as short term, 5-10 years as medium term, and 10-30 years as long term.

B. Describe the impact of climate-related risks and opportunities on the insurer's business, strategy, and financial planning.

In describing the impact of climate-related risks and opportunities on the insurer's business, strategy, and financial planning, insurers should consider including the following:

- Discuss if and how the insurer provides products or services to support the transition to a low carbon economy or helps customers adapt to climate-related risk.
- Discuss if and how the insurer makes investments to support the transition to a low carbon economy.

C. Describe the resilience of the insurer's strategy, taking into consideration different climate-related scenarios, including a 2 degree Celsius or lower scenario.

Risk Management

3. Disclose how the insurer identifies, assesses, and manages climate-related risks.

In disclosing how the insurer identifies, assesses, and manages climate-related risks, insurers should consider including the following:

- Describe how the insurer considers the impact of climate-related risks on its underwriting portfolio, and how the company is managing its underwriting exposure with respect to physical, transition and liability risk.*
- Describe any steps the insurer has taken to encourage policyholders to manage their potential physical and transition climate-related risks, if applicable.*
- Describe how the insurer has considered the impact of climate-related risks on its investment portfolio, including what investment classes have been considered.*

A. Describe the insurers’ processes for identifying and assessing climate-related risks.

In describing the insurers’ processes for identifying and assessing climate-related risks, insurers should consider including the following:

- Discuss whether the process includes an assessment of financial implications and how frequently the process is completed.*

B. Describe the insurer’s processes for managing climate-related risks.

C. Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management.
In describing how processes for identifying, assessing, and managing climate-related risks are integrated into the insurer’s overall risk management, insurers should consider including the following:

- Discuss whether climate-related risks are addressed through the insurer’s general enterprise-risk management process or a separate process and how frequently the process is completed.
- Discuss the climate scenarios utilized by the insurer to analyze its underwriting risks, including which risk factors the scenarios consider, what types of scenarios are used, and what timeframes are considered.
- Discuss the climate scenarios utilized by the insurer to analyze risks on its investments, including which risk factors are utilized, what types of scenarios are used, and what timeframes are considered.

Metrics and Targets

4. Disclose the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material.

In disclosing the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material, insurers should consider including the following:

- Discuss how the insurer uses catastrophe modeling to manage the climate-related risks to your business. Please specify for which climate-related risks the insurer uses catastrophe models to assess, if any.
  A. Disclose the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process.

In disclosing the metrics used by the insurer to assess climate-related risks and opportunities in line with its strategy and risk management process, insurers should consider including the following:

- In describing the metrics used by the insurer to assess and monitor climate risks, consider the amount of exposure to business lines, sectors, and geographies vulnerable to climate-related physical risks [answer in absolute amounts and percentages if possible], alignment with climate scenarios, [1 in 100 years probable maximum loss, Climate VaR, carbon intensity], and the amount of financed or underwritten carbon emissions)
  B. Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.
  C. Describe the targets used by the insurer to manage climate-related risks and opportunities and performance against targets.
Closed-ended questions directly correspond to the narrative above, allowing for explanation and qualification of the yes/no answers. Closed-ended questions are voluntary for reporting year 2022 and individual states may elect not to request them.

**Governance**
- Does the insurer have publicly stated goals on climate-related risks and opportunities? (Y/N)
- Does your board have a member, members, a committee, or committees responsible for the oversight of managing the climate-related financial risk? (Y/N)
- Does management have a role in assessing climate-related risks and opportunities? (Y/N)
- Does management have a role in managing climate-related risks and opportunities? (Y/N)

**Strategy**
- Has the insurer taken steps to engage key constituencies on the topic of climate risk and resiliency? (Y/N) *
- Does the insurer provide products or services to support the transition to a low carbon economy or help customers adapt to climate risk? (Y/N)
- Does the insurer make investments to support the transition to a low carbon economy? (Y/N)
- Does the insurer have a plan to assess, reduce or mitigate its greenhouse gas emissions in its operations or organizations? (Y/N)*

**Risk Management**
- Does the insurer have a process for identifying climate-related risks? (Y/N)
  - If yes, are climate-related risks addressed through the insurer’s general enterprise-risk management process? (Y/N)
- Does the insurer have a process for assessing climate-related risks? (Y/N)
  - If yes, does the process include an assessment of financial implications? (Y/N)
- Does the insurer have a process for managing climate-related risks? (Y/N)
- Has the insurer considered the impact of climate-related risks on its underwriting portfolio? (Y/N/Not Applicable)*
- Has the insurer taken steps to encourage policyholders to manage their potential climate-related risks? (Y/N)*
- Has the insurer considered the impact of climate-related risks on its investment portfolio? (Y/N)*
- Has the insurer utilized climate scenarios to analyze their underwriting risk? (Y/N)
- Has the insurer utilized climate scenarios to analyze their investment risk? (Y/N)

**Metrics and Targets**
- Does the insurer use catastrophe modeling to manage your climate-related risks? (Y/N)
- Does the insurer use metrics to assess and monitor climate-related risks? (Y/N)
- Does the insurer have targets to manage climate-related risks and opportunities? (Y/N)
- Does the insurer have targets to manage climate-related performance? (Y/N)
2022ProposedClimateRiskSurvey

* Asterisks represent questions derived from the original Climate Risk Disclosure Survey.
Date: 4/7/22

2022 Spring National Meeting
Kansas City, Missouri

Report of the Life Insurance and Annuities (A) Committee

The Life Insurance and Annuities (A) Committee met April 7, 2022. During this meeting, the Committee:

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted the report of the Accelerated Underwriting (A) Working Group, including its interim meeting minutes and the Accelerated Underwriting in Life Insurance Educational Report.


4. Heard an update from the Annuity Suitability (A) Working Group and learned that although 21 states have adopted the best interest revisions to the Suitability in Annuity Transactions Model Regulation (#275) and seven states have state insurance regulations pending, adoption by the remaining states remains a priority. The Working Group plans to meet in May to continue work on a Frequently Asked Questions (FAQ) document to promote greater uniformity in the adoption of Model #275.

5. Adopted the report of the Life Actuarial (A) Task Force.

6. Discussed having the Life Insurance Online Guide (A) Working Group focus on updating life insurance information on the NAIC website.

7. Heard a brief update from Workstream Four of the Special (EX) Committee on Race and Insurance that it hopes to focus on marketing and distribution in underserved communities.
Date: 4/7/22

2022 Spring National Meeting
Kansas City, Missouri

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

The Health Insurance and Managed Care (B) Committee met April 7, 2022. During this meeting, the Committee:

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted the report of the Consumer Information (B) Subgroup, which met March 22. During this meeting, the Subgroup took the following action:
   A. Discussed potential work for 2022.
   B. Heard a presentation on consumer understanding of surprise medical bills.

3. Adopted the report of the Health Innovations (B) Working Group, which met April 4 and took the following action:
   A. Adopted its 2021 Fall National Meeting minutes.
   B. Heard a presentation from the federal Centers for Medicare & Medicaid Services (CMS) on its approach to the expected end of the COVID-19 public health emergency.
   C. Heard presentations from the Oregon Health Authority (OHA) and the Massachusetts Health Connector about state preparations for the expected end of the COVID-19 public health emergency.
   D. Heard a presentation from consumer representatives on suggested priorities to protect underserved consumers after the expected end of the COVID-19 public health emergency.
   E. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on updates to its research on the health disparity impacts of telehealth services and alternative payment models.

4. Adopted the report of the Health Actuarial (B) Task Force.

5. Adopted the report of the Regulatory Framework (B) Task Force.

6. Adopted the report of the Senior Issues (B) Task Force.

7. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the implementation of the federal No Surprises Act (NSA) since its Jan. 1 launch date. The update highlighted the CMS’s activities supporting the implementation and enforcement of the NSA, including a No Surprises Help Desk and other web resources, such as frequently asked questions (FAQ) documents.

8. Adjourned into a regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
The Property and Casualty Insurance (C) Committee met April 7, 2022. During this meeting, the Committee:

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted the following task force and working group reports:
   A. Casualty Actuarial and Statistical (C) Task Force.
   B. Surplus Lines (C) Task Force.
   C. Title Insurance (C) Task Force.
   D. Workers’ Compensation (C) Task Force.
   E. Cannabis Insurance (C) Working Group.
   F. Catastrophe Insurance (C) Working Group.
   G. Terrorism Insurance Implementation (C) Working Group.

3. Adopted revised charges reappointing the Pet Insurance (C) Working Group with the charge to “Complete the development of a model law to establish appropriate regulatory standards for the pet insurance industry.”


5. Heard a presentation from NAIC staff on private passenger auto (PPA) insurance results over the past 10 years.

6. Heard a presentation from Susanna Gotsch (CCC Intelligent Solutions) and Robert Hartwig (University of South Carolina) regarding inflationary pressures in the property/casualty (P/C) insurance industry.


8. Heard an update from Peter Kochenburger (University of Connecticut School of Law) on a recent ordinance in San Jose, CA, requiring liability insurance for gun owners.
Date: 4/7/22

2022 Spring National Meeting
Kansas City, Missouri

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

The Market Regulation and Consumer Affairs (D) Committee met April 7, 2022. During this meeting, the Committee:

1. Adopted its 2021 Fall National Meeting minutes.

2. Adopted its revised 2022 charges. The Privacy Protections (D) Working Group will be reporting to the Innovation, Cybersecurity, and Technology (H) Committee; the Speed to Market (H) Working Group will be reporting to the Market Regulation and Consumer Affairs (D) Committee; the Advisory Organization Oversight Examination (D) Working Group name was shortened to the Advisory Organization (D) Working Group; and the Antifraud Education Enhancement (D) Working Group is disbanded.

3. Adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Advisory Organization Examination Oversight (D) Working Group; the Market Analysis Procedures (D) Working Group; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Guidelines (D) Working Group; the Market Regulation Certification (D) Working Group; the Privacy Protections (D) Working Group; and the Speed to Market (D) Working Group. The reports included the following items of significance:
   A. Heard an update from the Market Information System (D) Task Force on its report of recommendations regarding the incorporation of artificial intelligence (AI) in the NAIC market information systems (MIS).
   B. Heard an update from the Market Conduct Annual Statement Blanks (D) Working Group that the Other Health Market Conduct Annual Statement (MCAS) Data Call and Definitions is being exposed on the Working Group’s web page. The Working Group anticipates adopting the blank prior to June 1.
   C. Heard an update from the Market Regulation Certification (D) Working Group on the status of the Voluntary Market Regulation Certification Program. The Working Group expects to complete its work by the 2022 Fall National Meeting.
   D. Heard an update from the Advisory Organization Examination Oversight (D) Working Group that it is beginning discussion on advisory organizations that offer telematics services.

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Report of the Financial Condition (E) Committee

The Financial Condition (E) Committee met April 5, 2022. During this meeting, the Committee:

1. Adopted its Jan. 12, 2022, and 2021 Fall National Meeting minutes, which included the following action:
   A. Adopted the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation.
   B. Adopted the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers.
   C. Exposed a request for comment suggesting a revised approach to risk-based capital (RBC) requirements for structured securities and other asset backed securities (ABS).

2. Adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force, the Capital Adequacy (E) Task Force, the Financial Stability (E) Task Force, the Reinsurance (E) Task Force, the Valuation of Securities (E) Task Force, the Group Capital Calculation (E) Working Group, the Restructuring Mechanisms (E) Working Group, and the National Treatment and Coordination (E) Working Group.

3. Received an extension request from the Mortgage Guaranty Insurance (E) Working Group on its work on the Mortgage Guaranty Insurance Model Act (#630).

4. Received an update on certain committee-supported initiatives related to low interest rates and asset risk.

Note: Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial—will be considered for adoption by the Executive (EX) Committee and Plenary through the Financial Condition (E) Committee’s technical changes report process. Pursuant to this process, which was adopted by the NAIC in 2009, a listing of the various technical changes will be sent to the NAIC members shortly after completion of the Fall National Meeting, and the members will have 10 days to comment with respect to those items. If no objections are received with respect to a particular item, the technical changes will be considered adopted by the NAIC membership and effective immediately.
Date: 4/6/22

2022 Spring National Meeting  
Kansas City, Missouri

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

The Financial Regulation Standards and Accreditation (F) Committee met April 4, 2022, in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Alabama, Mississippi, and North Carolina.

The Financial Regulation Standards and Accreditation (F) Committee met April 5, 2022. During this meeting, the Committee:

1. Adopted its 2021 Summer National Meeting minutes.

2. Adopted, immediately by reference, revisions made during 2021 to NAIC publications that are required for accreditation purposes (e.g., the Accounting Practices and Procedures Manual [AP&P Manual]) and were deemed insignificant. Exposed an update to the examination coordination guidelines recommended by the Financial Examiners Handbook (E) Technical Group for a 30-day public comment period ending May 6.

3. Exposed the 2021 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to be acceptable for accreditation but not required for a 30-day public comment period ending May 6. The revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership.

4. Exposed the proposed updates to the Preamble of the Accreditation Program Manual to reference VM-21, Requirements for Principle-Based Reserves for Variable Annuities, for a 30-day public comment period ending May 6. The proposed revisions serve as a reference for how captives that reinsure variable annuity business are addressed in the accreditation standards.
Date: 4/7/22

2022 Spring National Meeting
Kansas City, Missouri

Report of the International Insurance Relations (G) Committee

The International Insurance Relations (G) Committee met April 7, 2022. During this meeting, the Committee:

1. Adopted its Jan. 18, 2022, and 2021 Fall National Meeting minutes.

2. Discussed international efforts on sustainability and climate, including a presentation by the Sustainable Insurance Forum (SIF) on its mission and workstreams and by Liberty Mutual on how it is addressing these issues.

3. Heard an update on recent activities and priorities of the International Association of Insurance Supervisors (IAIS), including: 1) the comparability assessment process for the aggregation method (AM); 2) an update on the targeted jurisdictional assessments (TJAs) as part of the implementation of the holistic framework; 3) recommendations from the Climate Risk Steering Group; and 4) a survey of membership on diversity, equity, and inclusion (DE&I) initiatives.

4. Heard an update on international activities, including: 1) recent and upcoming meetings, events, and speaking engagements with international regulators; 2) the Spring 2022 International Fellows Virtual Program; and 3) upcoming meetings and participation in workstreams at the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee.
Report of the International Insurance Relations (H) Committee

The Innovation, Cybersecurity, and Technology (H) Committee met April 5, 2022. During this meeting, the Committee:

1. Adopted structural and charge revisions, which included the following action:
   A. Moved the Speed to Market (H) Working Group to the Market Regulation and Consumer Affairs (D) Committee.
   B. Moved the Privacy Protections (D) Working Group from the Market Regulation and Consumer Affairs (D) Committee to the Innovation, Cybersecurity, and Technology (H) Committee.
   C. Modified the charge to the Privacy Protections (H) Working Group to add the words “data ownership and use rights” to the charge.
   D. Appointed a new working group, the Innovation in Technology and Regulation (H) Working Group, and adopted proposed charges.

2. Adopted the report of the Big Data and Artificial Intelligence (H) Working Group, including its 2022 work plan including the following workstreams:
   A. Complete survey work including analysis of the private passenger auto (PPA) artificial intelligent (AI)/machine learning (ML) survey results and development of a homeowners and life insurance AI/ML survey.
   B. Analyze third-party vendors providing data and AI/ML models in the insurance industry.
   C. Gather data and evaluate information on governance models/frameworks and software tools/resources from various sources, including vendors, academics, industry, and international supervisory authorities. This could assist state insurance regulators in overseeing and monitoring industry’s use of data and AI/ML and eliminate unintended bias in such use.
   D. Determine how to implement the expectations outlined in the NAIC AI Principles and provide suggestions on next steps, which could include regulatory guidance such as model governance.
   E. Received a report on the status of the AI/ML survey work.

3. Adopted the report of the Cybersecurity (H) Working Group, which met March 23 and took the following action:
   A. Reviewed its charges and discussed potential projects including:
      i. The development of a cybersecurity response plan to aid state insurance regulators in situations where cybersecurity events take place within the insurance industry.
      ii. The development of a cybersecurity survey to better understand cybersecurity practices by insurers.
      iii. The development of cybersecurity-related training that would be beneficial to state insurance regulators.
   B. Heard a report on state, federal, and international cybersecurity efforts.
4. Adopted the report of the E-Commerce (H) Working Group, which met March 30 and took the following action:
   A. Heard a summary of the recent state and industry surveys regarding the federal Uniform Electronic Transactions Act (UETA), actions taken by states regarding e-commerce both during and because of the COVID-19 pandemic, and industry concerns and recommendations moving forward with electronic commerce.
   B. Discussed its overall work plan and timelines moving forward.

5. Received a report on the Casualty Actuarial and Statistical (C) Task Force predictive model review process. The report included an update on the Task Force’s meetings on rate filing issues and its predictive analytics webinars called the “Book Club.” The Task Force has reviewed 54 rate models and produced 127 reports to assist state insurance regulators with model reviews.

6. Received a report from the Privacy Protections (D) Working Group, which met April 4 and took the following action:
   A. Heard updates on state and federal privacy legislation.
   B. Discussed comments received from the American Council of Life Insurers (ACLI) and the Health Coalition on the Working Group’s 2022 work plan.

7. Discussed various Committee-level projects, including:
   A. The creation of a new Collaboration Forum that will serve as a platform for multiple NAIC committees to work together to identify and address foundational issues and develop a common framework that can inform the specific workstreams in each group. The first Collaboration Forum will be on algorithmic bias.
   B. The development of a portal or library of resources related to innovation, cybersecurity, data and consumer privacy, and technology tentatively called the “ICT-Hub.”
   C. The creation of a forum to facilitate training and education of state insurance regulators on innovation and technology topics, suptech issues, and potential ways that data and technology might affect the insurance sector in the future.

8. Received an update on implementation of the Insurance Data Security Model Law (#668) and the Unfair Trade Practices Act (#880) revised language specific to rebating.
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

- Amendments to the *Unfair Trade Practices Act* (#880)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. Two states have enacted the revisions to this model.

Life Insurance and Annuities (A) Committee

- Amendments to the *Annuity Disclosure Model Regulation* (#245)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Suitability in Annuity Transactions Model Regulation* (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. Seven states have enacted the revisions to the model.

- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 14 states have adopted the revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Health Maintenance Organization Model Act* (#430)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.

- Amendments to the *Insurance Holding Company System Regulatory Act* (#440)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Seven states have adopted the revisions to this model.

- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Two states have adopted the revisions to this model.
Property and Casualty Insurance (C) Committee

- Adoption of the *Real Property Lender-Placed Insurance Model Act* (#631)—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

Financial Condition (E) Committee

- Amendments to the *Credit for Reinsurance Model Law* (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019, conference call. 47 states have enacted this model.

- Amendments to the *Credit for Reinsurance Model Regulation* (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019, conference call. 31 states have enacted this model.