EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Aug. 17, 2021, Minutes

Adopted the Amendments to 2021 Proposed Charges (Attachment One)
Adopted the Amendments to the Valuation Manual (Attachment Two)
Adopted the Amendments to the Annuity Disclosure Model Regulation (#245) (Attachment Three)
Failed to Adopt the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBM) (Attachment Four)
Adopted the Guideline for Definition of Reciprocal State in Receivership Laws (Attachment Five)
Adopted the Revised Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions (Attachment Six)
Adopted the Amendments to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) (Attachment Seven)
Adopted the Amendments to the Process for Evaluating Qualified and Reciprocal Jurisdictions (Attachment Eight)
Report on States’ Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Nine)
The Executive (EX) Committee and Plenary met in Columbus, OH, Aug. 17, 2021. The following members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Reyn Norman (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Bryant Henley (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida (HI); Doug Omnen (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by My Chi To (NY); Judith L. French represented by Carrie Haughawout (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

1. **Adopted the Report of the Executive (EX) Committee**

Commissioner Altmaier reported that the Executive (EX) Committee met Aug. 15 and adopted the Aug. 13 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Executive (EX) Committee adopted the report of the Executive (EX) Committee, which met July 13, June 29, and May 20 and took the following action: 1) discussed creating a new standing Committee on Innovation, Technology, and Cybersecurity; 2) received a mid-year financial update and an overview of the preliminary 2022 budget; 3) adopted the Audit Committee report, including the 2020/2021 Service Organization Control (SOC) reports; 4) adopted the Internal Administration (EX1) Subcommittee’s May 13 minutes; and 5) approved a Fiscal for the Solvency Workpaper Software Modernization Project – Implementation Preparation Phase.

The Executive (EX) Committee adopted the reports of its task forces: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force; 4) the Long-Term Care Insurance (EX) Task Force; and 5) the Special (EX) Committee on Race and Insurance.

The Executive (EX) Committee discussed the potential formation of a standing “H” committee to address issues concerning innovation, technology, and cybersecurity.

The Executive (EX) Committee received a status report on the NAIC State Ahead strategic plan implementation.

The Executive (EX) Committee 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 Annuity Disclosure Model Regulation (#245); 3) the Insurance Holding Company System Regulatory Act (#440); 4) the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450); 5) the Life Insurance Disclosure Model Regulation (#580); 6) the Nonadmitted Insurance Model Act (#870); and 7) new models, including the Pet Insurance Model Law and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

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

Director Cameron made a motion, seconded by Director Farmer, to adopt the Aug. 15 report of the Executive (EX) Committee. The motion passed unanimously.
2. **Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Spring National Meeting**

Director Cameron made a motion, seconded by Director Farmer, to adopt by consent the committee, subcommittee, and task force minutes of the Spring National Meeting. The motion passed unanimously.

3. **Adopted Amendments to 2021 Proposed Charges**

Commissioner Mais made a motion, seconded by Director Lindley-Myers, to adopt the amendments to the Special (EX) Committee on Race and Insurance, the Regulatory Framework (B) Task Force, the Antifraud (D) Task Force, and the Financial Stability (E) Task Force charges (Attachment One). The motion passed unanimously.

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

Commissioner Caride reported that the Life Insurance and Annuities (A) Committee met Aug. 16. During this meeting, the Committee adopted its July 19 minutes, which included the following action: 1) adopted its June 30 minutes, which included appointing the Index-Linked Variable Annuity (A) Subgroup; 2) adopted its Spring National Meeting minutes; 3) adopted a frequently asked questions (FAQ) guidance document to assist the states as they move forward with adopting the revisions to the *Suitability in Annuity Transactions Model Regulation* (#275); and 4) adopted a package of 15 *Valuation Manual* amendments.

The Committee adopted the report of the Accelerated Underwriting (A) Working Group, including its July 29 minutes. During this meeting, the Working Group discussed the latest draft of the accelerated underwriting educational report.

The Committee adopted the report of the Life Actuarial (A) Task Force. During this meeting, the Task Force exposed the Society of Actuaries (SOA) 2022 Generally Recognized Expense Table (GRET).

The Committee discussed the next steps for the Life Insurance Illustration Issues (A) Working Group. The Committee asked Richard Wicka (WI) to develop a chair report for its review at the Fall National Meeting. The chair report will detail the work of the group and include a summary of comments that have been received and incorporated into its work product over the years. The Committee will review the report and provide guidance to the Working Group on next steps at the Fall National Meeting.

The Committee heard an update from Workstream Four of the Special (EX) Committee on Race and Insurance. The Workstream intends to convene regular meetings starting in September to achieve its charges/goals.

5. **Adopted Amendments to the *Valuation Manual***

Commissioner Caride reported that a package of 15 *Valuation Manual* amendments was adopted by the Life Insurance and Annuities (A) Committee during its July 19 meeting. Most of these amendments provide technical clarifications and guidance to existing requirements in the *Valuation Manual*.

There are two amendments that are more substantive in nature: 1) Amendment Proposal Form (APF) 2020-09, which modifies the Life Principle-Based Reserving (PBR) Exemption to allow a company that received commissioner approval for the exemption in the prior year to retain its exemption if it meets certain requirements, and not require VM-20, Requirements for Principle-Based Reserves for Life Products, when all new issues arise due to policyholder conversions; and 2) APF 2020-10 (Attachment Two), which allows the use of future mortality improvement beyond the valuation date.

Commissioner Caride made a motion, seconded by Commissioner Donelon, to adopt the package of *Valuation Manual* amendments, excluding APF 2020-10. The motion was adopted by 51 jurisdictions, representing 97.81% of the applicable premiums written.

Commissioner Caride made a motion, seconded by Commissioner Mulready, to adopt APF 2020-10 as an amendment to the *Valuation Manual*. The motion was adopted by 48 jurisdictions, representing 88.75% of the applicable premiums written, with Louisiana, New Mexico, and New York opposed. Commissioner Altmaier confirmed that both votes satisfied the requirements to amend the *Valuation Manual*. 
6. **Adopted Amendments to the Annuity Disclosure Model Regulation (#245)**

Commissioner Caride reported that the amendments to Model #245 were adopted unanimously by the Life Insurance and Annuities (A) Committee at the 2018 Summer National Meeting. Under the current model, the illustration of “non-guaranteed elements” are prohibited. This prohibition could be construed to include participating income annuities because of the formula used to calculate the dividend scale. These amendments allow for the illustration of participating income annuities. At the time these amendments were adopted, the Committee was working on additional revisions to Model #245 to allow, under certain circumstances, the illustration of indices in existence for fewer than 10 years, which is prohibited under Model #245. At that time, the Committee decided to hold the participating income annuity amendments at the Committee level, pending resolution of the indices issue with the intent to move all amendments to Model #245 at one time.

During the Spring National Meeting, the Committee voted to disband the Annuity Disclosure (A) Working Group working on these additional indices amendments, as it was still unable, after many years, to reach consensus.

Commissioner Caride made a motion, seconded by Commissioner Ommen, to adopt the participating income annuity revisions to Model #245 (Attachment Three). The motion passed with California abstaining, noting that California laws are stronger than Model #245, and New York opposing.

Executive Deputy Superintendent To noted that New York would be voting no because “this particular amendment allows insurers to show in their illustrations of expected dividends an assumption of an increase in interest rates over time to a long-term average, which would always be the case even if interest rates were below that average. Illustrations should be a means of showing consumers how a given product works and should not be a means of competition between companies, assuming an increase in interest rates in these illustrations is misleading to consumers.”

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

Commissioner Godfread reported that the Health Insurance and Managed Care (B) Committee met Aug. 16. During this meeting, the Committee adopted its June 22 and Spring National Meeting minutes, which included the following action: 1) adopted the PBM Model; and 2) forwarded the PBM Model to the Executive (EX) Committee and Plenary to consider adoption.

The Health Insurance and Managed Care (B) Committee adopted the report of the Consumer Information (B) Subgroup, which met July 1 and May 25. During these meetings, the Subgroup took the following action: 1) discussed a plan to complete several short consumer guides on the claims process; and 2) discussed draft claims process-related guides; i.e., appeals process, medical necessity, explanation of benefits (EOBs), claims filing, and billing codes. The Subgroup agreed to consider and make proposed edits to the guides over the next few weeks.

The Committee adopted the report of the Health Innovations (B) Working Group, which met July 27. During this meeting, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) discussed its approach to fulfilling charges received from the Special (EX) Committee on Race and Insurance; 3) heard presentations on hospital price transparency requirements from the federal Centers for Medicare & Medicaid Services (CMS) and insurer price transparency requirements from the CMS Center for Consumer Information and Insurance Oversight (CCIIIO); 4) heard a presentation from FAIR Health on its research and resources related to health care price transparency; and 5) heard a presentation from Consumers’ Checkbook on ways to make health care price information relevant and understandable for consumers.

The Committee adopted the report of the Regulatory Framework (B) Task Force and the Senior Issues (B) Task Force.

The Committee heard a presentation from Jeff Wu (CCIIIO) on the Biden administration’s federal legislative and administrative initiatives and priorities. The presentation included a discussion of the administration’s plans on working with the states with respect to the implementation and enforcement of the provider provisions of the federal No Surprises Act (NSA).

The Committee heard a panel discussion from Molly Smith (American Hospital Association—AHA), Emily Carroll (American Medical Association—AMA), and Melanie de Leon (Federation of State Medical Boards—FSMB) regarding the implementation and enforcement of the NSA’s provider requirements.

The Committee received an update on the work of the Special (EX) Committee on Race and Insurance Workstream Five. The Workstream met July 8 and June 10. During these meetings, the Workstream discussed data collection issues, provider network,
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provider directories, and cultural competency. Based on its discussions on data collection, the Workstream released a draft “best practices” document for a public comment period ending Aug. 19. The Workstream plans to discuss any comments received on the draft document during its Aug. 26 meeting. The Workstream anticipates developing a similar “best practices” document on provider network, provider directories, and cultural competency.

8. Considered for Adoption the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs)

Commissioner Godfread reported that work to develop the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs) began in 2019 to develop an NAIC model providing state departments of insurance (DOIs) direct authority to regulate PBMs rather than to regulate indirectly through the insurer. This regulatory approach stems from the expanding role of PBMs in the prescription drug supply chain, the resulting impact on consumer access to prescription drugs, and their affordability.

After many meetings and extensive and robust discussions with stakeholders about the proposed model, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup completed work on the model and adopted it in October 2020.

After exposing the proposed model for an additional public comment period, the Regulatory Framework (B) Task Force adopted it in March. The Health Insurance and Managed Care (B) Committee deferred action on the model during the Spring National Meeting because of questions about a proposed drafting note, which provided statutory citations to state laws regulating various PBM business practices.

The Subgroup included this note as a compromise, as some states wanted the model to focus only on PBM licensing and registration provisions, and other states wanted to include substantive provisions addressing certain PBM business practices. The Subgroup also believed there was a lack of national consensus regarding the regulation of these PBM business practices to include in the model’s substantive provisions.

In June, the Committee reconvened to consider adoption of the model. During this meeting, concerns were raised about the potential of a lack of uniformity in adoption by the states—a key component of the NAIC model law development procedures—if states selected different provisions from this proposed drafting note to include in their state law.

Given this concern, some stakeholders suggested that the drafting note was not the appropriate approach to take and instead suggested that a charge be given to the Subgroup to develop a white paper that would examine current and emerging state laws related to the PBM business practices outlined in the drafting note.

Based on these discussions, during its June 22 meeting, the Committee deleted the proposed drafting note and adopted the model.

The Committee took this action as well because the Task Force adopted a charge for the Subgroup to develop a white paper just prior to the Committee’s June 22 meeting. The white paper will explore existing and emerging state laws on PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing and discuss the implications of the Rutledge vs. Pharmaceutical Care Management Association (PCMA) court decision on such business practices.

At its core, this model is a licensure model that state DOIs can use to directly regulate PBMs. Sections 1 through 4 set out the model’s purpose, scope, and definitions. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals. Section 6—Gag Clauses and Other Pharmacy Benefit Managers Prohibited Practices includes language related to gag clauses and information-sharing for the purposes of enforcement. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model. Section 8—Regulations provides that the commissioner may promulgate regulations relating to PBMs that are not inconsistent with the model.

Commissioner Altmaier stated that a model shall only be presented to the Executive (EX) Committee and Plenary for consideration if a minimum two-thirds majority of the responsible parent committee has voted to adopt the model. A member’s vote based on whether he or she will make efforts to have the model introduced in his or her respective state legislature or the law in his or her state already meets or exceeds the minimum national standard set by the model.

Commissioner Schmidt noted that Kansas will be voting “no” on adoption of this PBM model because “as seen in the minutes and materials that came out of the drafting group, including the notes and summary of the issues that the drafting group addressed but did not come to consensus on and the action of the Committee to remove the contentious drafting note, the model law we are voting on does not address the issues that many states are interested in regulating. The drafting group worked hard
on its charge, and its work should be commended. However, the final product before us today is, simply, an ineffective piece of legislation that I doubt will be adopted by a majority of my sister states. I believe the wiser course of action would have been to continue the hard work of drafting model legislation that addresses the substantive issues affecting health care in our states. States will remain free to adopt the model, no PBM legislation, a completely different legislation, or a modified version of the PBM model that includes more substantive topics. As the opposition to including the drafting note was concern about uniformity, we see here another example of bureaucracy interfering with flexible, good government. We will not have uniform adoption, so there is no need to adopt this model.”

Commissioner Dodrill reported that over the past couple of years, West Virginia’s legislature adopted a much more robust statute on licensure and regulations of PBMs. Mr. Henley noted that California will abstain as California law already includes licensure and regulation of PBMs.

Commissioner Navarro reported that Delaware will abstain, as Delaware already passed stronger legislation. Commissioner Godfread will vote “no,” as this is a license and registration model that North Dakota already has. He expressed concerns that he is not sure DOIs are the right place for this function.

Commissioner Donelon asked the sponsor to what extent this model purports to regulate PBMs. Louisiana licenses them as third-party administrators (TPAs), and so does New Jersey.

Jolie H. Matthews (NAIC) noted that the draft model has a direct way for state DOIs to regulate as PBMs versus as a TPA as Louisiana does.

Director Lindley-Myers noted that Missouri will abstain. The Board of Pharmacy is under the DOI already, and there are some provisions Missouri could not enact.

Commissioner Chaney stated that he has no statutory authority to regulate PBMs at this time. Director Fox noted that she would abstain, as it is unlikely Michigan would adopt what has been proposed. Superintendent Toal said New Mexico already has stronger laws and regulations. Commissioner Ommen said Iowa already has licensing and regulatory authority, and this model is significantly different than Iowa’s.

Chief Deputy Commissioner Slape indicated that Texas would support the model, as it has similar laws.

Commissioner Altman and Commissioner Mais expressed their gratitude to NAIC staff and the states involved in the drafting.

Commissioner Lawrence reported that Tennessee has a new PBM law subject to a court challenge, and this model could possibly assist with that challenge.

Commissioner Godfread noted that work will continue on a PBM white paper to address the various remaining issues. He also thanked the drafters.

Director Dunning said he will vote “yes,” as regulation of PBMs and this model has been long awaited as a starting point by the Nebraska legislature.


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

Commissioner Schmidt reported that the Property and Casualty Insurance (C) Committee met Aug. 16 and adopted its Spring National Meeting minutes.
The Committee adopted the reports of its task forces and working groups: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force; the Workers’ Compensation (C) Task Force; the Cannabis Insurance (C) Working Group; the Catastrophe Insurance (C) Working Group; the Pet Insurance (C) Working Group; the Terrorism Insurance Implementation (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group.

The Committee adopted an extension for revisions to the proposed Pet Insurance Model Law and adopted updates to the Title Insurance Consumer Shopping Tool Template.

The Committee took the following action: 1) heard a presentation from the Association of Bermuda Insurers and Reinsurers (ABIR) and the Insurance Development Forum on ways to close the insurance protection gap; 2) heard a report on the cyberinsurance market, including results from the Cybersecurity and Identity Theft Insurance Coverage Supplement; 3) heard a report on the private flood insurance market, including results from the Private Flood Insurance Supplement; 4) heard an update on the Special (EX) Committee on Race and Insurance, including the fact that Workstream Three, focused on property/casualty (P/C) insurance issues, will take the new charges and formulate a work plan; and 5) planned a future meeting to hear from interested parties to discuss auto insurance refunds related to reduced driving from the COVID-19 pandemic.

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

Commissioner Clark reported that the Market Regulation and Consumer Affairs (D) Committee met Aug. 16. During this meeting, the Committee adopted its July 27 minutes, which included the following action: 1) adopted its Spring National Meeting minutes; 2) adopted revised charges for the Antifraud (D) Task Force; 3) adopted the short-term, limited-duration (STLD) Market Conduct Annual Statement (MCAS) data call and definitions; 4) adopted the travel insurance MCAS data call and definitions; 5) adopted digital claims data in the private passenger auto (PPA) and homeowners data call and definitions; and 6) heard presentations from a state insurance regulator, an NAIC funded consumer representative, and an industry trade representative on the benefits and challenges of collecting market conduct data annually on a transactional level.

The Committee heard a presentation from Peter Kochenburger (University of Connecticut School of Law) and an NAIC funded consumer representative on claim optimization and the potential of using artificial intelligence (AI) to evaluate the willingness of insureds or claimants to accept values less than the fair and equitable amount. The presenter encouraged state insurance regulators to determine the extent of use of predictive analytics in claim settlements and require insurers to report on the algorithmic models used in claim handling.

The Committee adopted the Regulatory Information Retrieval System (RIRS) proposed coding structure changes.

The Committee 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 Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Guidelines (D) Working Group; the Market Analysis Procedures (D) Working Group; and the Privacy Protections (D) Working Group. The report of the Financial Stability (E) Task Force included revised charges.

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

Commissioner White reported that the Financial Condition (E) Committee met Aug. 14. During this meeting, the Committee adopted its July 8 and Spring National Meeting minutes, which included the following action: 1) adopted changes to Model #440 and Model #450 that are intended to make explicit, rather than implicit, the regulatory authority that a commissioner should have relative to the continuation of essential services of an insurance company from an affiliate during a receivership; and 2) updated the life risk-based capital (RBC) bond factors effective for the 2021 reporting period.

The Committee 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 Examination Oversight (E) Task Force; the Financial Stability (E) Task Force; the Receivables and Insolvency (E) Task Force; the Reinsurance (E) Task Force; the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force; the Group Capital Calculation (E) Working Group; the Group Solvency Issues (E) Working Group; the Mortgage Guaranty Insurance (E) Working Group; the Mutual Recognition of Jurisdictions (E) Working Group; the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; and the National Treatment and Coordination (E) Working Group. The report of the Financial Stability (E) Task Force included revised charges.

The Committee adopted a referral to the Statutory Accounting Principles (E) Working Group that requests consideration of changes to the Working Group’s maintenance policy.
The Committee took the following action: 1) adopted revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions*; and 2) adopted revised charges for the renamed Macroprudential (E) Working Group.

**Note:** Items adopted within the Financial Condition (E) Committee’s task force and working group reports that are 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 Summer 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.

12. **Adopted the Guideline for Definition of Reciprocal State in Receivership Laws**

Commissioner White reported that the Receivership and Insolvency (E) Task Force drafted the *Guideline for Definition of Reciprocal State in Receivership Laws* as an alternative to address how states define “reciprocal state.” The Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

The Guideline gives states a possible option to resolve the issue of reciprocity and full faith and credit for stays and injunctions. While some states have updated the reciprocity language in their receivership laws, most states’ receivership laws are based on older versions of the NAIC receivership model.

The Guideline does not require a state or jurisdiction to be accredited to be reciprocal, but it uses the same criteria; i.e., essentially that a state have a receivership scheme.

Commissioner White made a motion, seconded by Chief Deputy Commissioner Slape, to adopt the *Guideline for Definition of Reciprocal State in Receivership Laws* (Attachment Five). The motion passed unanimously.

13. **Adopted the Revised SSAP No. 71**

Commissioner White summarized the proposed changes to *Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions* and provided an overview of the key points of the levelized commission agenda item 2019-24, which were adopted by the Financial Condition (E) Committee into the proposed changes to SSAP No. 71.

The proposed revisions “clarify that an insurance entity cannot use third-party structures to recharacterize and delay recognition of liabilities for initial sales commission owed, regardless of how a third-party arrangement is structured with regards to the timing of the payment from the insurers. This guidance clarifies that it is the writing of the insurance contract that obligates the insurer and recognition of expense shall occur consistently among insurers. SSAP No. 71 does not require advanced recognition for expected renewals or normal persistency metrics. When an insurance policy is issued, renewed, or metrics are met that require additional commission, then SSAP No. 71 consistently requires expense recognition for all insurers.”

The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15 adopted revisions that are effective Dec. 31. The Working Group vote was 13 states in favor and one state opposed. On March 23, the Accounting Practices and Procedures (E) Task Force adopted these revisions with a vote of 41 members in favor and two opposed (Louisiana and Oklahoma). On April 13, the Committee adopted these same revisions to SSAP No. 71 with a vote of 11-3 (Mississippi, New Mexico, and South Carolina dissenting).

Commissioner White noted that the proposed clarification to SSAP No. 71 is necessary because a handful of companies are using an accounting practice that allows them to expense commissions over several years, while the rest of the industry abides by the current requirements of SSAP No. 71, which requires these commissions to be expensed as they are incurred.

Commissioner White also noted that a permitted accounting practice would be available to the companies in question as well.

Commissioner White made a motion, seconded by Superintendent Cioppa, to adopt the changes to SSAP No. 71 (Attachment Six).
Superintendent Toal made a subsidiary motion, seconded by Commissioner King, to amend the motion to delay the implementation of these proposed changes to SSAP No. 71 to Dec. 31, 2022. The motion failed.

Chief Deputy Commissioner Slape noted, “the issue before us today is one of the foundations of statutory accounting; i.e., that commissions are expensed from day one. These rules have been followed for decades by all companies except those few who have been using off-balance sheets. They have already had three years notice to follow the rules. It defies logic that they need five years to come into compliance. They can seek a permitted practice from the domiciliary regulator instead of coming to this body for an exception.”

Commissioner Navarro noted that, as a domestic regulator of one of the companies in question, he is inclined to grant one more year to comply.

On consideration of the main motion, the motion passed with American Samoa, Arkansas, Delaware, Georgia, Idaho, Louisiana, Mississippi, Montana, New Mexico, and Oklahoma dissenting.

14. **Adopted the Amendments to the Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)**

Commissioner White reported that the purpose of these revisions is to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities, specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

The changes were unanimously adopted by both the Receivership and Insolvency (E) Task Force and the Financial Condition (E) Committee.

Commissioner White made a motion, seconded by Chief Deputy Commissioner Slape, to adopt the amendments to Model #440 and Model #450 (Attachment Seven). The motion passed unanimously.

15. **Adopted Amendments to the Process for Evaluating Qualified and Reciprocal Jurisdictions**

Commissioner White reported that the **Process for Evaluating Qualified and Reciprocal Jurisdictions** was first adopted by the NAIC in 2013 to provide a documented evaluation process for creating and maintaining the NAIC List of Qualified Jurisdictions. The document has now been updated to incorporate the 2019 revisions to the **Credit for Reinsurance Model Law (#785)** and the **Credit for Reinsurance Model Regulation (#786)** addressing "reciprocal."

The revised document was exposed by the Reinsurance (E) Task Force in the Spring, modified to address comments from interested parties as well as informal suggestions from the Federal Insurance Office (FIO), and adopted by the Task Force on July 27. On Aug. 14, the Financial Condition (E) Committee unanimously adopted the revised document.

Commissioner White made a motion, seconded by Superintendent Toal, to adopt the amendments to the **Process for Evaluating Qualified and Reciprocal Jurisdictions** (Attachment Eight). The motion passed unanimously.

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

Director Dunning reported that the Financial Regulation Standards and Accreditation (F) Committee met Aug. 13 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 Arkansas; Indiana; Michigan; New Jersey; and Washington, DC.

The Committee also met Aug. 14 in open session and adopted: 1) its Spring National Meeting minutes; and 2) its 2022 proposed charges, which remain unchanged from its 2021 charges.

The Committee adopted the revisions to the **Part A: Laws and Regulations Preamble** to account for inclusion of the **Term and Universal Life Insurance Reserve Financing Model Regulation (#787)**, which will be a new accreditation standard effective Sept. 1, 2022, with enforcement beginning Jan. 1, 2023.
Draft Pending Adoption

The Committee recommended exposure of the 2020 revisions to Model #440 and Model #450 effective for all states Jan. 1, 2026, for a one-year public comment period beginning Jan. 1, 2022. The revisions implement a GCC for the purpose of group solvency supervision and an LST for macroprudential surveillance. The exposure was revised from the initial referral to allow GCC filing exemptions to qualifying groups meeting the standards set forth in Model #450, Section 21A and Section 21B, without the requirement to file at least once.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Aug. 16. During this meeting, the Committee adopted its May 5 and Spring National Meeting minutes, which included the following action: 1) heard an update on upcoming International Association of Insurance Supervisors (IAIS) committee meetings and activities; 2) heard an update on the Organisation for Economic Co-operation and Development (OECD) and other supervisory cooperation activities; 3) approved submission of NAIC comments on the IAIS draft Application Paper on Macroprudential Supervision; 4) heard a presentation on Scalar Methodologies from the American Academy of Actuaries (Academy); 5) heard an update on key 2020–2021 projects of the IAIS; 6) heard an update on international activities; and 7) received an update on NAIC events.

The Committee approved submission of NAIC comments on the IAIS Draft Issues Paper on Insurer Culture and the Draft Revised Application Paper on Supervisory Colleges.

The Committee heard an update on key 2021 projects and priorities of the IAIS, including: 1) implementation assessment activities related to the holistic framework for systemic risk; 2) the ongoing Insurance Capital Standard (ICS) monitoring period; and 3) the peer review process of certain Insurance Core Principles (ICPs) 9 and 10; and 4) 2022–2023 strategic planning priorities.

The Committee heard updates on: 1) international activities, including recent virtual meetings and events with international colleagues; 2) plans for the virtual 2021 NAIC Fall International Fellows Program; 3) recent meetings of the OECD Insurance and Private Pensions Committee; 4) recent meetings of the Sustainable Insurance Forum (SIF); and 5) an upcoming virtual webinar of the European Union (EU)-U.S. Dialogue Project.

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

Commissioner Altmaier referred to the written report for updates on the states’ implementation of NAIC-adopted model laws and regulations (Attachment Nine).

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

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Draft: 7/21/2021
Adopted by the Executive (EX) Committee and Plenary, Aug. 17, 2021
Adopted by the Executive (EX) Committee, Aug. 15, 2021
Adopted by the Special (EX) Committee on Race and Insurance, July 21, 2021

2021/2022 Proposed Charges

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

The mission of the Special (EX) Committee on Race and Insurance is to serve as the NAIC’s coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.

Ongoing Support of NAIC Programs, Products or Services

1. The Special (EX) Committee on Race and Insurance will:
   A. Serve as the NAIC’s coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
   B. Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work on issues affecting people of color and/or historically underrepresented groups, particularly in predictive modeling, price algorithms, and artificial intelligence (AI).
   C. (Workstream One) Continue research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including:
      1. Seek additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts.
      2. Collect input on any existing gaps in available industry diversity-related data.
   D. (Workstream Two) In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity, and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.
   E. (Workstream Two) Research best practices among state insurance departments on DE&I efforts and develop forums for sharing relevant information among states and with stakeholders, as appropriate.
   F. Continue research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. Make recommendations for statutory or regulatory changes and additional steps, including:
      1. (Workstream Four) The impact of traditional life insurance underwriting on traditionally underserved populations, considering the relationship between mortality risk and disparate impact.
      2. (Workstream Three) Developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance, including issues related to:
         a. Rating and underwriting variables, such as socioeconomic variables and criminal history, including:
            1. Identifying proxy variables for race.
            2. Correlation versus causation, including discussion of spurious correlation and rational explanation.
            3. Potential bias in underlying data.
            4. Proper use of third-party data.
         b. Disparate impact considerations.
   G. (Workstreams Three, Four, and Five) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds, including consideration of legal and privacy concerns. Consider a data call to identify insurance producer resources available and products sold in specific ZIP codes to identify barriers to access.
   H. Continue research and analysis related to insurance access and affordability issues, including:
      1. (Workstream Four) The marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.
      2. (Workstream Four) Disparities in the number of cancellations/rescissions among minority policyholders.

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3. (Workstream Five) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with a specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.

4. (Workstream Five) Examination of the use of network adequacy and provider directory measures (e.g., provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.

5. (Workstream Five) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.

6. (Workstream Three) Whether steps need to be taken to mitigate the impact of residual markets, premium financing, and nonstandard markets on historically underrepresented groups.

7. Make referrals for the development of consumer education and outreach materials, as appropriate.

1. Direct NAIC and Center for Insurance Policy & Research (CIPR) staff to conduct necessary research and analysis, including:
   1. (Workstream Three) The status of studies concerning the affordability of auto and homeowners insurance, including a gap analysis of what has not been studied.
   2. (Workstream Three) The availability of producer licensing exams in foreign languages, steps exam vendors have taken to mitigate cultural bias, and the number and locations of producers by company compared to demographics in the same area.
   3. (Workstream Five) Aggregation of existing research on health care disparities and the collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

The Accelerated Underwriting (A) Working Group, as part of its ongoing work to consider the use of external data and data analytics in accelerated life underwriting, will include an assessment of and recommendations, as necessary, regarding the impact of accelerated underwriting on minority populations.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE – NEW CHARGES

1. The Health Insurance and Managed Care (B) Committee will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and the effect on the states of proposed and enacted federal legislation and regulations, including, where appropriate, an emphasis on equity considerations and the differential impact on underserved populations; and communicate the NAIC’s position through letters and testimony, when requested.

The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group of the Regulatory Framework (B) Task Force will develop model educational material for state departments of insurance (DOIs) and research disparities in and interplay between mental health parity and access to culturally competent care for people of color and/or historically underrepresented groups.

The Health Innovations (B) Working Group will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE – NEW CHARGES

The Producer Licensing (D) Task Force will receive a report on the availability of producer licensing exams in foreign languages, the steps exam vendors have taken to mitigate cultural bias, and the number and location of producers by company compared to demographics in the area.
2021 REVISED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2021.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The Accident and Sickness Insurance Minimum Standards (B) Subgroup will:
   A. Review and consider revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).

3. The ERISA (B) Working Group will:
   A. Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans.
   B. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.

4. The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will:
   A. Monitor, report and analyze developments related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.
5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
   B. Develop a white paper to: 1) analyze and assess the role PBMs, Pharmacy Services Administrative Organizations (PSAOs) and other supply chain entities, play in the provision of prescription drug benefits; 2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating and spread pricing, including the implications of the Rutledge vs. Pharmaceutical Care Management Association (PCMA) decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
2021 Revised Charges

ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The Antifraud Education Enhancement (D) Working Group will:
   A. Develop seminars, trainings and webinars regarding insurance fraud. Provide three webinars by the 2021 Fall National Meeting.

3. The Antifraud Technology (D) Working Group will:
   A. Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.
   B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2021 Fall National Meeting.

4. The Improper Marketing of Health Insurance (D) Working Group will:
   A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.
   B. Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.
2021 Revised Charges

FINANCIAL STABILITY (E) TASK FORCE

The mission of the Financial Stability (E) Task Force is to consider issues concerning domestic or global financial stability as they pertain to the role of state insurance regulators.

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (E) Task Force will:
   A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.
      1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.
   B. Consider state insurance regulators’ input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.
      1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
      2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative.
   C. Serve as a forum to coordinate state insurance regulators’ perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important” and “internationally active” both pre- and post-designation, including:
      1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
      2. Analyze proposed rules by the federal agencies that relate to financial stability.
      3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers (G-SIIs) and internationally active insurance groups (IAIGs).
      4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

2. The Macroprudential (E) Working Group will:
   A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;
   B. Assist with the remaining MPI projects related to counterparty disclosures and capital stress testing as needed;
   C. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;
   D. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective;
   E. Oversee the documentation of the NAIC’s macroprudential policies, procedures, and tools; and
   F. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.

The Liquidity Assessment (EX) Subgroup will:
   A. Continue to consider regulatory needs for data related to liquidity risk, and develop recommendations as needed.
   B. Refine and implement a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee.
   C. Continue to develop and administer data collection tools, leveraging existing data where feasible, to provide the Financial Stability (EX) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating market conditions affected by the COVID-19 pandemic.
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<th>Valuation Manual Amendment Proposal Descriptions</th>
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<td>Sect II, VM-20, VM-51</td>
<td>Clarify the definition of individually underwritten life insurance and the applicability of PBR requirements for group contracts with individual risk selection issued under insurance certificates.</td>
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<td>VM-20 Section 2.H and new Section 2.I</td>
<td>Provide clearer guidance on the boundaries of a company’s latitude in following VM-20 steps</td>
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<td>VM-21, Section 6.C.5:</td>
<td>Update the reference to required minimum distribution age</td>
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<td>VM-02 Section 3.A</td>
<td>Clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.</td>
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<td>VM-50, VM-51</td>
<td>Revise VM-50 and VM-51 to allow experience reporting a reinsurer or third-party administrator and a correction to VM-51 Appendix 4</td>
<td>5/27/2021</td>
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<td>14</td>
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<td>VM-21 Section 1.E (new), 3.H (new), VM-31 Section 3.E.1, 3.F.2.e</td>
<td>Update VM-31 materiality language to be consistent new section of VM-21 addressing materiality.</td>
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<td>VM 51 App 4</td>
<td>Remove &quot;at issue&quot; from Smoker Status data element name to allow for use of the smoker status at the time of data submission</td>
<td>6/24/2021</td>
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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   American Academy of Actuaries, Life Reserves Work Group
   Addition of language to clarify the definition of individually underwritten life insurance and the applicability of Principle-Based Reserve (PBR) requirements for group insurance contracts with individual risk selection issued under insurance certificates.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   January 1, 2021, version of the Valuation Manual, with the revisions to APF 2020-11 (adopted by LATF on 2/11/21) shown in blue text.

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   Individual insurance certificates issued under a group contract which utilize an individual risk selection process, pricing, premium rate structures and product features are similar to individual life insurance policies. They are currently excluded from VM-20 because they are filed under a group contract, but they should be subject to VM-20 due to this similarity. See Appendix.

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

NAIC Staff Comments:

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Notes: APF 2019-33

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Appendix

Issue

Certain contracts issued under a master group contract require individual risk selection in order to qualify for issuance of the group insurance certificate; the certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification; and they are managed in a similar manner as individual ordinary life insurance contracts. These individual certificates should follow the same reserve requirements as other individual life contracts of the same product type. Therefore, a change is needed within the Valuation Manual to bring these individual certificates into scope of VM-20.

Six changes are recommended:

1) Within the Reserve Requirements section (Section II), change the minimum reserve requirements to also apply to group life contracts which, other than the difference between issuing a policy and issuing a group certificate, have the same or mostly similar contract provisions, risk selection process, and underwriting as individual ordinary life contracts (Section II, subsection 1.D);

2) Within the Reserve Requirements section (Section II), add a transition period for individual group certificates issued on or before 1/1/2024 (Section II, subsections 1.F.1 and 1.F.2);

3) Within the Reserve Requirements section (Section II), add language and guidance note to subsection 1.G and the corresponding footnote to include premiums from group life contracts which have individual certificates that were issued using individual risk selection processes (Section II, subsection 1.G.1, footnote, and guidance note) and to clarify the Calculation for Exemption (Section II, subsection 1.G.2). Comment notes need to refer to NAIC Blanks (E) Working Group to update the PBR Supplement;

4) Add new paragraph, VM-20 Section 1.B (and reformat to make current paragraph Section 1.A) to clarify group life certificates issued using individual risk selection processes, including a definition and requirements to be met, are subject to the requirements of VM-20;

5) Add guidance note after first sentence in VM-20 Section 2.A.1 that group life certificates that meet the definition for individual risk selection process use the same VM-20 Reserving Categories as defined in Section 2;

6) Draft referral to the NAIC Blanks (E) Working Group to revise the VM-20 Reserves Supplement, Part 2 to report premiums for total Group Life and Group Life with certificates subjected to an individual risk selection process and which meet all of the conditions as defined in VM-20 Section 1.B separately.
II. Reserve Requirements

This section provides the minimum reserve requirements by type of product, as set forth in the seven subsections below, as follows:

1. Life Insurance Products
2. Annuity Products
3. Deposit-Type Contracts
4. Health Insurance Products
5. Credit Life and Disability Products
6. Riders and Supplemental Benefits
7. Claim Reserves

All reserve requirements provided by this section relate to business issued on or after the operative date of the Valuation Manual. All reserves must be developed in a manner consistent with the requirements and concepts stated in the Overview of Reserve Concepts in Section I of the Valuation Manual.

Subsection 1: Life Insurance Products

A. This subsection establishes reserve requirements for all contracts issued on and after the operative date of the Valuation Manual that are classified as life contracts as defined in SSAP No. 50 in the AP&P Manual, with the exception of annuity contracts and credit life contracts. Minimum reserve requirements for annuity contracts and credit life contracts are provided below in subsection 2 and subsection 5, respectively.

B. Minimum reserve requirements for variable and nonvariable individual life contracts—excluding guaranteed issue life contracts, preneed life contracts, industrial life contracts, and policies of companies exempt pursuant to the life PBR exemption in paragraph D below subsection 1.F.2 below. For this purpose, joint life policies are considered individual life.

C. Minimum reserve requirements of VM-20 are considered principle-based valuation requirements for purposes of the Valuation Manual.

D. Minimum reserve requirements for individual certificates under group life contracts (regardless of the issue date of the master group life contract) which meet all the requirements in VM-20 Section I.B are provided by VM-20, except for election of the transition period in subsection 1.F.1 below.

E. Minimum reserve requirements for life contracts not subject to VM-20 are those pursuant to applicable requirements in VM-A and VM-C. For guaranteed issue life contracts issued after Dec. 31, 2018, mortality tables are defined in VM Appendix M, Mortality Tables (VM-M), and the same table shall be used for reserve requirements as is used for minimum nonforfeiture requirements as defined in VM-02, Minimum Nonforfeiture Mortality and Interest.

Guidance Note: The terms “policies” and “contracts” are used interchangeably.
A company may elect to establish minimum reserves pursuant to applicable requirements in VM-A and VM-C for:

1. Business described in subsection 1.D above and issued on or after the operative date of the Valuation Manual and prior to 1/1/2024.

2. Business not described subsection 1.D otherwise subject to VM-20 requirements and issued during the first three years following the operative date of the Valuation Manual.

A company electing to establish reserves using the requirements of VM-A and VM-C may elect to use the 2017 Commissioners’ Standard Ordinary (CSO) Tables as the mortality standard following the conditions outlined in VM-20 Section 3. If a company during the three years elects to apply VM-20 to a block of such business, then a company must continue to apply the requirements of VM-20 for future issues of this business.

G. Life PBR Exemption

1. A company meeting at least one of the conditions in subsection 1.G.2 below may file a statement of exemption for individual ordinary life insurance policies or certificates, except for policies or certificates in subsection 1.G.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in subsection 1.G.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to September 1 and require the company to follow the requirements of VM-20 for the ordinary life policies or certificates covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in subsection 1.G.2 below, 2) the policies or certificates contain those in subsection 1.G.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies or certificates. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Condition for Exemption:

The company has less than $300 million of ordinary life exemption premiums, and if the company is a member of an NAIC group of life insurers which includes other life insurance companies, the group has combined ordinary life exemption premiums of less than $600 million, or

The only new policies or certificates that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies or certificates valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

Exemption premium is determined as follows:
a. The amount reported in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.1; plus

b. The portion of the amount in the prior calendar year life/health annual statement, Exhibit 1, Part 1, Column 3 (“Ordinary Life Insurance”), line 20.2 assumed from unaffiliated companies; minus

c. Amounts included in either (a) or (b) that are associated with guaranteed issue insurance policies and/or preneed life insurance policies; minus

d. Amounts included in either (a) or (b) that represent transfers of reserves in force as of the effective date of a reinsurance assumed transaction; plus

e. Amounts of premium for individual life certificates issued under a group life certificate which meet the conditions defined in VM-20, Section 1.B, and that are not included in either (a) or (b).

Guidance Note:
(i) Definitions of preneed and guaranteed issue insurance policy are in VM-01.
(ii) For statements of exemption filed for calendar year 2022 and beyond, the amount in subsection 2.e was reported in the prior calendar year life/health annual statement, VM-20 Reserve Supplement, Part 2, if applicable.

3. Policies and Certificates Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies or certificates, or policies or certificates – other than ULSG – that contain a rider with a secondary guarantee, in which the secondary guarantee does not meet the VM-01 definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in subsection 1.G.1 – 1.G.3 above applies only to policies or certificates issued or assumed in the current year, and it applies to all future valuation dates for those policies or certificates. However, if policies or certificates did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies or certificates. The minimum reserve requirements for the ordinary life policies, including individual certificates under group life contracts which meet all the requirements in VM-20 Section 1.B, subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

VM Change 4 – VM-20: Requirements for Principle-Based Reserves for Life Products

VM-20: Requirements for Principles-Based Reserves for Life Products

Section 1: Purpose

A. These requirements establish the minimum reserve valuation standard for individual life insurance policies issued on or after the operative date of the Valuation Manual and subject to a principle-based valuation with an NPR floor under Model #20. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for policies of individual life insurance.
B. Individual life certificates under a group life contract shall be subject to the requirements of VM-20 if all of the following are met. These requirements constitute the Commissioners Reserve Valuation Method (CRVM) for such certificates.

1. An individual risk selection process, defined as follows, is used to obtain group life insurance coverage;

An individual risk selection process is one that is based on characteristics of the insured(s) beyond sex, gender, age, tobacco usage, and membership in a particular group. This may include, but is not limited to, completion of an application (beyond acknowledgement of membership to the group, sex, gender and age), questionnaire(s), online health history or tele-interview to obtain non-medical and medical or health history information, prescription history information, avocations, usage of tobacco, family history, or submission of fluids such as blood, Home Office Specimens (HOS), or oral fluid. The resulting risk classification is determined based on the characteristics of the individual insured(s) rather than the group, if any, of which it is a member (e.g., employer, affinity, etc.). The individual certificate holder is charged a premium rate based solely on the individual risk selection process and not on membership in a specific group.

Guidance Note: The use of evidence of insurability does not by itself constitute an individual risk selection process. Use of information obtained from a census or question(s) regarding gender, occupation, age, income and/or tobacco usage solely for purposes of determining a rate classification does not by itself qualify a group as having used an individual risk selection process. Group insurance where the underwriting based on the characteristics of the group and census data but where some individuals are subjected to individual risk selection as a result of compensation level, age, an existing medical condition or impairment, late entry into the group, failure of the group to meet minimum participation requirements or voluntary buy-up of increased coverage does not meet the definition of an individual risk selection process.

2. The individual certificates utilize premiums or cost of insurance schedules and charges based on the individual applicant’s issue age, duration from underwriting, coverage amount and risk classification and there is a stated or implied schedule of maximum gross premiums or net cash surrender value required in order to continue coverage in force for a period in excess of one year;

Guidance Note: Coverage amount does not imply a requirement for banding of premiums or charges but rather rates or charges that are multiplied by number of units of coverage of face amount (or net amount at risk) per $1,000 to obtain the actual premium or charge.

3. The group master contract is designed, priced, solicited, and managed similar to individual ordinary life insurance policies rather than specific to the group as a whole;

4. The individual certificates have similar acquisition approaches, provisions, certificate-holder rights, pricing, and risk classification to individual ordinary life insurance contracts.

5. The individual certificates are issued on or after the operative date of the Valuation Manual except election of the transition period in Section 2, subsection 1.F.1.
Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

Guidance Note: Since group insurance subject to an individual risk selection process and meeting all the requirements in Section 1.B is subject to VM-20 requirements, Section 2.A shall apply—meaning that any such contracts will be included in one of the VM-20 Reserving Categories defined by Section 2.A.1, Section 2.A.2, and 2.A.3. All requirements in VM-31 which apply to a VM-20 Reserving Category shall apply to any group insurance subject to individual risk selection that has been included in that VM-20 Reserving Category.

The company may elect to exclude one or more groups of policies from the stochastic reserve calculation and/or the deterministic reserve calculation. When excluding a group of policies from a reserve calculation, the company must document that the applicable exclusion test defined in Section 6 is passed for that group of policies. The minimum reserve for each VM-20 Reserving Category is defined by Section 2.A.1, Section 2.A.2 and Section 2.A.3, and the total minimum reserve equals the sum of the Section 2.A.1, Section 2.A.2 and Section 2.A.3 results below, defined as:
VM Change 6 – VM-20 Reserves Supplement, Part 2: Life PBR Exemption

Refer to NAIC Blanks (E) Working Group, request for modification to the supplemental report for the Life PBR Exemption, to show the premiums for group life that utilized an individual risk selection process and meets all of the requirements in VM-20 Section 1.B. as these premiums are currently grouped together with other group insurance in Exhibit 1. As there are other instances where the ordinary life premiums are not included in the determination of the Life PBR Exemption (e.g., for guaranteed issue policies), it may be useful to request addition of the breakdown of premiums used to determine the exemption.

Possible insertion between questions 1 and 2 for disclosure of premiums used in the determination of eligibility for the Life PBR exemption, split by ordinary life and group subject to an individual risk selection process and meeting all of the requirements in VM-20 Section 1.B.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

Joint submission by NAIC staff and Staff of Office of Principle-Based Reserving, California Department of Insurance – Clarify areas of confusion relating to the topic of materiality.

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


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

See attached Appendix.

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

See attached Appendix.

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Appendix

**ISSUE:**

Skipping steps in VM-20 is not allowed on grounds of immateriality. Some companies are skipping some VM-20 requirements altogether, without providing a simplification, approximation, or modeling technique that satisfies the VM-20 Section 2.G requirement that such simplifications neither materially understate nor downwardly bias the reserves. Simply skipping portions of the requirements, such as not computing an NPR, or not computing the DR and/or SR when exclusion tests have not been performed, inherently bias the reserve downward since their omission can only be neutral or decrease the resulting reserve. Without computing even a simplified model for Section 2.G analysis that shows there is not a decrease in the final reserve, this makes the skipping of the step violate Section 2.G. This APF clarifies that these types of omissions are not allowed. This has always been the case, but perhaps needs more emphasis in the *Valuation Manual*.

**SECTION:**

VM-20 Section 2.H and new Section 2.I, and VM-20 Section 7.E.1.g

**REDLINE:**

VM-20 Section 2.H

H. The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks under VM-20 Section 9.B.1. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

**Guidance Note:**

For example, the standard may be expressed as an impact of more than X dollars or Y% of the reserve, whichever is greater, where X and Y are chosen in a manner that is meant to stand the test of time and not need periodic revision.

The standard is based on the impact relative to the size of the NPR, DR and SR as opposed to the impact relative to the overall financial statement (e.g., total company reserves or surplus). Reviewing items that may lead to a material misstatement of the financial statement in the current year is appropriate in its own context, but it is not appropriate for identifying material risks for PBR, which itself is an emerging risk.

Note that the criteria apply to the NPR, DR and SR, and not just the final reported reserve. For example, if the DR is less than the NPR, the criteria still apply to the DR.

The standard also applies to exclusion tests, as they are an element of the principle-based valuation.
Section 2.G and Section 2.H provide companies some flexibility in assumption setting and modeling methodologies, but they do not allow for skipping mandated steps without providing a valid approximation, simplification, or modeling technique under Section 2.G that neither materially understates nor downwardly biases the reserve.

Examples of omissions that would not satisfy VM-20 Section 2.G: not computing even a simplified NPR, not computing even a simplified DR or SR without having passed the relevant exclusion test(s), omitting prescribed mortality margins, not establishing any lapse margins, not building even a simplified asset model for the DR, using the alternative investment strategy without first determining that it produces a higher reserve than the company investment strategy, and ignoring post-level term losses.

Guidance Note: The issue here is not the use of approximations; it is about skipping mandated VM-20 requirements. Thus, for example, this does not rule out the use of a relatively simple asset model that is acceptable pursuant to VM-20 Section 7.E.1.a, nor the judicious use of the previous year’s assumption development work to save time and effort.

VM-20 Section 7.E.1.g Guidance Note

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the model investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the model investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance. Or, the company may be able to rely on a previous year’s determination as to which strategy produces a higher reserve, if the assets and strategy have not changed very substantially since then.
**REASONING:**

Some companies have mistakenly believed that it was permissible to skip certain significant steps outlined in VM-20, without using a valid approximation or simplification that they have shown does not materially understate or bias reserves in a downward direction.

Note: Comment letters were received on an earlier draft of this APF, in response to which this newer version has eliminated any mention of PIMR and has made it clearer that a simplified asset model may in some circumstances be acceptable and that a full-blown run of both the actual investment strategy and the alternative investment strategy is not necessarily something that has to be done every year.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
Clarify NPR calculation requirements.

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

VM-20 Section 3.B.1 – 3.B.3, and VM-20 Section 3.B.6.d.i

January 1, 2020 NAIC Valuation Manual

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

See attached.

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

Clarify any confusion on whether more direct calculations of the NPR to reflect non-annual premium modes, etc., are allowed. The current guidance note in Section 3.B.3 states that these may be reflected either “directly or through adjusting accounting entries”. However, due to some confusion on this point, I suggest emphasizing that more direct calculation methods are not prohibited. This is consistent with SSAP 51R, Paragraph 24:

24. Since terminal reserves are computed as of the end of a policy year and not the reporting date, the terminal reserve as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date.
This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in paragraphs 25-28. Other appropriate methods, including an exact reserve valuation, may also be used.

For re-exposure, to address both the question posed in the initial exposure of clearly reflecting both mean and mid-terminal adjustments, as well as to address comments received, I recommend language consistent with SSAP 51R, paragraph 24. SSAP 51R paragraphs 25-28 are referenced by paragraph 24. They are provided below for completeness, and specific references for policies subject to the Valuation Manual are highlighted.

Mean Reserve Method
25. Under the mean reserve method, the policy reserve equals the average of the terminal reserve at the end of the policy year and the initial reserve (the initial reserve is equal to the previous year’s terminal reserve plus the net annual valuation premium for the current policy year). When reserves are calculated on the mean reserve basis, it is assumed that the net premium for a policy is collected annually at the beginning of the policy year and that policies are issued ratably over the calendar year.

26. However, as premiums are often received in installments more frequently than annually and since the calculation of mean reserves assumes payment of the current policy year’s entire net annual premium, the policy reserve is overstated by the amount of net modal premiums not yet received for the current policy year as of the valuation date. As a result, it is necessary to compute and report a special asset to offset the overstatement of the policy reserve.

27. This special asset is termed “deferred premiums.” Deferred premiums are computed by taking the gross premium (or premiums) extending from (and including) the modal (monthly, quarterly, semiannual) premium due date or dates following the valuation date to the next policy anniversary date and subtracting any such deferred premiums that have actually been collected. Deferred premium assets shall also be reduced by loading. Since the calculation of mean reserves assumes payment of the current policy year’s entire net annual premium, deferred premium assets are considered admitted assets to compensate for the overstatement of the policy reserve. For policies subject to the Valuation Manual requirements, the deferred premium asset will continue to be calculated for the net premium reserve component of the total principle-based reserve.

Mid-Terminal Method
28. Under the mid-terminal method, the policy reserves are calculated as the average of the terminal reserves on the previous and the next policy anniversaries. These reserves shall be accompanied by an unearned premium reserve consisting of the portion of valuation premiums paid or due covering the period from the valuation date to the next policy anniversary date. For policies subject to the Valuation Manual requirements, the adjustment to the unearned premium reserve will continue to be calculated for the net premium reserve component of the total principle-based reserve.

Since the guidance note at the end of Section 3.B.3 contains requirements and not just guidance, it should be taken out of a guidance note. This requires moving the four terms to Section 3.B.1 and updating two cross references in VM-20 Section 3.B.6.d.i.

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

NAIC Staff Comments:
W/National Meetings/2010/TF-LHA
B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:
   a. A policy with “multiple secondary guarantees” is one that: a) simultaneously has more than one shadow account; b) simultaneously has more than one cumulative premium type of guarantee; or c) simultaneously has at least one of each. A single shadow account with a variety of possible end dates to the secondary guarantee, depending on the policyholder’s choice of funding level, constitutes a single—not multiple—secondary guarantee.

Guidance Note:
Policy designs that are created simply to disguise guarantees or exploit a perceived loophole must be treated in a manner similar to more typical product designs with similar guarantees. If a policy contains multiple secondary guarantees, such that a subset of those secondary guarantees in combination represent an implicit guarantee that would produce a higher NPR if that implicit guarantee were treated as an explicit secondary guarantee of the policy, then the policy should be treated as if that implicit guarantee were an explicit guarantee. For example, if there were a policy with a “sequential secondary guarantee” where only one secondary guarantee applied at any given point in time but with a series of secondary guarantees strung together with one period ending when the next one began, the combined terms of the secondary guarantees would be regarded as a single secondary guarantee.

b. The “fully funded secondary guarantee” at any time is:
   i. For a shadow account secondary guarantee, the minimum shadow account fund value necessary to fully fund the secondary guarantee for the policy at that time. For any policy for which the secondary guarantee contractually cannot be fully funded in advance, this shall be the present value of the contractually permitted premium stream that would fully fund the guarantee at the earliest possible date (using the valuation interest rate and mortality standard specified in Section 3.C).
   ii. For a cumulative premium secondary guarantee, the amount of cumulative premiums required to have been paid to that time that would result in no future premium requirements to fully fund the guarantee, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee. For any policy for which the secondary guarantee contractually cannot be fully funded in advance, this shall be the present value of the contractually permitted premium stream that would fully fund the guarantee at the earliest possible date (using the valuation interest rate and mortality standard specified in Section 3.C).

c. The “actual secondary guarantee” at any time is:
   i. For a shadow account secondary guarantee, the actual shadow account fund value at that time.
   ii. For a cumulative premium secondary guarantee, the actual premiums paid to that point in time, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

d. The “level secondary guarantee” at any time is:
   i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.6.c.i.
For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.6.c.i, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4, Section 3.B.5 and Section 3.B.6 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4, Section 3.B.5 and Section 3.B.6, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

3. Since terminal NPRs are computed as of the end of a policy year and not the reporting date, the terminal NPR as of policy anniversaries immediately prior and subsequent to the reporting date are adjusted to reflect that portion of the net premium that is unearned at the reporting date. This is generally accomplished using either the mean reserve method or the mid-terminal method as discussed in SSAP 51R. Other appropriate methods, including an exact reserve valuation, may also be used.

VM-20 Section 3.B.6.d.i

As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASGx+t, as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted FFSGx+t, as outlined in Section 3.B.1.b.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   Tim Cardinal, FSA, MAAA, CERA. Cardinalis 1 Consulting. Clarify and introduce a third permissible technique for the calculation of company experience rates.

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

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
   See attached Appendix and Excel file.
Appendix

SECTION:

REDLINE:
9.C.2.d.vi. If the company uses the aggregate comp any experience for a group of mortality segments when determining the company experience mortality rates for each of the individual mortality segments in the group, the company shall use one of the following methods:

a. Use techniques to further subdivide the aggregate experience into the various mortality segments (e.g., start with aggregate non-smoker and then use the conservation of total deaths principle, normalization or other approach to divide the aggregate mortality into super preferred, preferred and residual standard non-smoker class assumptions).

b. Use techniques to adjust the experience of each mortality segment in the group to reflect the aggregate company experience for the group (e.g., by credibility weighting the individual mortality segment experience with the aggregate company experience for the group).

c. Use a two-step sequential method, which
   1) forms subgroups which are groups of mortality segments and are subsets of the aggregate class of mortality segments being aggregated,
   2) uses techniques as in (b) to adjust the experience of each subgroup from (1) to reflect the aggregate company experience for the group and conserve deaths, and
   3) finally, uses techniques as in (a) to further subdivide the subgroups’ adjusted experience from (2) into the various mortality segments while conserving each subgroup’s deaths determined in step (2)’s conservation of deaths.

For example, if mortality segments vary by sex, risk class, and face bands, then
   1) segments that differ by face band are aggregated to form subgroups that vary just by sex and risk class,
   2) the subgroups’ mortality experience is credibility weighted with the aggregate company experience for the group and normalized, and
   3) the subgroups’ adjusted mortality experience are then subdivided into the various mortality segments based on credible, external face band relativities and conservation of deaths is applied to each subgroup’s normalized deaths determined in (2).

REASONING:
A minor point is clarity. “Either” can mean one or both. The intent is one of a) or b) but not both. The major issue is both a) and b) have weaknesses in contexts with high levels of granularity resulting in a large number of mortality segments such as 120 or 360 segments. For example consider a block with 360 mortality segments determined by 2 sexes x 6 risk classes x 5 face bands x 3 product types x 2 underwriting types (such as full and accelerated). A company may have very high credibility for each of 12 segments as determined by 2 sexes x 6 risk classes but have very low credibility for each of the 360 segments. Both a) and b) could produce company experience rates that negate the very reasons a company uses a high level of granularity. Using b) for example, all segment rates would be equal to the aggregate A/E rates, which is equivalent to no granularity. By applying b) to subgroups and applying a) to divide the subgroups, the proposed technique c) is more robust drawing upon a) and b)’s strengths.
while mitigating their weakness. If there is one subgroup which is the aggregate then a) is a special case of c). If each subgroup is a segment then b) is a special case of c). See the attached excel file that adds two examples to the NAIC examples for a) and b). Example 8 is an example of a correct way to apply c) and Example 9 is an incorrect way.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
Rachel Hemphill, Texas Department of Insurance

Title of the Issue:
1. Modify Life PBR Exemption to not require annual exemption requests if the company continues to meet the premium thresholds and does not have any ULSG with material SG.
2. Not require VM-20 when all new issues arise due to policyholders exercising guarantees or options (e.g. for conversion) in existing policies valued under VM-A/VM-C.

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

Valuation Manual Section II, Subsection 1.D
January 1, 2020 NAIC Valuation Manual

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

See attached.

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

Reduce filing burden for companies and state regulators by making the Life PBR Exemption a one-time filing until conditions for the exemption change. Allow exemption for companies that do not meet the premium thresholds, but are only issuing new policies that would be subject to VM-20 due to policyholders exercising guarantees or options (e.g. for conversion) from existing policies being valued under the pre-PBR framework.

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

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Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company fails to meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies. In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:

   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million; or
   
   b. The only new policies subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies that are being valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:

   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed...
transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.
Life Actuarial (A) Task Force
Amendment Proposal Form 2020-10
Exposed for a 12-day public comment period ending June 7, 2021

Request for Comment: During the exposure, commenters are specifically asked to address the four versions exposed for the handling of YRT for the 2017-2019 issue years.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/25/21.
Life Actuarial (A) Task Force/ Health Actuarial 
(B) Task Force 
Amendment Proposal Form 

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


Reflect a prudent level of mortality improvement beyond the valuation date.

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


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

See attached Appendix.

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

We propose to reflect a prudent level of mortality improvement beyond the valuation date, using SOA analysis for best estimate future mortality improvement and margin. The requirements also need to be clarified for the handling of historical or anticipated future mortality deterioration (i.e., negative improvement).

With the reflection of a prudent level of future mortality improvement in the mortality assumption, the interim 1/2cx approach to YRT is a reasonable consideration for a long-term approach.

For LATF consideration for re-exposure, there are four versions of the handling of the 2017-2019 issue year carveout from the interim YRT solution: 1) the original exposure, removing the carveout with the 1/2cx being made a longer term approach, 2) a modified version that removes the carveout, but makes that removal contingent on the first set of SOA future mortality rates being adopted, in case of delay, 3) a modified version that removes the carveout, but allows for a phase-in of the effect of this change, and 4) a version making the carveout long-term. These versions are presented starting on Page 6 of this document, after the other edits which do not vary based on this options.
Appendix

VM-20 Section 6.A.2.b.v:

v. Anticipated mortality improvement beyond the projection start date shall be reflected in the mortality assumption for the purpose of calculating the stochastic exclusion ratio. The future mortality improvement factors shall be no greater than the unloaded factors determined by the SOA adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).

VM-20 Section 9.C.2.h:

h. Mortality improvement shall not be incorporated beyond the valuation date in the company experience mortality rates. However, historical mortality improvement from the central point of the underlying company experience data to the valuation date may be incorporated.

Guidance Note: Future mortality improvement is not applied to the company experience mortality rates, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.

VM-20 Section 9.C.3.g:

g. Mortality improvement shall not be incorporated beyond the valuation date in the industry basic table. However, historical mortality improvement from the date of the industry basic table (e.g., Jan. 1, 2008, for the 2008 VBT and July 1, 2015, for the 2015 VBT) to the valuation date shall be incorporated using the improvement factors for the applicable industry basic table as determined by the SOA, adopted by LATF, and published on the SOA website, https://www.soa.org/research/topics/indiv-val-exp-study-list/ (Mortality Improvement Rates for AG-38 for Year-End YYYY).

Guidance Note: Future mortality improvement is not applied to the industry basic table, since it would be duplicative of the future mortality improvement that is applied to the prudent estimate assumptions for mortality in Section 9.C.7.f.
To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the most recent set of prior mortality improvement rates adopted by LATF and published on the SOA website.

VM-20 Section 9.C.7.a:
If applicable industry basic tables are used in lieu of company experience as the anticipated experience assumptions, or if the level of credibility of the data as provided in Section 9.C.5 is less than 20%, the prudent estimate assumptions for each mortality segment shall equal the respective mortality rates in the applicable industry basic tables as provided in Section 9.C.3, adjusted as necessary pursuant to Section 9.C.7.e and for any applicable improvement pursuant to Section 9.C.3.g, plus the prescribed margin as provided in Section 9.C.6.c, plus any applicable additional margin pursuant to Section 9.C.6.d.v and/or Section 9.C.6.d.vi, future mortality improvement, pursuant to Section 9.C.7.f, shall be applied to the prudent estimate assumption for mortality.

Section 9.C.7.b.vi:
Beginning in the first policy duration after policy duration E, the prudent estimate mortality assumptions for each policy in a given mortality segment are determined as a weighted average of the company experience mortality rates with margins and the applicable industry basic table with margins, in which the weights on the company rates grade linearly from 100% down to 0%. This grading must be completed—i.e., must reach 100% of industry table—no later than the beginning of the first policy duration after policy duration Z (the determination of the applicable industry basic table is described in Section 9.C.3). Thus, the prudent estimate mortality rate, prior to any adjustments pursuant to Sections 9.C.7.c, 9.C.7.d, 9.C.7.e and 9.C.7.f below, is:

VM-20 Section 9.C.7.f (new section):

Twenty years of future mortality improvement that the company anticipates beyond the valuation date shall be applied to the prudent estimate assumptions for mortality, using prudent future mortality improvement factors no greater than the loaded factors determined by the SOA, adopted by LATF, and published on the SOA website, at [link/reference to SOA site TBD].

Guidance Note: Mortality improvement may be positive or negative (i.e., deterioration). The anticipated mortality improvement may be lower than the rates published by the SOA, even zero, for example, if the company’s best estimate for mortality improvement for a particular block, such as simplified issue, is lower. Prior to adoption by LATF of the first set of future mortality improvement factors, the future mortality improvement rates shall be 0%.

To allow time for companies to reflect the updated mortality improvement rates, the rates that are to be used in the year-end YYYY valuation should be adopted by LATF and published on the SOA website by September of YYYY. If this timeline is not met, then at the company’s option they may use the mortality improvement rates for the prior year (year YYYY-1).
VM-31 Section 3.D.3.i:

i. **Mortality Improvement** – Description of and rationale for the mortality improvement assumptions applied up to the valuation date and the mortality improvement assumptions applied beyond the valuation date. Such a description shall include the assumed start and end dates of the improvements and a table of the annual improvement percentage(s) used, both without and with margin, separately for company experience and the industry basic table(s), along with a sample calculation of the adjustment (e.g., for a male preferred nonsmoker age 45).

VM-31 Section 3.D.11.c.i:

i. If the company believes the method used to determine anticipated experience mortality assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.
C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.


Deleted: For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:

Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020 up until adoption by LATF of the first set of unloaded future mortality improvement factors, at which point this shall apply for all policies issued on or after Jan. 1, 2017:

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

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Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
2017-2019 for Long-Term YRT – Version 3:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

For policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020, the company may elect, with domiciliary commissioner approval, a phase-in of the current methodology for non-guaranteed YRT reinsurance with allowance for future mortality improvement from the methodology in the 2021 Valuation Manual for non-guaranteed YRT reinsurance without allowance for future mortality improvement, provided that the company uses a weighted average of the results from the two methodologies, with the weight for the prior methodology being no more than \( \frac{2020-YYYY}{2020-2021} \), where YYYY is the current valuation year and 2020 is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-20 Section 8.C.18 and Guidance Note:

18.

When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.
current valuation year and 20XX is the final year of the phase-in. A company may elect to phase in these requirements over a 3-year period beginning Jan. 1, 2022 and ending Dec. 31, 2024. A company may elect a longer phase-in period of up to seven years beginning Jan. 1, 2022 and ending Dec. 31, 2028, with approval of the domiciliary commissioner.

VM-31 Section 3.D.8.g (new):

g. Phase-In: If electing a phase-in period as described in VM-20 Section 8.C, documentation of the length of the phase-in approved by the company’s domiciliary commissioner, the result of the current and prior methodologies, the weights applied to each result, and confirmation that reinsurance assumptions for the calculation of the prior methodology are discussed in Section 3.D.8.b above.
2017-2019 for Long-Term YRT – Version 4:

C. Reflection of Reinsurance Cash Flows in the Deterministic Reserve or Stochastic Reserve

For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:
For non-guaranteed YRT reinsurance ceded or assumed, the cash-flow modeling requirements in Sections 8.C.1 through 8.C.14 below do not apply since non-guaranteed YRT reinsurance ceded or assumed does not need to be modeled; see Section 8.C.18 below. YRT shall include other reinsurance arrangements that are similar in effect to YRT.

VM-20 Section 8.C.18 and Guidance Note:

18. For policies issued on or after Jan. 1, 2020, and optionally for policies issued on or after Jan. 1, 2017, and before Jan. 1, 2020:
When the reinsurance ceded or assumed is on a non-guaranteed YRT or similar basis, the corresponding reinsurance cash flows do not need to be modeled. Rather, for a ceding company, the post-reinsurance-ceded DR or SR shall be the pre-reinsurance-ceded DR or SR pursuant to Section 8.D.2, plus any applicable provision pursuant to Section 8.C.15 and Section 8.C.17, minus the NPR reinsurance credit from Section 8.B. For an assuming company, the DR or SR for the business assumed on a non-guaranteed YRT or similar basis shall be set equal to the NPR from Section 3.B.8, plus any applicable provision pursuant to Section 8.C.16 and Section 8.C.17. In the case where there are also other reinsurance arrangements that are not on a non-guaranteed YRT or similar basis, the reinsurance credit shall include the modeled reinsurance credit reflecting those other reinsurance arrangements. In particular, where there are also other reinsurance arrangements that are dependent on the non-guaranteed YRT or similar actuarial judgment shall be used to project cash flows consistent with the above outlined treatment for non-guaranteed YRT or similar arrangements.

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Deleted: Guidance Note: The above method is an interim approach. A longer-term solution to YRT is intended to be adopted by state insurance regulators, after state insurance regulators and industry have had additional time to consider and evaluate the variety of approaches that have been put forward as a potential longer-term solution.
1. Identify yourself, your affiliation and a very brief description (title) of the issue.

Rachel Hemphill, TDI – Allows exemption of policies from prior issue years when there is a change in the Life PBR Exemption requirements.

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


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

Valuation Manual Section II, Subsection 1.D

D. Life PBR Exemption

1. A company meeting the at least one of the conditions in D.2 below may file a statement of exemption for ordinary life insurance policies, except for policies in D.3 below, issued directly or assumed during the current calendar year, that would otherwise be subject to VM-20. If a company has no business issued directly or assumed during the current calendar year that would otherwise be subject to VM-20, a statement of exemption is not required. For a filed statement of exemption, the statement must be filed with the domiciliary commissioner prior to July 1 of that year certifying that at least one of the two conditions in D.2 was met based on premiums from the prior calendar-year annual statement and the statement of exemption must also be included with the NAIC filing for the second quarter of that year.

The domiciliary commissioner may reject such statement prior to Sept. 1 and require the company to follow the requirements of VM-20 for the ordinary life policies covered by the statement.

If a filed statement of exemption is not rejected by the domiciliary commissioner, the filing of subsequent statements of exemption is not required as long as the company continues to qualify for the exemption; rather, ongoing statements of exemption for each new calendar year will be deemed to not be rejected, unless: 1) the company does not meet either condition in D.2 below, 2) the policies contain those in D.3 below, or 3) the domiciliary commissioner contacts the company prior to Sept. 1 and notifies them that the statement of exemption is rejected. If any of these three events occur, then the statement of exemption for the current calendar year is rejected and a new statement of exemption must be filed and not rejected in order for the company to exempt additional policies.

In the case of an ongoing statement of exemption, rather than include a statement of exemption with the NAIC filing for the second quarter of that year, the company should enter “SEE
EXPLANATION” in response to the Life PBR Exemption supplemental interrogatory and provide as an explanation that the company is utilizing an ongoing statement of exemption.

2. Conditions for Exemption:
   a. The company has less than $300 million of ordinary life premiums, and if the company is a member of an NAIC group of life insurers, the group has combined ordinary life premiums of less than $600 million; or
   b. The only new policies that would otherwise be subject to VM-20 being issued or assumed by the company are due to election of policy benefits or features from existing policies valued under VM-A and VM-C and the company was exempted from, or otherwise not subject to, the requirements of VM-20 in the prior year.

3. Policies Excluded from the Life PBR Exemption:
   a. Universal life with secondary guarantee (ULSG) policies with a secondary guarantee that does not meet the VM-01, Definitions for Terms in Requirements, definition of a “non-material secondary guarantee.”

4. Each exemption, or lack of an exemption, outlined in D.1 – D.3 above applies only to policies issued or assumed in the current year, and it applies to all future valuation dates for those policies. However, if policies did not qualify for the Life PBR Exemption during the year of issue but would have qualified for the Life PBR Exemption if the current Valuation Manual requirements had been in effect during the year of issue, then the domiciliary commissioner may allow an exemption for such policies. The minimum reserve requirements for the ordinary life policies subject to the exemption are those pursuant to applicable methods required in VM-A and VM-C using the mortality as defined in VM-20 Section 3.C.1 and VM-M Section 1.H.

Valuation Manual Section II, Subsection 1.D - Footnote

1 Premiums are measured as total (first year, single, and renewal) direct plus total (first year, single, and renewal) reinsurance assumed from an unaffiliated company from the ordinary life line of business reported in the prior calendar year life/health annual financial statement, Exhibit 1, Part 1, Column 3, “Ordinary Life Insurance” excluding premiums for guaranteed issue policies and preneed life contracts and excluding amounts that represent the transfer of reserves in force as of the effective date of a reinsurance assumed transaction and are reported in Exhibit 1 Part 1, Column 3 as ordinary life insurance premium. Preneed is as defined in VM-01.

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

Addresses the exemption of policies issued in 2020 and 2021 (such as conversions) that may be exempted under the 2022 Valuation Manual requirements but did not qualify under the 2020 or 2021 Valuation Manual requirements.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   Identification:
   Dany Provencher, Appointed Actuary, Industrial Alliance group of companies

   Title of the issue:
   Asset collar when modeled reserve is negative

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

   VM-20 Section 7.D.3

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

   If for all model segments combined, the aggregate annual statement value of the final starting assets, less the
   corresponding PIMR balance, is
   (a) less than 98% of the modeled reserve; or
       (i) 98% of the modeled reserve if modeled reserve is positive;
       (ii) 102% of the modeled reserve if modeled reserve is negative; or
   (b) greater than the largest of:
       (i) 102% of the modeled reserve;
       (ii) the NPR for the same set of policies, net of due and deferred premiums thereon:
           and
       (iii) zero,
   then the company shall provide documentation in the PBR Actuarial Report that provides reasonable assurance that
   the modeled reserve is not materially understated as a result of the estimate of the amount of starting assets.

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

   If modeled reserve is negative, using assets corresponding to 100% of modeled reserve, would not fall within the
asset collar.

* This form is not intended for minor corrections, such as formatting, grammar, cross-references or spelling. Those types of changes do not require action by the entire group and may be submitted via letter or email to the NAIC staff support person for the NAIC group where the document originated.
Life Actuarial (A) Task Force
Amendment Proposal Form 2021-03
Exposed for a 21-day public comment period ending May 3, 2021

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

Please submit comments to Reggie Mazyck (RMazyck@naic.org) by COB 5/3/21.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
   
   American Academy of Actuaries, Variable Annuity Reserves & Capital Work Group

   Update the reference to the required minimum distribution (RMD) age in the VM-21 Standard Projection Amount for the Setting Every Community Up for Retirement Enhancement (SECURE) Act change.

2. Identify the document, including the date if the document is “released for comment,” and the location in the document where the amendment is proposed:
   
   January 1, 2021, version of the Valuation Manual

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

   In VM-21, Section 6.C.5:

   i. For tax-qualified contracts, add the following to the revised GAPV² corresponding to an initial withdrawal age of ≤4 the federal required minimum distribution (RMD) age.

   \[
   0.50 \times \begin{cases} 
   0.95 - \sum_{i=\text{initial age}}^{\text{final age}} \text{GAPV}_{\text{adj.}}^{\text{scaled}}, & \text{if contract is a tax-qualified GMWB,} \\
   0.85 - \sum_{i=\text{initial age}}^{\text{final age}} \text{GAPV}_{\text{adj.}}^{\text{scaled}}, & \text{if contract is a tax-qualified hybrid GMIB,} 
   \end{cases}
   \]

   j. Scale the revised GAPV² values at all future initial withdrawal ages—i.e., all ages greater than ≤4 the federal required minimum distribution (RMD) age, as identified in the preceding step—such that the sum of the revised GAPV² values equals 0.95 for tax-qualified GMWB contracts and 0.85 for tax-qualified hybrid GMIB contracts again.

   n. The cohorts and their associated weights as determined in Section 6.C.5.a through Section 6.C.5.k are for a contract with attained age equal to its issue age. Because the discount rate used in this determination is fixed, generally these calculations only need to be performed once for a given set of contracts with a certain issue age, guaranteed benefit product, and tax status.

   Guidance Note: Cohorts and their associated weights may need to be revised if prescribed assumptions are updated.

4. State the reason for the proposed amendment? (You may do this through an attachment.)
The Standard Projection’s withdrawal delay cohort method includes an adjustment at the required minimum distribution (RMD) age. The SECURE Act changed the RMD age from 70.5 to 72. This proposed amendment implements the change by directly referencing the RMD age. The direct reference will reduce Valuation Manual maintenance for any future changes.

The proposed guidance note presumes that Section 6.C.5.n refers to how cohorts and weights are unaffected by changes in interest rates at each reporting date because the discount rate for the calculations is fixed, but it indicates that periodic updates to underlying prescribed assumptions may require recalculations. LATF is requesting comments on this interpretation and its applicability to this RMD change vs. Standard Projection assumption updates more broadly.

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

NAIC Staff Comments:

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

1. Identify yourself, your affiliation and a very brief description (title) of the issue.
Brian Bayerle, ACLI – edits adopted changes to VM-02 for improved clarity and to remove potential circularity.

2. Identify the document, including the date if the document is "released for comment," and the location in the document where the amendment is proposed:
Valuation Manual (January 1, 2021 edition), VM-02 Section 3.A

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

4. State the reason for the proposed amendment? (You may do this through an attachment.)
Subsequent the adopted changes to the federal tax code (IRC S. 7702), this proposed change would clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.
Section 3: Interest

A. The nonforfeiture interest rate for any life insurance policy issued in a particular calendar year beginning on and after the operative date of the Valuation Manual shall be equal to 125% of the calendar year statutory valuation interest rate defined for the NPR in the Valuation Manual for a life insurance policy with nonforfeiture values, whether or not such sections apply to such policy for valuation purposes, rounded to the nearer one-quarter of 1%, provided, however, that the nonforfeiture interest rate shall not be less than the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

Guidance Note: For flexible premium universal life insurance policies as defined in Section 3.D of the Universal Life Insurance Model Regulation (#585), this is not intended to prevent an interest rate guarantee less than the nonforfeiture interest rate.

Deleted: applicable interest rate prescribed to meet the definition of life insurance
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation

Title of the Issue: Clarify the definition of modeled company investment strategy and the comparison to the alternative investment strategy.

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

January 1, 2020 NAIC Valuation Manual
- VM-01
- VM-20 Section 7.E
- VM-21 Section 4.D
- VM-31 Sections 3.D.6 and 3.F.6

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

See attached.

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

There is an inconsistency in VM-20/VM-21 and VM-31 regarding the term “model investment strategy”. The term “model investment strategy” is used throughout VM-20 and VM-21 to describe the investment strategy used in the model as a proxy for the company’s actual investment strategy. However, VM-31 uses the term “modeled company investment strategy” in several places rather than “model investment strategy”. “Modeled company investment strategy” is the preferred term, so VM-20 and VM-21 have been modified to use “modeled company investment strategy” so that the terminology in VM-20, VM-21 and VM-31 are consistent.

Also, to address the ambiguity of whether the final investment strategy in the model is the initial investment strategy based on the company’s investment strategy or the alternative investment strategy when the alternative strategy is constraining, the term “modeled company investment strategy” has been added to the definitions in VM-01 (and a parenthetical has been added to VM-31) to clarify that the term refers to the investment strategy in the model prior to comparison to the alternative investment strategy. In addition, VM-21 has been modified to be consistent with the wording in VM-20 to clarify that the assets in the alternative investment strategy should use the same weighted average life (WAL) as the assets in the modeled company investment strategy.
VM-01 Changes:

VM-01 provides definitions for terms used in the Valuation Manual. The definitions in VM-01 do not apply to documents outside the Valuation Manual even if referenced or used by the Valuation Manual, such as the AP&P Manual. Some terms in the Valuation Manual may be defined in specific sections of the Valuation Manual instead of being defined in VM-01.

- The term "margin" means an amount included in the assumptions used to determine the modeled reserve that incorporates conservatism in the calculated value consistent with the requirements of the various sections of the Valuation Manual. It is intended to provide for estimation error and adverse deviation.

- The term "modeled company investment strategy" means the investment strategy used in the model that is intended to be a representation of the actual investment strategy of the company. It is before the comparison is made to the alternative investment strategy. It does not refer to the alternative investment strategy when the alternative investment strategy is constraining.

- The term "modeled reserve" means the deterministic reserve on the policies determined under VM-20 Section 2.A.1.a, 2.A.2.a and 2.A.3.b, plus the greater of the deterministic reserve and the stochastic reserve on the policies determined under Section 2.A.1.b, 2.A.2.b and 2.A.3.c.

VM-20 Changes:

Section 7: Cash-Flow Models

E. Reinvestment Assets and Disinvestment

1. At the valuation date and each projection interval as appropriate, model the purchase of general account reinvestment assets with available cash and net asset and liability cash flows in a manner that is representative of and consistent with the company’s investment policy for each model segment, subject to the following requirements:
   a. The "modeled company investment strategy" may incorporate a representation of the actual investment policy that ranges from relatively complex to relatively simple. In any case, the PBR Actuarial Report shall include documentation supporting the appropriateness of the representation relative to actual investment policy.
   
   Guidance Note: A complex model representation may include, for example, illiquid or callable assets whereas a simple model representation may involve mapping of more complex assets to combinations of, for example, public non-callable corporate bonds, U.S. Treasuries and cash.

   b. The final maturities and cash-flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a fixed or floating rate interest basis, shall be determined by the company as part of the model representation.

   c. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the then-current U.S. Department of the Treasury (Treasury Department) curve along the relevant scenario and the requirements for gross asset spread assumptions stated below.

   d. For purchases of public non-callable corporate bonds, use the gross asset spreads over Treasuries prescribed in Section 9.F.8.a through Section 9.F.8.c. (For purposes of this
subsection, “public” incorporates both registered and 144a securities.) The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four.

e. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in Section 9.F.8.d for interest rate swap spreads.

f. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps as defined in Section 9.F.8.

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy (in compliance with Section 7.L) are not affected by this requirement.

Guidance Note: VM-31 requires a demonstration of compliance with VM-20 Section 7.E.1.g. In many cases, particularly if the modeled company investment strategy does not involve callable assets, it is expected that the demonstration of compliance will not require running the reserve calculation twice. For example, an analysis of the weighted average net reinvestment spread on new purchases by projection year (gross spread minus prescribed default costs minus investment expenses) of the modeled company investment strategy compared to the weighted average net reinvestment spreads by projection year of the alternative strategy may suffice. The assumed mix of asset types, asset credit quality or the levels of non-prescribed spreads for other fixed income investments may need to be adjusted to achieve compliance.

VM-21 Changes:
Section 4: Determination of the Stochastic Reserve
D. Projection of Assets
4. General Account Assets
   a. General account assets shall be projected, net of projected defaults, using assumed investment returns consistent with their book value and expected to be realized in future periods as of the date of valuation. Initial assets that mature during the projection and positive cash flows projected for future periods shall be invested in a manner that is representative of and consistent with the company’s investment policy, subject to the following requirements:
      i. The final maturities and cash flow structures of assets purchased in the model, such as the patterns of gross investment income and principal repayments or a
fixed or floating rate interest basis, shall be determined by the company as part of the model representation;

ii. The combination of price and structure for fixed income investments and derivative instruments associated with fixed income investments shall appropriately reflect the projected Treasury Department curve along the relevant scenario and the requirements for gross asset spread assumptions stated below;

iii. For purchases of public non-callable corporate bonds, follow the requirements defined in VM-20 Sections 7.E, 7.F and 9.F. The prescribed spreads reflect current market conditions as of the model start date and grade to long-term conditions based on historical data at the start of projection year four;

iv. For transactions of derivative instruments associated with fixed income investments, reflect the prescribed assumptions in VM-20 Section 9.F for interest rate swap spreads;

v. For purchases of other fixed income investments, if included in the modeled company investment strategy, set assumed gross asset spreads over U.S. Treasuries in a manner that is consistent with, and results in reasonable relationships to, the prescribed spreads for public non-callable corporate bonds and interest rate swaps.

b. Notwithstanding the above requirements, the stochastic reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).

Policy loans, equities and derivative instruments associated with the execution of a clearly defined hedging strategy are not affected by this requirement.

Drafting Note: This limitation is being referred to Life Actuarial (A) Task Force for review.

VM-31 Changes:

Section 3: PBR Actuarial Report Requirements

D. Life Report – This subsection establishes the Life Report requirements for individual life insurance policies valued under VM-20.

6. Assets – The following information regarding the asset assumptions used by the company in performing a principle-based valuation under VM-20:

r. Modeled Company Investment Strategy and Reinvestment Assumptions – Description of the modeled company investment strategy (before comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and
documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

s. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-20 Section 7.E.1.g, showing that the modeled reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.

F. **VA Report** – This subsection establishes the VA Report requirements for variable annuity contracts valued under VM-21.

6. **General Account Assets** – The following information regarding the general account asset assumptions used by the company in performing a principle-based valuation under VM-21:

   a. **Modeled Company Investment Strategy and Reinvestment Assumptions** – Description of the modeled company investment strategy (before the comparison to the alternative investment strategy), including asset reinvestment and disinvestment assumptions, and documentation supporting the appropriateness of the modeled company investment strategy compared to the actual investment policy of the company.

   b. **Alternative Investment Strategy** – Documentation demonstrating compliance with VM-21 Section 4.D.4.b showing that the stochastic reserve is the higher of that produced using the modeled company investment strategy and the alternative investment strategy.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Angela McNabb & Pat Allison – NAIC staff support

Revisions to VM-50 and VM-51 to allow for data experience reporting to be performed by a reinsurer or third-party administrator and a correction to VM-51 Appendix 4.

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


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

See attached redline document.

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

This APF is needed for the following reasons:

1. VM-51 Appendix 4 includes a column indicating the position within the data file for each field. This is not valid as the NAIC’s RDC system was designed to accept comma delimited files. This APF will remove that column.

2. The VM-51 Section 2.B states that companies must submit data for all their direct written business prior to reinsurance ceded. The only exception is in the case of assumption reinsurance where policies have been legally novated. The NAIC has received feedback from a number of companies indicating that they have business that is reinsured and fully administered by the reinsurer. Since the ceding companies do not have the data, it represents a hardship for them to submit this business.

3. Currently, VM-51 Appendix 4 only allows one company code. In order to allow a reinsurer or third-party administrator to submit data on behalf of the direct writer, the NAIC must be able to identify both the submitting company and the direct writer of the block of business. This APF adds an additional field to accomplish this. By having the submitting company’s code, any questions the NAIC has regarding the data can be directed to the submitting company without fear of breaching confidentiality.

4. Having separate identifiers for the submitting company and direct writer will allow the NAIC to validate the reconciliations required by VM-50 Section 4.B.3.

Below are examples showing how the reconciliations would work according to the amended language in VM-50 Section 4.B.3.

Example 1: This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.c. Company A is a direct writer selected for VM-51 reporting.

- The company has retained and administers 35,000 policies (out of a total of 100,000).
- Company B (a reinsurer not selected to submit their own business) administers 50,000 policies for Company A.
o Company C (a reinsurer selected to submit their own direct business) administers 15,000 policies for Company A.

### RECONCILIATION FOR COMPANY A (Direct Writer)

<table>
<thead>
<tr>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Business as Reported in Company A’s Annual Statement</td>
<td>100,000</td>
</tr>
<tr>
<td>Business being reported by Company B</td>
<td>(50,000)</td>
</tr>
<tr>
<td>Business being reported by Company C</td>
<td>(15,000)</td>
</tr>
<tr>
<td>Totals included in Company A’s data submissions</td>
<td>35,000</td>
</tr>
</tbody>
</table>

**Example 2:** This example illustrates the scenario described in the redlined language in VM-50 Section 4.B.3.a. Company D is another direct writing company selected for VM-51 reporting. Company B has been asked by Companies A and D to submit data Company B has assumed and administers.

- Company B administers 50,000 policies for Company A.
- Company B administers 100,000 policies for Company D.
- Company B is not required to reconcile to their Annual Statement since they were not selected to submit their direct business.
- In this example, Company B is a reinsurer. However, Company B could also be a third-party administrator that is not an insurance company.

### RECONCILIATION FOR COMPANY B

<table>
<thead>
<tr>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business being reported on behalf of Company A</td>
<td>50,000</td>
</tr>
<tr>
<td>Business being reported on behalf of Company D</td>
<td>100,000</td>
</tr>
<tr>
<td>Totals included in Company B’s data submission</td>
<td>150,000</td>
</tr>
</tbody>
</table>

**Example 3:** This example illustrates the scenario described in redlined language in VM-50 Section 4.B.3.b. Company C has also been asked by company A to submit data Company C has assumed and administers.

- Company C has 1,500,000 policies reported in their Annual Statement.
- Company C has 250,000 of reinsurance assumed policies which should not be included in their submission. Reinsurance assumed should only be included when the ceding company requests that the reinsurer report it on their behalf.
- Company C has 1,250,000 policies of direct written business that they must report.
- In addition to Company C’s direct written business, they will also be reporting 15,000 policies that they administer on behalf of Company A (per Company A’s request).

### RECONCILIATION FOR COMPANY C

<table>
<thead>
<tr>
<th>Policy Count</th>
<th>Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Business as Reported in Company C’s Annual Statement</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Assumed Reinsurance Total</td>
<td>(250,000)</td>
</tr>
<tr>
<td>Subtotal - Direct Written Business for Company C</td>
<td>1,250,000</td>
</tr>
<tr>
<td>Business being reported on behalf of Company A</td>
<td>15,000</td>
</tr>
<tr>
<td>Totals included in Company C’s data submissions</td>
<td>1,265,000</td>
</tr>
</tbody>
</table>
Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

1. PBR may require development of assumptions and margins based on company experience, industry experience or a blend of the two. The collection of experience data provides a database to establish industry experience tables or factors, such as valuation tables or factors as needed.

2. The development of industry experience tables provides a basis for assumptions when company data is not available or appropriate and provides a comparison basis that allows the state insurance regulator to perform reasonableness checks on the appropriateness of assumptions as documented in the actuarial reports.

3. The collection of experience data may assist state insurance regulators, reviewing actuaries, auditors and other parties with authorized access to the PBR actuarial reports to perform reasonableness checks on the appropriateness of principle-based methods and assumptions, including margins, documented in those reports.

4. The collection of experience data provides an independent check on the accuracy and completeness of company experience studies, thereby encouraging companies to establish a disciplined internal process for producing experience studies. Industry aggregate or sub-industry aggregate experience studies may assist a company when setting experience-based assumptions. As long as the confidentiality of each company's submitted results is maintained, a company may obtain results of a study on companies' submitted experience for use in formulating experience assumptions.

5. The collection of experience data will provide a basis for establishing and updating the assumptions and margins prescribed by regulators in the Valuation Manual.

6. The reliability of assumptions based on company experience is founded on reliable historical data from comparable characteristics of insurance policies including, but not limited to, underwriting standards and insurance policy benefits and provisions. As with
all forms of experience data analysis, larger and more consistent statistical samples have a
greater probability of producing reliable analyses of historic experience than smaller or
inconsistent samples. To improve statistical credibility, it is necessary that experience data
from multiple companies be combined and aggregated.

7. The collection of experience data allows state insurance regulators to identify outliers and
monitor changes in company experience factors versus a common benchmark to provide a
basis for exploring issues related to those differences.

8. PBR is an emerging practice and will evolve over time. Research studies other than those
contemplated at inception may be useful to improvement of the PBR process, including
increasing the accuracy or efficiency of models. Because the collection of experience data
will facilitate these improvements, research studies of various types should be encouraged.

9. The collection of experience data is not intended as a substitute for a robust review of
companies’ methodologies or assumptions, including dialogue with companies’ actuaries.

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

1. Model #820 provides the legal authority for the Valuation Manual to prescribe experience
reporting requirements with respect to companies and lines of business within the scope of
the model.

2. The statutes and regulations requiring data submissions generally apply to all companies
licensed to sell life insurance, A&H insurance and deposit-type contracts. These companies
must submit experience data as prescribed by the Valuation Manual.

3. Section 4A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

1. For the purposes of implementing the experience reporting required by state laws based on
Section 13 of Model #820, an Experience Reporting Agent will be used for the purpose of
collecting, pooling and aggregating data submitted by companies as prescribed by lines of
business included in VM-51.

2. The NAIC is designated as Experience Reporting Agent for the Statistical Plan for
Mortality beginning Jan. 1, 2020, and NAIC expertise in collecting and sorting data from
multiple sources into a cohesive database in a secure and efficient manner, but the
designation of the NAIC as Experience Reporting Agent does not preclude state insurance
regulators from independently engaging other entities for similar data required under this
Valuation Manual or other data purposes.

Section 3: Experience Reporting Requirements

A. Statistical Plans

1. Consistent with state laws based on Section 13 of Model #820, the Experience Reporting
Agent shall collect experience data based on statistical plans defined in the Valuation
Manual.

2. Statistical plans are detailed instructions that define the type of experience data being
collected (e.g., mortality; elective policyholder behavior, such as surrenders, lapses,
premium payment patterns, etc.; and company expense data, such as commissions, policy expenses, overhead expenses etc.). The state insurance regulators serving on the Life Actuarial (A) Task Force and Health Actuarial (B) Task Force, or any successor body, will be responsible for prescribing the requirements for any statistical plan by applicable line of business. For each type of experience data being collected, the statistical plan will define the data elements and format of each data element, as well as the frequency of the collection of experience data. The statistical plan will define the process and the due dates for submitting the experience data. The statistical plan will define criteria that will determine which companies must submit the experience data. The statistical plan will also define the scope of business that is to be included in the experience data collection, such as lines of business, product types, types of underwriting, etc. Statistical plans are defined in VM-51 of the Valuation Manual. Statistical plans will be added to VM-51 of the Valuation Manual when they are ready to be implemented. Additional data elements and formats to be collected will be added as necessary, in subsequent revisions to the Valuation Manual.

3. Data must conform to common data definitions. Standard definitions provide for stable and reliable databases and are the basis of meaningful aggregated insurance data. This will be accomplished through a uniform set of suggested minimum experience reporting requirements for all companies.

B. Role and Responsibilities of the Experience Reporting Agent

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

2. The Experience Reporting Agent will aggregate the experience of companies using a common set of classifications and definitions to develop industry experience tables.

3. The Experience Reporting Agent will seek to enter into agreements with a group of state insurance departments for the collection of information under statistical plans included in VM-51. The number of states that contract with the Experience Reporting Agent will be based on achieving a target level of industry experience prescribed by VM-51 for each line of business in preparing an industry experience table.

a. The agreement between the state insurance department(s) and the Experience Reporting Agent will be consistent with any data collection and confidentiality requirements included within Model #820 and the Valuation Manual. Those state insurance departments seeking to contract with the Experience Reporting Agent will inform the Experience Reporting Agent of any other state law requirements, including laws related to the procurement of services that will need to be considered as part of the contracting process.

b. Use of the Experience Reporting Agent by the contracting state insurance departments does not preclude those state insurance departments or any other state insurance departments from contracting independently with another Experience Reporting Agent for similar data required under this Valuation Manual or other data purposes.

4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will be responsible for the content and maintenance of the experience reporting requirements. The Life
Actuarial (A) Task Force or Health Actuarial (B) Task Force or a working group will monitor the data definitions, quality standards, appendices and reports described in the experience reporting requirements to assure that they take advantage of changes in technology and provide for new regulatory and company needs.

5. To ensure that the experience reporting requirements will continue to be useful, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will seek to review each statistical plan on a periodic basis at least once every five years. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force should have regular dialogue, feedback and discussion of this topic. In seeking feedback and engaging in discussions, the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force shall include a broad range of data users, including state insurance regulators, consumer representatives, members of professional actuarial organizations, large and small companies, and insurance trade organizations.

6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company’s request. In the event of a material deficiency identified in the external audit or in the event of an identified security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D. The term “good cause” shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

1. Consult with the NAIC (as appropriate) in the design and implementation of the experience retrieval process;

2. Assist with the data validation process for data intended to be forwarded to the SOA or other actuarial professional organizations to develop industry experience tables;

3. Analyze data, including any summarized or aggregated data, produced by the Experience Reporting Agent;
4. Create initial experience tables and any revised tables;

5. Provide feedback in the development and evaluation of requests for proposal for services related to the reporting of experience requirement;

6. Create statutory valuation tables as appropriate and necessary;

7. Determine and produce additional industry experience tables or reports that might be suggested by the data collected;

8. Work with the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force, in accordance with the *Valuation Manual* governance process, in developing new reporting formats and modifying current experience reporting formats;

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

**Section 4: Data Quality and Ownership**

**A. General Requirements**

1. The quality, accuracy and consistency of submitted data is key to developing industry experience tables that are statistically credible and represent the underlying emerging experience. Statistical procedures cannot easily detect certain types of errors in reporting of data. For example, if an underwriter fails to evaluate the proper risk classification for an insured, then the “statistical system” has little chance of detecting such an error unless the risk classification is somehow implausible.

2. To ensure data quality, coding a policy, loss, transaction or other body of data as anything other than what it is known as is prohibited. This does not preclude a company from coding a transaction with incomplete detail and reporting such transactions to the Experience Reporting Agent, but there can be nothing that is known to be inaccurate or deceptive in the reporting. An audit of a company’s data submitted to the Experience Reporting Agent under a statistical plan in VM-51 can include comparison of submitted data to other company files.

3. When the Experience Reporting Agent determines that the cause of an edit exception could produce systematic errors, the company must correct the error and respond in a timely fashion, with priority given to errors that have the largest likelihood to affect a significant amount of data. When an error is found that has affected data reported to the Experience Reporting Agent, the company shall report the nature of the error and the nature of its likely impact to the Experience Reporting Agent. Retrospective correction of data subject to systematic errors shall be done when the error affects a significant amount of data that is still being used for regulatory purposes and it is reasonably practical to make the correction through the application of a computer program or a procedure applied to the entire data set without the need to manually examine more than a small number of individual records.

**B. Specific Requirements**

1. Once the data file is submitted by the company, the Experience Reporting Agent will perform a validity check of the data elements within each data record in the data file for proper syntax and verify that required data elements are populated. The Experience Reporting Agent will notify the company of all syntax errors and any missing data elements
that are required. Companies are required to respond to the Experience Reporting Agent by submitting a corrected data file. The Experience Reporting Agent will provide sufficient notice to reporting companies of changes, procedures and error tolerances to enable the companies to adequately prepare for the data submission.

2. Each submission of data filed by an insurance company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. At a minimum, these control totals shall include applicable record counts, claim counts, amounts insured and claim amounts. Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent. The reconciliation must include policy count and insurance amount.
   a. If a third-party administrator that is not an insurance company or an insurance company not required to submit their direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
   b. If the third-party administrator is an insurance company that is required to submit their direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
   c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or third-party administrator must include lines indicating the amount of business that is being reported by the reinsurer or third-party administrator. The NAIC will use this information to confirm that all in-scope business is reported and there is no double counting of policies.

4. Validity checks are designed to identify:
   a. Improper syntax or incomplete coding (e.g., a numeric field that is not numeric, missing elements of a date field);
   b. Data elements containing codes that are not contained within the set of possible valid codes;
   c. Data elements containing codes that are contained within the set of possible valid codes but are not valid in conjunction with another data element code;
   d. Required data elements that are not populated.

5. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.
6. Errors of a consistent nature are referred to as “systematic.” Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of insurer company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.

7. The Experience Reporting Agent will undertake reasonability checks that include the comparison of aggregate and company experience for underwriting class and type of coverage data elements for the current reporting period to company and aggregate experience from prior periods for the purpose of identifying potential coding or reporting errors. When reporting instructions are changed, newly reported data elements shall be examined to see that they correlate reasonably with data elements reported under the old instructions.

8. At a minimum, reasonability checks by the Experience Reporting Agent will include:
   a. An unusually large percentage of company data reported under a single or very limited number of categories;
   b. Unusual or unlikely reporting patterns in a company’s data;
   c. Claim amounts that appear unusually high or low for the corresponding exposures;
   d. Reported claims without corresponding policy values and exposures;
   e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;
   f. Unusual shifts in the distribution of business from one reporting period to the next.

9. If a company’s unusual pattern under Section 4.B.8.a, Section 4.B.8.b or Section 4.B.8.c is verified as accurate (that is, the reason for the apparent anomaly is an unusual mix of business), then it is not necessary that a similar pattern for the same company be reconfirmed year after year.

10. The Experience Reporting Agent will keep track of the results of the validity and reasonability checks and may adjust thresholds in successive reporting years to maintain a reasonable balance between the magnitude of errors being found and the cost to companies.

11. Results that may indicate a likelihood of critical indications, as defined below, will be reported to the company with an explanation of the unusual findings and their possible significance. When the possible or probable errors appear to be of a significant nature, the Experience Reporting Agent will indicate to the company that this is a “critical indication.” “Critical indications” are those that, if not corrected or confirmed, would leave a significant degree of doubt whether the affected data should be used in reports to the state insurance regulator and included in industry databases. It is intended that Experience Reporting Agents will have reasonable flexibility to implement this under the direction of the state insurance regulators. Also, under the direction of the state insurance regulators, the Experience Reporting Agent may grade the severity of indications, or it may simply
identify certain indications as critical. While companies are expected to undertake a reasonable examination of all indications provided to them, they are not required to respond to every indication except for those labeled by the Experience Reporting Agent as "critical."

12. The Experience Reporting Agent will use its discretion regarding the omission of data from reports owing to the failure of an insurer company to respond adequately to unusual reasonability indications. Completeness of reports is desirable, but not at the risk of including data that appears to have an unreasonably high chance of containing significant errors.

13. Companies shall acknowledge and respond to reasonability queries from the Experience Reporting Agent. This shall include specific responses to all critical indications provided by the Experience Reporting Agent. Other indications shall be studied for apparent errors, as well as for indications of systematic errors. Corrections for critical indications shall be provided to the Experience Reporting Agent or, when a correction is not feasible, the extent and nature of the error shall be reported to the Experience Reporting Agent.

C. Ownership of Data

1. Experience data submitted by companies to the Experience Reporting Agent will be considered the property of the companies submitting such data, but the recognition of such ownership will not affect the ability of state insurance regulators or the NAIC to use such information as authorized by state laws based on Model #820 or the Valuation Manual, or, in case of state insurance regulators, for solvency oversight, financial examinations and financial analysis.

2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the Valuation Manual. The Experience Reporting Agent will be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

1. Using the data collected under statistical plans, as defined in the Valuation Manual, the Experience Reporting Agent produces aggregate databases as defined by this Valuation Manual. The Experience Reporting Agent, and/or other persons assisting the Experience Reporting Agent, will utilize those databases to produce industry experience tables and reports as defined in the Valuation Manual. In order to ensure continued relevance of reports, each defined data collection and resulting report structure shall be reviewed for usefulness at least once every five years since initial adoption or prior review.

2. Data compilations are evaluated according to four distinct, and often competing, standards: quality, completeness, timeliness and cost. In general, quality is a primary goal in developing any statistical data report. The priorities of the other three standards vary according to the purpose of the report.

3. The Experience Reporting Agent may modify or enlarge the requirements of the Valuation Manual, through recommendation to the Life Actuarial (A) Task Force or Health Actuarial (B) Task Force and in accordance with the Valuation Manual governance process for information to accommodate changing needs and environments. However, in most cases,
changes to existing data reporting systems will be feasible only to provide information on future transactions. Requirements to submit new information may require that companies change their systems. Also, the Experience Reporting Agent may need several years before it can generate meaningful data meeting the new requirements with matching claims and insured amounts. The exact time frames for implementing new data requirements and producing reports will vary depending on the type of reports.

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

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

2. Statistical compilations are aggregate reports that generally match appropriate exposure amounts and transaction event amounts to evaluate the recent experience for a line of business. For example, a statistical compilation of mortality experience would match insurance face amounts exposed to death with actual death claims paid. Here the exposure amount is the total insurance face amount exposed to death, and the transaction event amounts would be the death claims paid. As another example, a statistical compilation of surrender experience would match total cash surrender amounts exposed to surrender with actual surrender amounts paid. Here the exposure amount is the total cash surrender amounts that could be surrendered, and the transaction event amounts would be the total surrender amounts actually paid. Statistical compilations can be performed for the industry or for the state of domicile.

3. In addition to statistical compilations, state insurance regulators can specify additional reports based on elements in the statistical plans in VM-51. State insurance regulators can also use statistical compilations and additional reports to evaluate non-formulaic assumptions.

4. The Life Actuarial (A) Task Force or Health Actuarial (B) Task Force will specify the reports to be provided to the professional actuarial associations to fulfill their roles as specified in Section 3.C of this VM-50. In general, the reports are expected to include statistical compilation at the industry level.

5. State insurance regulators can use the reports to review long-term trends. Aggregate experience results may indicate areas warranting additional investigation.

D. Supplemental Reports

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

E. Reports to State Insurance Departments

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

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

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

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

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

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

B. Treatment of Confidential Information

1. Confidential information may be shared only with those individuals and entities specified in state laws based on Section 14B(3) of Model #820. Any agreement between a state insurance department and the Experience Reporting Agent will address the extent to which the Experience Reporting Agent is authorized to share confidential information consistent with state law.

2. The Experience Reporting Agent may be required to use confidential information in order to prepare compilations of aggregated experience data that do not permit identification of individual company experience or personally identifiable information. These reports of aggregated information, including those reports referenced in Section 5 of VM-50, are not considered confidential information, and the Experience Reporting Agent may make publicly available such reports. Reports using aggregate experience data will have...
sufficient diversification of data contributors to avoid identification of individual companies.

3. Consistent with state laws based on Section 14B(3) of the Model #820 and any agreements between a state insurance department and the Experience Reporting Agent, access to the confidential information will be limited to:
   a. State, federal or international regulatory agencies;
   b. The company with respect to confidential information it has submitted, and any reports prepared by the Experience Reporting Agent based on such confidential information;
   c. The NAIC, and its affiliates and subsidiaries;
   d. Auditor(s) of the Experience Reporting Agent for purposes of the experience reporting function outlined in this VM-50; and
   e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.
Section 1: Introduction

A. The experience reporting requirements are defined in Section 3 of VM-50. The experience reporting requirements state that the Experience Reporting Agent will collect experience data based on statistical plans that are defined in VM-51 of the Valuation Manual. Statistical plans are to be added to VM-51 of the Valuation Manual when they are ready to be implemented.

B. Each statistical plan shall contain the following information:

1. The type of experience data to be collected (e.g., mortality experience; policy behavior experience, such as surrenders, lapses, conversions, premium payment patterns, etc.; and company expense experience, such as commission expense, policy issue and maintenance expense, company overhead expenses etc.);

2. The scope of business to be included in the experience data to be collected (e.g., line(s) of business, such as individual or group, life, annuity or health; product type(s), such as term, whole life, universal life, indexed life, variable life, fixed annuity, indexed annuity, variable annuity, LTC or disability income; and type of underwriting, such as medically underwritten, simplified issue (SI), GI, accelerated, etc.);

3. The criteria for determining which companies or legal entities must submit the experience data to be collected;

4. The process for submitting the experience data to be collected, which will include the frequency of the data collection, the due dates for data collection and how the data is to be submitted to the Experience Reporting Agent;

5. The individual data elements and format for each data element that will be contained in each experience data record, along with detailed instructions defining each data element or how to code each data element. Additional information may be required, such as questionnaires and plan code forms that will assist in defining the individual data elements that may be unique to each company or legal entity submitting such experience data elements;

6. The experience data reports to be produced.

Section 2: Statistical Plan for Mortality

A. Type of Experience Collected Under This Statistical Plan
The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan is the individual ordinary life line of business. Such business is to include direct written business issued in the U.S. All values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 2.B.2. Therefore, reinsurance assumed from a ceding company shall be excluded from data collection to avoid double-counting of experience submitted by an issuer and by its reinsurers; however, assumption reinsurance of an individual ordinary life line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan. The ordinary life line of business does not include separate lines of business, such as SI/GI, worksite, individually solicited group life, direct response, final expense, preneed, home service, credit life, and corporate-owned life insurance (COLI)/bank-owned life insurance (BOLI)/charity-owned life insurance (CHOLI).

2. In the event a reinsurer or third-party administrator is responsible for administering a block of business, the reinsurer or third-party administrator may submit that block of business on behalf of the direct writer. In this case the reinsurer or third-party administrator must be identified in Appendix 4 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 4 Item 2 - NAIC Company Code of Direct Writer.

   a. As defined in VM-50 Section 4.B.3, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or third-party administrators must include lines indicating the amount of business that is being reported by the reinsurers and/or third-party administrators. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or third-party administrators to ensure that all business is included and there is no double counting of policies.

   b. If an insurance company is required to submit their direct written business and they also have reinsurance assumed business, they should only submit the assumed business if asked to do so by the ceding company since some ceding companies may not have been selected for data submission.

3. The direct writing company is ultimately responsible for all the data submitted for their company.

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

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

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

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be two years prior to the reporting calendar year. For example, if the current calendar year is 2018 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2016, which is the observation calendar year.

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

i. Report policies in force during or issued during calendar year 20XX.

ii. Report terminations that were incurred in calendar year 20XX and reported before July 1, 20XX+1. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the Valuation Manual in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Dec. 31 of the reporting calendar year.

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

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.
Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by June 30 of the year after the observation year.

Plans of insurance should be carefully matched with the three-digit codes in item 19, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

i. For policies issued before Jan. 1, 1990, companies may certify that submitting data presents a hardship due to fields not readily available in their systems/databases or legacy computer systems that continue to be used for older issued policies and differ from computer systems for newer issued policies.

ii. For policies issued on or after Jan. 1, 1990, companies must:

   a) Document the percentage that the face amount of policies excluded are relative to the face amount of submitted policies issued on or after Jan. 1, 1990; and

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

F. Experience Data Reports Required by This Statistical Plan

1. Using the data collected under this statistical plan, the Experience Reporting Agent will produce an experience data report that aggregates the experience data of all companies whose data have passed all of the validity and reasonableness checks outlined in Section 4 of VM-50 and has been determined by the Experience Reporting Agent to be acceptable to be used in the development of industry mortality experience.

2. The Experience Reporting Agent will provide to the SOA or other actuarial professional organizations an experience data report of aggregated experience that does not disclose a company’s identity, which will be used to develop industry mortality experience and valuation mortality tables.

3. As long as a company is licensed in a state, that state insurance regulator will be given access to a company’s experience data that is stored on a confidential database at the Experience Reporting Agent. Access by the state insurance
regulator will be controlled by security credentials issued to the state insurance regulator by the Experience Reporting Agent.
Appendix 1: Preferred Class Structure Questionnaire

PREFERRED CLASS STRUCTURE QUESTIONNAIRE

Fill out this preferred class structure questionnaire based on companywide summaries, such as underwriting guideline manuals, compilations of issue instructions or other documentation.

The purpose of this preferred class structure questionnaire is to gather information on different preferred class structures. This questionnaire varies between nonsmoker/non-tobacco and smoker/tobacco users and provides for variations by issue year, face amount and plan. If the company has the standard Relative Risk Score (RR Score) information available, the company should map its set of preferred class structure to sets of RR Scores. Except for new preferred class structures or new sets of RR Scores applied to existing preferred class structure(s), the response to the questionnaire should remain the same from year to year.

If a company has determined sets of RR Scores for its preferred class structures, it should provide separate preferred class structure responses for each set of RR Scores applied to a preferred class structure. If a company has not determined sets of RR Scores for its preferred class structures, it should fill out this questionnaire with its preferred class structures and update the preferred class structure questionnaire at such future time that sets of RR Scores for the preferred class structures are determined. When sets of RR Scores are used, there is to be a one-to-one correspondence between a preferred class structure and a set of RR Scores.

The information given in this questionnaire will be used both to map a set of RR Scores to policy level data and as a check on the policy-level data submission. Submit this questionnaire along with the initial data submission to the Experience Reporting Agent.

Each preferred class structure must include at least two classes (e.g., one preferred class and one standard class). Make as many copies of this preferred class structure questionnaire as necessary for your individual life business and submit in addition to policy-level detail information.

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

PREFERRED CLASS STRUCTURE – Part 1 Nonsmokers/Non-Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for nonsmokers/non-tobacco users

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range \( \text{Date through Date} \)
b) Issue Age Range \( \text{Date through Date} \)
c) Face Amount Range \( \text{Date through Date} \)
d) Plan Types (use three-digit codes from item 19, Plan)
Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Nonsmoker/Non-Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

PREFERRED CLASS STRUCTURE – Part 2 Smokers/Tobacco Users

Preferred class structure must have at least one preferred and one standard class. Use multiple copies of this page if needed for smokers/tobacco users

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date  
b) Issue Age Range Date through Date  
c) Face Amount Range Date through Date  
d) Plan Types (use three-digit codes from item 19, Plan)
a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)

Number of Smoker/Tobacco User Risk Classes

a) Issue Date Range Date through Date
b) Issue Age Range Date through Date
c) Face Amount Range Date through Date
d) Plan Types (use three-digit codes from item 19, Plan)
Appendix 2: Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

<table>
<thead>
<tr>
<th>Company</th>
<th>NAIC Company Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

MORTALITY CLAIMS

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

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

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

4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six month run out are -to be included.
Are such pending claims included in the study data? □ Yes □ No

If no indicate time period for which this occurred: __________________

5. The face amounts and death claim amounts are to be included without capping by amount. Are the face amounts and death claims/exposures included without capping by amount?
   □ Yes □ No

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

6. For death claims on policies issued before 1990:

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

   If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.
Appendix 3: Additional Plan Code Form

If you need an additional plan code(s) for a product(s) in addition to those plan codes in Item 19, Plan, of the statistical plan for life insurance mortality, fill in this form using plan codes in the range 300 to 999. Your data submission should reflect the plan codes in this form. Make as many copies as necessary for your individual life business and submit in addition to policy-level information. When this form is used, it must be sent to the Experience Reporting Agent at the time that data is submitted.

Completed by: ______________________ Title: _______________________________
Company:__________________________ NAIC Company Code: _________________ Date: ______
Phone Number: _____________________ Email:_______________________________

Add comments or attachments where necessary.

Enter unique three-digit plan codes for each product.

<table>
<thead>
<tr>
<th>Plan Code For Product I</th>
<th>Plan Code for Product II</th>
<th>Plan Code for Product III</th>
</tr>
</thead>
</table>

Enter specific plan names for each product.

A. General Product Information

<table>
<thead>
<tr>
<th>Product</th>
<th>Product</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In what year was each product introduced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Briefly describe the product.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Enter three-digit plan code in the range 300 to 999.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For the products listed, please fit each product into one of the categories below.

<table>
<thead>
<tr>
<th>Categories for Product I</th>
<th>Categories for Product II</th>
<th>Categories for Product III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
<td>1 Traditional Whole Life Plans</td>
</tr>
<tr>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
<td>2 Term Insurance Plans</td>
</tr>
<tr>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
<td>5 Variable Life Plans (without Secondary Guarantees)</td>
</tr>
<tr>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
<td>6 Variable Life Plans with Secondary Guarantees</td>
</tr>
<tr>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
<td>7 Nonforfeiture</td>
</tr>
<tr>
<td>8 Other</td>
<td>8 Other</td>
<td>8 Other</td>
</tr>
</tbody>
</table>
### Appendix 4: Mortality Data Elements and Format

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COLUMN</th>
<th>LENGTH</th>
<th>DATA ELEMENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1–5</td>
<td>9</td>
<td>Submitting Company ID</td>
<td>ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company’s Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>2</td>
<td>1–5</td>
<td>5</td>
<td>NAIC Company Code of the Direct Writer of Business</td>
<td>The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, items 1 and 2 must contain the same value.</td>
</tr>
<tr>
<td>3</td>
<td>6–9</td>
<td>4</td>
<td>Observation Year</td>
<td>Enter Calendar Year of Observation</td>
</tr>
<tr>
<td>4</td>
<td>10–29</td>
<td>20</td>
<td>Policy Number</td>
<td>Enter Policy Number. For Policy Numbers with length less than 20, left justify the number, and blank fill the empty columns. Any other unique identifying number can be used instead of a Policy Number for privacy reasons.</td>
</tr>
<tr>
<td>5</td>
<td>30–32</td>
<td>3</td>
<td>Segment Number</td>
<td>If only one policy segment exists, enter segment number ‘1.’ For a single life policy, the base policy is to be put in the record with segment number ‘1.’ Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. For joint life policies, the base policy of the first life is to be put in a record with segment number ‘1,’ and the base policy of the second life is to be put in a separate record with segment number ‘2.’ Joint life policies with more than two lives are not to be submitted. Subsequent policy segments are in separate records with information about that coverage and differing segment numbers. Policy segments with the same policy number are to be submitted for: a) Single life policies; b) Joint life policies; c) Term/paid up riders; or d) Additional amounts of insurance including purchase through dividend options.</td>
</tr>
<tr>
<td>6</td>
<td>33–34</td>
<td>2</td>
<td>State of Issue</td>
<td>Use standard, two-letter state abbreviation codes (e.g., NY for New York)</td>
</tr>
<tr>
<td>ITEM COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td>--------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>45</td>
<td>1</td>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 = Unknown or unable to subdivide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Unisex – Unknown or unable to identify</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 = Unisex – Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 = Unisex – Female</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>36-43</td>
<td>8</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter the numeric date of birth in YYYYMMDD format</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>44</td>
<td>1</td>
<td>Age Basis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 = Age Nearest Birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = Age Last Birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Age Next birthday</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Drafting Note:</strong> Professional actuarial organization will need to develop either age next birthday mortality tables or procedure to adapt existing mortality tables to age next birthday basis.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>45-47</td>
<td>3</td>
<td>Issue Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter the insurance Issue Age</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>48-55</td>
<td>8</td>
<td>Issue Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enter the numeric calendar year in YYYYMMDD format.</td>
<td></td>
</tr>
<tr>
<td>ITEM COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>56</td>
<td>1</td>
<td>Smoker Status (at issue)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Smoker status should be submitted where reliable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 = Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = No tobacco usage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 = Nonsmoker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 = Cigarette smoker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 = Tobacco user</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>57</td>
<td>1</td>
<td>Preferred Class Structure Indicator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0 = If no reliable information on multiple preferred and standard classes is available or if the policy segment was issued substandard or if there were no multiple preferred and standard classes available for this policy segment or if preferred information is unknown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 = If this policy was issued in one of the available multiple preferred and standard classes for this policy segment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Note: If Preferred Class Structure Indicator is 0, or if preferred information is unknown, leave next four items blank.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>58</td>
<td>1</td>
<td>Number of Classes in Nonsmoker Preferred Class Structure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker or no tobacco usage policies that could have been issued as one of multiple preferred and standard classes, enter the number of nonsmoker preferred and standard classes available at time of issue.</td>
<td></td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>5ω</td>
<td>1</td>
<td>Nonsmoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 3 or 4, or if preferred information is unknown, leave blank. For nonsmoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest nonsmoker Preferred Class number should have that number equal to the Number of Classes in Nonsmoker Preferred Class Structure.</td>
</tr>
<tr>
<td>16</td>
<td>6ω</td>
<td>1</td>
<td>Number of Classes in Smoker Preferred Class Structure</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker or tobacco user policies that could have been issued as one of multiple preferred and standard classes, enter the number of smoker preferred and standard classes available at time of issue.</td>
</tr>
<tr>
<td>17</td>
<td>6ψ</td>
<td>1</td>
<td>Smoker Preferred Class</td>
<td>If Preferred Class Structure Indicator is 0 or if Smoker Status is 0, 1 or 2, or if preferred information is unknown, leave blank. For smoker policy segments that could have been issued as one of multiple preferred and standard classes: 1 = Best preferred class 2 = Next Best preferred class after 1 3 = Next Best preferred class after 2 4 = Next Best preferred class after 3 5 = Next Best preferred class after 4 6 = Next Best preferred class after 5 7 = Next Best preferred class after 6 8 = Next Best preferred class after 7 9 = Next Best preferred class after 8 Note: The policy segment with the highest Smoker Preferred Class number should have that number equal to the Number of Classes in Smoker Preferred Class Structure.</td>
</tr>
<tr>
<td>ITEM</td>
<td>COLUMN</td>
<td>LENGTH</td>
<td>DATA ELEMENT</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 18   | 62-63  | 2      | Type of Underwriting Requirements | If underwriting requirement of ordinary business is reliably known, use code other than “99.” Ordinary business does not include separate lines of business, such as simplified issue/guaranteed issue, worksite, individually solicited group life, direct response, final expense, preneed, home service and COLI/BOLI/CHOLI.  
01 = Underwritten, but unknown whether fluid was collected  
02 = Underwritten with no fluid collection  
03 = Underwritten with fluid collected  
06 = Term Conversion  
07 = Group Conversion  
09 = Not Underwritten  
99 = For issues where underwriting requirement unknown or unable to subdivide |
| 19   | 64     | 1      | Substandard Indicator | 0 = Policy segment is not substandard  
1 = Policy segment is substandard  
2 = Policy segment is uninsurable  
Note:  
a. All policy segments that are substandard need to be identified as substandard or uninsurable.  
b. Submission of substandard policies is optional.  
c. If feasible, identify substandard policy segments where temporary flat extra has ceased as substandard. |
| 20   | 65-67  | 3      | Plan          | Exclude from contribution: spouse and children under family policies or riders. If Form for Additional Plan Codes was submitted for this policy, enter unique three-digit plan number(s) that differ from the plan numbers below:  
000 = If unable to distinguish among plan types listed below  
100 = Joint life plan unable to distinguish among joint life plan types listed below  
**Permanent Plans:**  
010 = Traditional fixed premium fixed benefit permanent plan  
011 = Permanent life (traditional) with term  
012 = Single premium whole life  
013 = Econolife (permanent life with lower premiums in the early durations)  
014 = Excess interest whole life  
015 = First to die whole life plan (submit separate records for each life)  
016 = Second to die whole life plan (submit separate records for each life)  
017 = Joint whole life plan – unknown whether 015 or 016 (submit separate records for each life) |
018 = Permanent products with non-level death benefits
019 = Permanent plans 010, 011, 012, 013, 014, 015, 016, 017, 018 combined (i.e. unable to separate)

Term Insurance Plans:
020 = Term (traditional level benefit and attained age premium)
021 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for five years)
211 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 10 years)
212 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 15 years)
213 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 20 years)
214 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 25 years)
215 = Term (level death benefit with guaranteed level premium for five years and anticipated level term period for 30 years)
022 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 10 years)
221 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 15 years)
222 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 20 years)
223 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 25 years)
224 = Term (level death benefit with guaranteed level premium for 10 years and anticipated level term period for 30 years)
023 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 15 years)
231 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 20 years)
232 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 25 years)
233 = Term (level death benefit with guaranteed level premium for 15 years and anticipated level term period for 30 years)
024 = Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 20 years)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>241</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>242</td>
<td>Term (level death benefit with guaranteed level premium for 20 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>025</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 25 years)</td>
</tr>
<tr>
<td>251</td>
<td>Term (level death benefit with guaranteed level premium for 25 years and anticipated level term period for 30 year)</td>
</tr>
<tr>
<td>026</td>
<td>Term (level death benefit with guaranteed level premium for 30 years and anticipated level term period for 30 years)</td>
</tr>
<tr>
<td>027</td>
<td>Term (level death benefit with guaranteed level premium period equal to anticipated level term period where the period is other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>271</td>
<td>Term (level death benefit with guaranteed level premium period not equal to anticipated level term period, where the periods are other than five, 10, 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>028</td>
<td>Term (decreasing benefit)</td>
</tr>
<tr>
<td>040</td>
<td>Select ultimate term (premium depends on issue age and duration)</td>
</tr>
<tr>
<td>041</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 15 years)</td>
</tr>
<tr>
<td>042</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 20 years)</td>
</tr>
<tr>
<td>043</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 25 years)</td>
</tr>
<tr>
<td>044</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for 30 years)</td>
</tr>
<tr>
<td>045</td>
<td>Return of Premium Term (level death benefit with guaranteed level premium for period other than 15, 20, 25 or 30 years)</td>
</tr>
<tr>
<td>046</td>
<td>Economatic term</td>
</tr>
<tr>
<td>059</td>
<td>Term plan, unable to classify</td>
</tr>
<tr>
<td>101</td>
<td>First to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>102</td>
<td>Second to die term plan (submit separate records for each life)</td>
</tr>
<tr>
<td>103</td>
<td>Joint term plan – unknown whether 101 or 102 (submit separate records for each life)</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable), issued without a Secondary Guarantee:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>061</td>
<td>Single premium universal life</td>
</tr>
<tr>
<td>062</td>
<td>Universal life (decreasing risk amount)</td>
</tr>
<tr>
<td>063</td>
<td>Universal life (level risk amount)</td>
</tr>
<tr>
<td>064</td>
<td>Universal life – unknown whether code 062 or 063</td>
</tr>
<tr>
<td>065</td>
<td>First to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>066</td>
<td>Second to die universal life plan (submit separate records for each life)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>067</td>
<td>Joint life universal life plan – unknown whether code 065 or 066 (submit separate records for each life)</td>
</tr>
<tr>
<td>068</td>
<td>Indexed universal life</td>
</tr>
</tbody>
</table>

**Universal Life Plans (Other than Variable) with Secondary Guarantees:**

- **071**: Single premium universal life with secondary guarantees
- **072**: Universal life with secondary guarantees (decreasing risk amount)
- **073**: Universal life with secondary guarantees (level risk amount)
- **074**: Universal life with secondary guarantees – unknown whether code 072 or 073
- **075**: First to die universal life plan with secondary guarantees (submit separate records for each life)
- **076**: Second to die universal life plan with secondary guarantees (submit separate records for each life)
- **077**: Joint life universal life plan with secondary guarantees unknown whether code 075 or 076 (submit separate records for each life)
- **078**: Indexed universal life with secondary guarantees

**Variable Life Plans issued without a Secondary Guarantee:**

- **080**: Variable life
- **081**: Variable universal life (decreasing risk amount)
- **082**: Variable universal life (level risk amount)
- **083**: Variable universal life – unknown whether code 081 or 082
- **084**: First to die variable universal life plan (submit separate records for each life)
- **085**: Second to die variable universal life plan (submit separate records for each life)
- **086**: Joint life variable universal life plan – unknown whether 084 or 085 (submit separate records for each life)

**Variable Life Plans with Secondary Guarantees:**

- **090**: Variable life with secondary guarantees
- **091**: Variable universal life with secondary guarantees (decreasing risk amount)
- **092**: Variable universal life with secondary guarantees (level risk amount)
- **093**: Variable universal life with secondary guarantees – unknown whether code 091 or 092
- **094**: First to die variable universal life plan with secondary guarantees (submit separate records for each life)
- **095**: Second to die variable universal life plan with secondary guarantees (submit separate records for each life)
096 = Joint life variable universal life plan with secondary guarantees – unknown whether code 094 or 095 (submit separate records for each life)

**Nonforfeiture:**
- 098 = Extended term
- 099 = Reduced paid-up
- 198 = Extended term for joint life (submit separate records for each life)
- 199 = Reduced paid-up for joint life (submit separate records for each life)

<table>
<thead>
<tr>
<th>In-force Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>If the policy segment was not in force at the end of the calendar year of observation</td>
</tr>
<tr>
<td>1</td>
<td>If the policy segment was in force at the end of the calendar year of observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>08</td>
</tr>
<tr>
<td>22</td>
<td>69–80</td>
</tr>
<tr>
<td>23</td>
<td>81–92</td>
</tr>
<tr>
<td>24</td>
<td>93–104</td>
</tr>
<tr>
<td>25</td>
<td>408–446</td>
</tr>
</tbody>
</table>

- Face amount of the policy segment at its issue date rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount and do not include cash value. If the policy was issued during the observation year, the Face Amount of Insurance at the Beginning of the Observation Year should be blank.

- Face amount of the policy segment at the beginning of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If the policy was issued during the observation year, the Face Amount at the Beginning of the Observation Year should be blank.

- Face amount of the policy segment at the end of the calendar year of observation rounded to nearest dollar. If policy provides payment of cash value in addition to face amount, include face amount, and do not include cash value. Exclude extra amounts attributable to 7702 corridors. If In-force Indicator is 0, enter face amount of the policy segment at the time of termination, if available; otherwise, leave blank.

- Death claim amount rounded to the nearest dollar. If In-force Indicator is 0 and Cause of Termination is 04, then enter the face amount. If In-force Indicator is 0 and Cause of Termination is not 04, then leave blank.

If the policy provides payment of cash value in addition to face amount, report face amount, and do not include cash value.
<table>
<thead>
<tr>
<th>Column</th>
<th>Code Range</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>117–124</td>
<td>8</td>
<td>Termination Reported Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date that the termination was reported.</td>
</tr>
<tr>
<td>27</td>
<td>125–132</td>
<td>8</td>
<td>Actual Termination Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If In-force Indicator is 1, leave blank. Enter in the format YYYYMMDD the eight-digit calendar date when the termination occurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If termination is due to death (Cause of Termination is 04), enter actual date of death.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If termination is lapse due to non-payment of premium (Cause of Termination is 01 or 02 or 14), enter the last day the premium was paid to.</td>
</tr>
<tr>
<td>28</td>
<td>133–134</td>
<td>2</td>
<td>Cause of Termination</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If In-force Indicator is 1, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = Termination type unknown or unable to subdivide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = Reduced paid-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = Extended term</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = Voluntary; unable to subdivide among 01, 02, 07, 09, 10, 11 or 13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>04 = Death</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>07 = 1035 exchange</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>09 = Term conversion – unknown whether attained age or original age</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10 = Attained age term conversion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11 = Original age term conversion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 = Coverage expired or contract reached end of the mortality table</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13 = Surrendered for full cash value</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>14 = Lapse (other than to Reduced Paid Up or Extended Term)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15 = Termination via payment of a discounted face amount while still alive, pursuant to an accelerated death benefit provision</td>
</tr>
<tr>
<td>29</td>
<td>145–144</td>
<td>10</td>
<td>Annualized Premium at Issue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium set at issue. Except for level term segments specified above, leave blank for non-base segments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For the base segments for ULSG, and Variable Life with Secondary Guarantees (VLSG) with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, enter the annualized billed premium set at issue. Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
<tr>
<td>30</td>
<td>145–154</td>
<td>10</td>
<td>Annualized Premium at the Beginning of Observation Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, enter the annualized premium for the policy year that includes the beginning of the observation year.</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td><strong>31</strong></td>
<td><strong>155-164</strong></td>
<td><strong>10</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annualized Premium at the End of Observation, if available. Otherwise, Annualized Premium as of Year/Actual Termination Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For level term segments with plan codes 021 through 027, 041 through 045 or 211 through 271 of Item 19, Plan, for each segment that has Item 20, with the Inforce Indicator = 1, enter the annualized premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized premium as of the Actual Termination Date (Item 26). Except for level term segments specified above, leave blank for non-base segments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For the base segments for ULSG and VLSG with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, use the annualized billed premium. For base segments that have Item 20, with the Inforce Indicator = 1, enter the annualized billed premium for the policy year that includes the end of the observation year. Otherwise, enter the annualized billed premium that would have been paid at the end of the observation year. If end of year premium is not available, enter the annualized billed premium as of the Actual Termination Date (Item 26).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Round to the nearest dollar.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If unknown, leave blank.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **32** | **165-166** | **2** |
|   | Premium Mode |
|   | 01 = Annual |
|   | 02 = Semiannual |
|   | 03 = Quarterly |
|   | 04 = Monthly Bill Sent |
|   | 05 = Monthly Automatic Payment |
|   | 06 = Semimonthly |
|   | 07 = Biweekly |
|   | 08 = Weekly |
|   | 09 = Single Premium |
|   | 10 = Other / Unknown |

<p>| <strong>33</strong> | <strong>167-168</strong> | <strong>10</strong> |
|   | Cumulative Premium Collected as of the Beginning of Observation Year |
|   | If not ULSG or VLSG, leave blank. |
|   | For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34</td>
<td>177-186</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>187-188</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>189-190</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>Cumulative Premium Collected as of the End of Observation Year if available. Otherwise Cumulative Premium Collected as of Actual Termination Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank. For ULSG, and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 1) For non-base segments, leave blank. 2) For base segments inforce at the end of the observation year, enter the cumulative premium collected as of the end of the observation year. 3) For base segments terminated during the observation year, enter the cumulative premium collected since issue, as of the Actual Termination Date (Item 26). Round to the nearest dollar. If unknown, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ULSG/VLSG Premium Type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 00 = Unknown 01 = Single premium 02 = ULSG/VLSG Whole life level premium 03 = Lower premium (term like) 04 = Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of Secondary Guarantee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For non-base segments, leave blank. If not ULSG or VLSG, leave blank. For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan: 00 = Unknown 01 = Cumulative Premium without Interest (Single Tier) 02 = Cumulative Premium without Interest (Multiple Tier) 03 = Cumulative Premium without Interest (Other) 04 = Cumulative Premium with Interest (Single Tier) 05 = Cumulative Premium with Interest (Multiple Tier) 06 = Cumulative Premium with Interest (Other) 11 = Shadow Account (Single Tier)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Shadow Account (Multiple Tier)</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Shadow Account (Other)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Both Cumulative Premium without Interest and Shadow Account</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Both Cumulative Premium with Interest and Shadow Account</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Other, not involving either Cumulative Premium or Shadow Account</td>
<td></td>
</tr>
</tbody>
</table>

### 37 (101-200)
**Cumulative Minimum Premium as of the Beginning of Observation Year**

- If not ULSG or VLSG, leave blank.
- For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:
- If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.
- If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:
  1) Leave non-base segments, blank.
  2) For base segments:
     - Enter the cumulative minimum premiums, including applicable interest, for all policy years up to the beginning of the observation year.
- Round to the nearest dollar.
- For policies issued in the observation year, leave blank.
- If unknown, leave blank.

### 38 (201-210)
**Cumulative Minimum Premium as of the End of Observation Year/ Actual Termination Date**

- If not ULSG or VLSG, leave blank.
- For ULSG and VLSG policies with plan codes 071 through 078 and 090 through 096 of Item 19, Plan:
- If Item 35, Type of Secondary Guarantee is blank, 00, 11, 12, 13 or 23, leave blank.
- If Item 35, Type of Secondary Guarantee is 01, 02, 03, 04, 05, 06, 21 or 22:
  1) For non-base segments, leave blank.
  2) For base segments inforce at the end of the observation year, enter the cumulative minimum premiums, including applicable interest, up to the end of the observation year.
  3) For base segments terminated during the observation year, enter the cumulative minimum premiums, including applicable interest, up to the Actual Termination Date (Item 26)
- Round to the nearest dollar.
|   | 211-220 | 10 | Shadow Account Amount at the Beginning of Observation Year | If not ULSG, or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.  
If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:  
1) Leave non-base segments blank.  
2) For base segments: Enter total amount of the Shadow Account at the beginning of the observation year. The Shadow Account can be positive, zero or negative. Round to the nearest dollar.  
For policies issued in the observation year, leave blank.  
If unknown, leave blank. |
|---|---|---|---|---|
| 39 | 221-230 | 10 | Shadow Account Amount at the End of Observation Year/Actual Termination Date | If not ULSG, or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:  
If Item 35, Type of Secondary Guarantee is blank, 00, 01, 02, 03, 04, 05, 06, or 23 leave blank.  
If Item 35, Type of Secondary Guarantee is 11, 12, 13, 21 or 22:  
1) For non-base segments, leave blank.  
2) For base segments in force at the end of the observation year, enter the total amount of the Shadow Account at the end of the observation year. The Shadow Account can be positive, zero or negative.  
3) For base segments terminated during the observation year, enter the total amount of the Shadow Account as of the Actual Termination Date (Item 26). The Shadow Account can be positive, zero or negative. Round to the nearest dollar.  
If unknown, leave blank. |
| 40 | 231-240 | 10 | Account Value at the Beginning of Observation Year | For non-base segments, leave blank.  
If not ULSG or VLSG, leave blank.  
For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan, the policy Account Value (gross of any loan) at the Beginning of the Observation Year. The policy...
<table>
<thead>
<tr>
<th>42</th>
<th>241-250</th>
<th>10</th>
<th>Account Value at the End of Observation Year/Actual Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Account Value can be positive, zero or negative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Round to the nearest dollar.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For policies issued in the observation year, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown, leave blank.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>43</th>
<th>251-260</th>
<th>10</th>
<th>Amount of Surrender Charge at the Beginning of Observation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
</tr>
</tbody>
</table>

1) If policy is in force at the end of observation year, enter the policy Account Value (gross of any loan) at the end of the Observation Year. The policy Account Value can be positive, zero or negative.

2) If policy terminated during the observation year, enter the policy Account Value (gross of any loan) as of the Actual Termination Date (Item 26). The policy Account Value can be positive, zero or negative.

Round to the nearest dollar.

If unknown, leave blank.

<table>
<thead>
<tr>
<th>44</th>
<th>261-270</th>
<th>10</th>
<th>Amount of Surrender Charge at the End of Observation Year/Actual Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If not ULSG or VLSG, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For ULSG and VLSG policies with plan codes 071 through 078 or 090 through 096 of Item 19, Plan:</td>
</tr>
</tbody>
</table>

1) If policy is in force at the end of observation year, enter the dollar amount of the Surrender Charge at the end of the Observation Year.

2) If policy terminated during the observation year, enter the dollar amount of the Surrender Charge.
<table>
<thead>
<tr>
<th>Row</th>
<th>Item</th>
<th>Columns</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>221-272</td>
<td>2</td>
<td>Operative Secondary Guarantee at the Beginning of Observation Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the beginning of the Observation Year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 00 through 23:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = If unknown whether the secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = If secondary guarantee is not in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = If secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = If all secondary guarantees have expired</td>
</tr>
<tr>
<td>46</td>
<td>273-274</td>
<td>2</td>
<td>Operative Secondary Guarantee at the End of Observation Year/Actual Termination Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The company defines whether a secondary guarantee is in effect for a policy with a secondary guarantee at the end of the Observation Year/Actual Termination Date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is blank, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If Item 35, Type of Secondary Guarantee is 00 through 23:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1) For non-base segments, leave blank.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2) For base segments in force at the end of observation year, enter the appropriate value below as of the end of observation year:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = If unknown whether the secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = If secondary guarantee is not in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = If secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = If all secondary guarantees have expired</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3) For base segments terminated during the observation year, enter the appropriate value below as of the Actual Termination Date (Item 26):</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>00 = If unknown whether the secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>01 = If secondary guarantee is not in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>02 = If secondary guarantee is in effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>03 = If all secondary guarantees have expired</td>
</tr>
<tr>
<td>47</td>
<td>275-276</td>
<td>2</td>
<td>State of Domicile</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Use standard, two-letter state abbreviations codes (e.g., FL for Florida) for the state of the policy owner’s domicile.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If unknown or outside of the U.S., leave blank.</td>
</tr>
</tbody>
</table>
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Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

Identification: David Neve, VP and Consulting Actuary, Actuarial Resources Corporation of GA
Title of the Issue: Clarify ULSG NPR calculation requirements

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

January 1, 2021 NAIC Valuation Manual, but incorporating APF 2020-03
Section 2.A.3 Section 3.B.1, 2, 5 and 6 Section 6.B.5.b
Section 3.a Section 3.C.2 and 3

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

See attached.

As a general overview, Section 3.B.5 stayed in 3.B.5 but was renumbered, but Section 3.B.6 was moved to 3.B.5.b and c.

Below is a detailed summary of the items that were moved to a new section (and/or renumbered) but were not redlined. In some cases, the wording was redlined after it was moved (if the wording changed).

<table>
<thead>
<tr>
<th>Prior version</th>
<th>New version</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.B.5 last half of first sentence</td>
<td>3.B.5.a</td>
</tr>
<tr>
<td>3.B.5 2nd and 3rd sentence</td>
<td>3.B.5.d</td>
</tr>
<tr>
<td>3.B.5.a thru g</td>
<td>renumbered as 3.B.5.d.i thru vii</td>
</tr>
<tr>
<td>3.B.6.a</td>
<td>3.B.5.b</td>
</tr>
<tr>
<td>3.B.6.b</td>
<td>3.B.5.c</td>
</tr>
<tr>
<td>3.B.6.c</td>
<td>3.B.5.c.i (with sub-bullets renumbered)</td>
</tr>
<tr>
<td>3.B.6.d</td>
<td>3.B.5.c.ii (with sub-bullets renumbered)</td>
</tr>
<tr>
<td>3.B.6.e</td>
<td>3.B.5.c.iii (with sub-bullets renumbered)</td>
</tr>
</tbody>
</table>
4. State the reason for the proposed amendment? (You may do this through an attachment.)

The NPR calculation requirements for ULSG products are currently contained in Section 3.B.5 and 3.B.6 of the Valuation Manual. The current wording takes the reader back and forth between Section 3.B.5 and 3.B.6 when trying to follow the reserve calculation for ULSG products, which can be confusing. And the current wording also has led some people to incorrectly interpret Section 3.B.5 to be applicable to UL products without a SG.

The APF combines the current 3.B.5 and 3.B.6 sections into a single section labeled 3.B.5 and clarifies how to determine the NPR when the policy duration at the valuation date is either prior to, or after the SG has expired. Importantly, no change has been made to the current requirements, only the formatting of the requirements to make them easier to follow. Note that the new wording has flipped the order of the old 3.B.5 and 3.B.6 when combining them in the new 3.B.5, but this movement is not shown as a tracked change (since no changes were made to the existing reserve calculation requirements in the two sections).

Section 3.A has also been revised to eliminate the confusion that can arise on whether the NPR for products in the All Other VM-20 Reserving Category is still a VM-20 reserve. The NPR requirement for products in the All Other VM-20 Reserving Category has been moved to Section 3.B.6.

Impacted references have been updated.
Section 2: Minimum Reserve

A. All policies subject to these requirements shall be included in one of the VM-20 Reserving Categories, as specified in Section 2.A.1, Section 2.A.2 and Section 2.A.3 below.

1. Term Reserving Category —

2. ULSG Reserving Category —

   c. The due and deferred premium asset, if any, shall be based on the valuation net premiums computed in accordance with Section 3.B.5.d, for the base policy, determined without regard to any NPR floor amount from Section 3.D.2.

3. All Other VM-20 Reserving Category— All policies and riders belonging to the All Other VM-20 Reserving Category are to be included in Section 2.A.3.c unless the company has elected to exclude a group of them from the stochastic reserve calculation or both the deterministic and stochastic reserve calculations and has applied the applicable exclusion test defined in Section 6, passed the test and documented the results.

Section 3: Net Premium Reserve

A. Applicability

1. The NPR for each policy must be determined on a seriatim basis pursuant to Section 3.

2. When valuing term riders pursuant to Paragraph E in “Riders and Supplemental Benefits Requirements” in Section II, the reserve requirements for term policies are applicable.

B. NPR Calculation

1. For the purposes of Section 3, the following terms apply:

   b. The “level secondary guarantee” at any time is:

      i. For a shadow account secondary guarantee, the shadow account fund value that would have existed at that time assuming payment of the level gross premium determined according to Section 3.B.5.c.i.1, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

      ii. For a cumulative premium secondary guarantee, the amount of cumulative level gross premiums determined according to Section 3.B.5.c.i.1, accumulated with any interest or accumulation factors per the contract provisions for the secondary guarantee.

2. Section 3.B.4 and Section 3.B.5 provide the calculation of a terminal NPR under the assumption of an annual mode gross premium. In Section 3.B.4 and Section 3.B.5, the gross premium referenced is the gross premium for the policy assuming an annual premium mode.

3. For all policies and riders within the Term Reserving Category, other than those addressed in Section 3.B.8 below, the NPR on any valuation date shall be equal to the actuarial present value of future...
benefits less the actuarial present value of future annual valuation net premiums as follows:

5. For all policies and riders within the ULSG Reserving Category, the NPR shall be determined as follows:
   a. If the policy duration on the valuation date is prior to the point when all secondary guarantee periods have expired, the NPR shall be the greater of the reserve amount determined in Section 3.B.5.c and the reserve amount determined in Section 3.B.5.d, subject to the floors specified in Section 3.D.2.
   b. If the policy duration on the valuation date is after the expiration of all secondary guarantee periods, the NPR shall be the reserve amount determined according to Section 3.B.5.d only, subject to the floors specified in 3.D.2.
   c. A reserve amount for the policy shall be calculated assuming the secondary guarantee is in effect as described below. If the policy has multiple secondary guarantees, the NPR shall be calculated as below for the secondary guarantee that provides the greatest NPR as of the valuation date. For the purposes of this subsection, let n be the longest number of years the policy can remain in force under the provisions of the secondary guarantee. However, if a shorter period produces a materially greater NPR, then n shall be that shorter number of years.
      i. As of the policy issue date:
         1. Determine the level gross premium at issue, assuming payments are made each year for which premiums are permitted to be paid, such period defined as v years in this subsection, that would keep the policy in force to the end of year n, based on policy provisions, including the secondary guarantee provisions, such as mortality, interest and expenses. In no event shall v be greater than n for purposes of the NPR calculated in this subsection.
         2. Determine the annual valuation net premiums at issue as that uniform percentage (the valuation net premium ratio) of the respective gross premiums such that at issue the actuarial present value of future valuation net premiums over the n-year period shall equal the actuarial present value of future benefits over the n-year period. The valuation net premium ratio determined shall not change for the policy.
         3. Using the level gross premium from Section 3.B.5.c.4) above, determine the value of the expense allowance components for the policy at issue as x₁, y₂<5, and z₁ defined below:

\[
x₁ = \text{a first-year expense equal to the level gross premium at issue}
\]

\[
y₂<5 = \text{an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year}
\]

\[
z₁ = \text{a first-year expense of $2.50 per $1,000 of insurance issued}
\]

The expense allowance shall be amortized over the span of years in the secondary guarantee period during which premiums are permitted to be paid. E_{x+t}, the expense allowance balance as of the end of the policy year t, shall be computed as follows:

\[
E_{x+t} = VNPRI_x \left[ \sum_{s=0}^{v} y₂<5 \cdot B \left( u_{x+t-s}, r \right) \right] + \sum_{s=0}^{v} z₁ \cdot \left( C_{x+t} \right) \left( 1 - u_{x+t-s}, r \right) \]

\[
\text{for } t < v
\]

\[
E_{x+v} = VNPRI_x \left( 1 - u_{x+v-s}, r \right) \]

\[
\text{for } t \geq v
\]

Where:

\[
x = 1, 2, \ldots \text{ (number of completed years since issue)}
\]
After the policy issue date, on each future valuation date, the NPR shall be determined as follows:

1. As of the valuation date for the policy being valued, determine the actual secondary guarantee, denoted ASG_{x+t}, as outlined in Section 3.B.1.c and the fully funded secondary guarantee, denoted FFSG_{x+t}, as outlined in Section 3.B.1.b.

2. Divide ASG_{x+t} by FFSG_{x+t} with the resulting ratio capped at 1. The ratio is intended to measure the level of prefunding for a secondary guarantee, which is used to establish reserves. Assumptions within the numerator and denominator of the ratio, therefore, must be consistent in order to appropriately reflect the level of prefunding. As used here, “assumptions” include any factor or value, whether assumed or known, which is used to calculate the numerator or denominator of the ratio.

3. Compute the net single premium (NSP_{x+t}) on the valuation date for the coverage provided by the secondary guarantee for the period of time ending at attained age x+n, using the interest, lapse and mortality assumptions prescribed in Section 3.C below. The net single premium (NSP) shall include consideration for death benefits only.

4. The NPR for an insured age x at issue at time t shall be according to the formula below:

\[
VNPR = \frac{\sum_{n=1}^{t-1}(1/A_{x+n|i|m|l})}{C_{x+t}} = 0 \quad \text{when } t = 1
\]

\[
\sum_{n=1}^{t-5} \frac{1}{A_{x+n|i|m|l}} \quad \text{when } 2 \leq t \leq 5
\]

\[
\Rightarrow C_{x+t} \leq 5 \quad \text{when } t > 5
\]

**Guidance Note:** For a non-integer value of t, \(C_{x+t}\) is obtained by taking the present value at duration t of \(E_{x+t}\), where T is the next higher integer; i.e., entails discounting by valuation interest, mortality, and lapse for the fractional year between the valuation date and next anniversary (T – t).
value of future valuation net premiums shall equal the actuarial present value of future benefits.

iii. Using the level gross premium from Section 3.B.5.d.i, determine the value of the expense allowance components for the policy at issue as x₁, y₂-5, and z₁ defined below.

- x₁ = a first-year expense equal to the level gross premium at issue
- y₂-5 = an expense equal to 10% of the level gross premium and applied in each year from the second through fifth policy year
- z₁ = a first-year expense of $2.50 per $1,000 of insurance issued

The expense allowance shall be amortized over the period during which premiums are permitted to be paid. Eₜ₊ₜ, the expense allowance balance, as of the end of policy year t, shall be calculated as follows:

\[ E_{t+\Delta} = VNPR \times \frac{1}{\delta_{x+t}(\Delta+1)} \left[ (x_1 + y_2) \left( \frac{1}{\delta_{x+t}(\Delta+1)} \right) + y_{2-5} \cdot C_{x+t} \right] \]

for \( t < s \)

= 0 \quad \text{for} \ t \geq s

where:

- \( t = 1,2,... \) (number of completed years since issue)

\[ VNPR = \text{Valuation Net Premium Ratio from 3.B.5.d.ii above} \]

- \( C_{x+t} = 0 \) \quad \text{when} \ t = 1

\[ = \sum_{n=1}^{s-1} \frac{1}{\delta_{x+t+n}(\Delta)} \] \quad \text{when} \ 2 \leq t \leq 5

\[ = C_{x+5} \] \quad \text{when} \ t > 5

iv. For a policy issued at age \( x \), at any duration \( t \), the net premium reserve shall equal:

\[ m_{x+t} \times f_{x+t} \]

where:

1. \( m_{x+t} = \) the actuarial present value of future benefits less the actuarial present value of future valuation net premiums and less the unamortized expense allowance for the policy, \( E_{x+t} \)

Guidance Note: For a non-integer value of \( t \), \( E_{x+t} \) is obtained by taking the present value at duration \( t \) of \( E_{x+\Delta} \), where \( \Delta \) is the next higher integer; i.e., entails discounting by valuation interest and survivorship for the fractional year between the valuation date and the next anniversary (\( T - 1 \)).

2. Let:

\[ e_{x+t} = \max \left( \text{the actual policy fund value on the valuation date}, 0 \right) \]

\[ f_{x+t} = \text{the policy fund value on the valuation date is that amount which, together with the payment of the future level gross premiums determined in Section 3.B.5.d.i above, keeps the policy in force for the entire period coverage is to be provided, based on the policy guarantees of mortality, interest and expenses.} \]

Then set \( e_{x+t} \) equal to:

1. if \( f_{x+t} \leq 0 \)
\[ \min\left(\frac{e_{x+t}}{f_{x+t}}, 1\right), \text{otherwise} \]

v. The future benefits used in determining the value of \( m_{n,x} \) shall be based on the greater of \( e_{x+t} \) and \( f_{x+t} \) together with the future payment of the level gross premiums determined in Section 3.B.5.d.i above, and assuming the policy guarantees of mortality, interest and expenses.

vi. The values of \( \bar{a} \) are determined using the NPR interest, mortality and lapse assumptions applicable on the valuation date.

vii. Actuarial present values referenced in this Section 3.B.5.d are calculated using the interest, mortality and lapse assumptions prescribed in Section 3.C.

6. For all policies and riders within the All Other VM-20 Reserving Category, the NPR shall be determined pursuant to applicable methods in VM-A and VM-C for the basic reserve. The mortality tables to be used are those defined in Section 3.C.1 and in VM-M Section 1.H.

7. The actuarial present value of future benefits equals the present value of future benefits including, but not limited to, death, endowment (including endowments intermediate to the term of coverage) and cash surrender benefits. Future benefits are before reinsurance and before netting the repayment of any policy loans.

8. For life insurance coverage that the company has assumed on a YRT basis, the reinsurer’s net premium reserve shall be one half year’s cost of insurance for the reinsured net amount at risk.

C. Net Premium Reserve Assumptions

2. Interest Rates

a. For NPR amounts calculated according to Section 3.B.5.d:

b. For NPR amounts calculated according to Section 3.B.4 or Section 3.B.5.c:

3. Lapse Rates

a. For NPR amounts calculated according to Section 3.B.5.d, the lapse rates used shall be 0% per year during the premium paying period and 0% per year thereafter.

\[ R_{x+t} = \frac{\text{FFSG}_{x+t} - \text{ASG}_{x+t}}{\text{FFSG}_{x+t} - \text{ULSG}_{x+t}}, \text{but not > 1 and not <0} \]

Where:

- \( \text{FFSG}_{x+t} \) – the fully funded secondary guarantee on the valuation date for the insured age \( x \) at issue
- \( \text{ASG}_{x+t} \) – the actual secondary guarantee on the valuation date for the insured age \( x \) at issue
- \( \text{ULSG}_{x+t} \) – the under-funded secondary guarantee on the valuation date for the insured age \( x \) at issue
Guidance Note: The FFSG\textsubscript{x+t}, ASG\textsubscript{x+t}, and LSG\textsubscript{x+t} are based on the secondary guarantee values as of the valuation date and will remain constant throughout the cash flow projection. This will result in a constant lapse assumption, calculated as of the valuation date, that does not vary by duration throughout the cash flow projection for the NPR calculation.

ii. As of the valuation date, which is \( t \) years after issue, the annual lapse rate for the policy shall be assumed to be level for all future years and denoted as \( L_{x+t} \), which shall be set equal to:

\[
L_{x+t} = R_{x+t} \cdot 0.01 + (1 - R_{x+t}) \cdot 0.005 \cdot r_{x+t}
\]

Where \( r_{x+t} \) is the ratio determined in Section 3.B.5.d.iv.2.

Guidance Note: By similar logic, it follows (from ASG\textsubscript{x+t} being 0 when \( t=0 \)) that the level annual lapse rate to be used in the calculations in Section 3.B.5.c.i.2 and 3.B.5.c.i.3 is 1%. On the other hand, when performing the calculations in Section 3.B.5.c.ii.3, \( L_{x+t} \), though level, is not generally equal to what it was for the same policy on the previous valuation date.

Section 6: Stochastic and Deterministic Exclusion Tests

B. Deterministic Exclusion Test (DET)

5. For purposes of determining the valuation net premiums used in the demonstration in Section 6.B.2:

a. If pursuant to Section 2, the NPR for the group of policies is the minimum reserve required under VM-A and VM-C, then the valuation net premiums are determined according to those minimum reserve requirements.

b. If the NPR is determined according to Section 3.B.4 or Section 3.B.5, then the lapse rates assumed for all durations shall for the purposes of the DET be set to 0%.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
1. Address determination of materiality. VM-21 often refers to materiality but is missing a discussion on how materiality is determined.
2. Address use of approximations and simplifications in VM-21.

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

VM-21 Section 1.E (new), VM-21 Section 3.H (new), VM-31 Section 3.E.1, VM-31 Section 3.F.2.e
January 1, 2021 NAIC Valuation Manual

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

See attached.

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

1. VM-21 often refers to materiality but is missing a discussion on how materiality is determined (a materiality standard), as VM-20 has in VM-20 Section 2.H. Moreover, the current language of Materiality in the VA Summary in VM-31 Section 3.E.1 (2021 edition) is based on the Life PBR Summary in VM-31 (2019 edition). The language of Materiality in the VA Summary in Section 3.E.1 of VM-31 should be updated, consistent with adding a new section to VM-21 to address materiality.

For reference, here are the relevant VM-20 passages:

VM-20 Section 2.H
The company shall establish, for the DR and SR, a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve. This standard shall be applied when identifying material risks. Such a standard shall also apply to the NPR with respect to VM-20 Section 2.G.

VM-31 Section 3.C.1
Life Summary – The PBR Actuarial Report shall contain a Life Summary of the critical elements of all sub-reports of the Life Report as detailed in Section 3.D. In particular, this Life Summary shall include:

1. VM-20 Materiality – The standard established by the company pursuant to VM-20 Section 2.H.

2. While it is common for companies to use a significant number of approximations, simplifications, and modeling efficiency techniques for their VM-21 valuation, VM-21 is missing an explicit allowance of approximations, simplifications, or modeling efficiency techniques. To understand the impact of the large number of approximations, simplifications, and modeling efficiency techniques, they should be covered in one location in the PBR reporting for VA, in contrast to the current reporting where they are scattered throughout the PBR Report. VM-20 Section 2.G does not allow simplifications to bias the reserve downward. This addresses the concern that a large number of immaterial simplifications could add up to a material understatement. VM-21 needs an assurance that simplifications do not compound one another to become material even more than VM-20, due to the very larger number of simplifications commonly used.

---

VM-21 Section 1.E (new)

Materiality

The company shall establish a standard containing the criteria for determining whether an assumption, risk factor or other element of the principle-based valuation has a material impact on the size of the reserve or TAR. This standard shall be applied when identifying material risks.

VM-21 Section 3.H (new)

H. A company may use simplifications, approximations and modeling efficiency techniques to calculate the stochastic reserve and/or the additional standard projection amount required by this section if the company can demonstrate that the use of such techniques does not understate TAR by a material amount, and the expected value of TAR calculated using simplifications, approximations and modeling efficiency techniques is not less than the expected value of TAR calculated that does not use them.

Guidance Note:

Examples of modeling efficiency techniques include, but are not limited to:

1. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters.
2. Generating a smaller liability or asset model to represent the full seriatim model using grouping compression techniques or other similar simplifications.

There are multiple ways of providing the demonstration required by Section 3.H. The complexity of the demonstration depends upon the simplifications, approximations or modeling efficiency techniques used. Examples include, but are not limited to:

1. Rounding at a transactional level in a direction that is clearly and consistently conservative or is clearly and consistently unbiased with an obviously immaterial impact on the result (e.g., rounding to the nearest dollar) would satisfy 3.H without needing a demonstration. However:
rounding to too few significant digits relative to the quantity being rounded, even in an unbiased way, may be material and in that event, the company may need to provide a demonstration that the rounding would not produce a material understatement of TAR.

2. A brute force demonstration involves calculating the minimum reserve both with and without the simplification, approximation or modeling efficiency technique, and making a direct comparison between the resulting TAR. Regardless of the specific simplification, approximation or modeling efficiency technique used, brute force demonstrations always satisfy the requirements of Section 3.H.

3. Choosing a reduced set of scenarios from a larger set consistent with prescribed models and parameters and providing a detailed demonstration of why it did not understate TAR by a material amount and the expected value of TAR would not be less than the expected value of TAR that would otherwise be calculated. This demonstration may be a theoretical, statistical or mathematical argument establishing, to the satisfaction of the insurance commissioner, general bounds on the potential deviation in the TAR estimate rather than a brute force demonstration.

4. Justify the use of randomly sampling withdrawal ages for each contract instead of following the exact prescribed WDCM method by demonstrating that the random sampling method is materially equivalent to the exact prescribed approach, and the simplification does not materially reduce the Additional Standard Projection Amount and the final reported TAR. In particular, the company should demonstrate that the statistical variability of the results based on the random sampling approach is immaterial by testing different random sets, e.g., if randomly selecting a withdrawal age for each contract, the probability distribution of the withdrawal age should be stable and not vary significantly when using different random number sets.

### VA Summary

The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:

1. **Materiality** - The Standard established by the company pursuant to VM-21 Section 1.E.

### VM-31 Section 3.E.1

#### VA Summary

- The PBR Actuarial Report shall contain a VA Summary of the critical elements of all sub-reports of the VA Report as detailed in Section 3.F. In particular, this VA Summary shall include:
  
  **1. Materiality** - The Standard established by the company pursuant to VM-21 Section 1.E.

### VM-31 Section 3.F.2.e

#### Approximations, Simplifications, and Modeling Efficiency Techniques

A description of each approximation, simplification or modeling efficiency technique used in reserve or TAR calculations, and a statement that the required VM-21 Section 3.H demonstration is available upon request and shows that: 1) the use of each approximation, simplification, or modeling efficiency technique does not understate TAR by a material amount; and 2) the expected value of TAR is not less than the expected value of TAR calculated without using the approximation, simplification, or modeling efficiency technique.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Angela McNabb & Pat Allison – NAIC staff support

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

January 1, 2021, version of the Valuation Manual – VM-51 Appendix 4

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

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<th>DATA ELEMENT</th>
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</table>
| 11   | 1 | Smoker Status *(at issue)* | Smoker status should be submitted where reliable.  
0 = Unknown  
1 = No tobacco usage  
2 = Nonsmoker  
3 = Cigarette smoker  
4 = Tobacco user |

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

In the event that additional underwriting is done after issue, it is possible that the preferred class would be inconsistent with the smoker status at issue. By removing the “at issue” specification, the smoker status would then be the current smoker status.

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

** NAIC Staff Comments: **

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**Notes:** APF 2021-10
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: □ New Model Law or X Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

   Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee

2. NAIC staff support contact information:

   Jennifer Cook  
   jcook@naic.org  
   202-471-3986

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   The Working Group would like to revise Section 6—Standards for Illustrations in the Annuity Disclosure Model Regulation (#245) to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or not adequately addressed in the current standards.

4. Does the model law meet the Model Law Criteria? X Yes or □ No (Check one)

   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? X Yes or □ No (Check one)

      If yes, please explain why: Consumers should receive accurate disclosures of the annuities they are purchasing.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

      X Yes or □ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   □ 1 x 2 □ 3 □ 4 □ 5 (Check one)

   High Likelihood Low Likelihood

   Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  X 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  X 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

Not an accreditation standard

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
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Appendix A. Annuity Illustration Example

*   *   *   *

Section 6. Standards for Annuity Illustrations

*   *   *   *

F. An illustration shall conform to the following requirements:

1. The illustration shall be labeled with the date on which it was prepared;

2. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled “page 4 of 7 pages”);

3. The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;

4. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;

5. The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;

6. Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;

7. Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;

8. Except as provided in Paragraph (22), the non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;
In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the “low scenario”); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the “high scenario”). The following requirements apply:

(a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;

(b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;

(c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;

(d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);

(e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:

(i) The allocation used in the illustration shall be the same for all three scenarios; and

(ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.

(f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;

(g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;

(h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and
(10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., “see page 1 for guaranteed elements”);

(11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;

(12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;

(13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;

(14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:

(a) The benefits and values are not guaranteed;

(b) The assumptions on which they are based are subject to change by the insurer; and

(c) Actual results may be higher or lower;

(15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;

(16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;

(17) Illustrations shall be concise and easy to read;

(18) Key terms shall be defined and then used consistently throughout the illustration;

(19) Illustrations shall not depict values beyond the maximum annuitization age or date;

(20) Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and

(21) Illustrations shall show both annuity income rates per $1000.00 and the dollar amounts of the periodic income payable.

(22) For participating immediate and deferred income annuities:

(a) Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);

(b) Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;
If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;

If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:

(i) Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and

(ii) The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subparagraph iii, below, based on the time to maturity or reinvestment (the “Tenor”) of the investments supporting the cohort of policies.

(iii) Maximum long-term interest rates should be calculated for tenors of 3 months (or less), 5 years, 10 years and 20 years (or more), using U.S. Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).

(iv) The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.

(v) Grading to the maximum long-term interest rates should take place over:

(I) No less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates; or

(II) No more than 20 years from the issue if the U.S. Treasury rates as of the illustration date are above the long-term rates.

(vi) When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall satisfy the following conditions:

(I) Assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates, and

(II) Illustrate dividends no less than half of the dividends illustrated under the current dividend scales.

(III) If (a) and (b) above are in conflict—i.e., if half of the current dividends are greater than would be permitted by Condition (a)—then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.
(vii) The illustration should include a disclosure that is substantially similar to the following:

The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current interest rates to long-term interest rates, over a period of [twenty] years. By regulation, the long-term assumed interest rates cannot and do not exceed the rates listed in column (c) of the table below.

(vii) If the illustration contains an additional dividend scale pursuant to subparagraph (vi) above, then the illustration should also include a disclosure that is substantially similar to the following:

The additional illustrated dividend scale is based on interest rates that are assumed no to increase and do not exceed the interest rates in column (b) of the table below.

<table>
<thead>
<tr>
<th>Tenor</th>
<th>Current Interest Rate</th>
<th>Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treasury Rate as of</td>
<td>Mean Reversed</td>
</tr>
<tr>
<td></td>
<td>12/31/2016</td>
<td>Treasury Rate</td>
</tr>
<tr>
<td>3 Month</td>
<td>0.51%</td>
<td>3.00%</td>
</tr>
<tr>
<td>(or less)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Year</td>
<td>1.93%</td>
<td>4.50%</td>
</tr>
<tr>
<td>10 Year</td>
<td>2.45%</td>
<td>5.00%</td>
</tr>
<tr>
<td>20 Years</td>
<td>3.06%</td>
<td>5.50%</td>
</tr>
<tr>
<td>(or more)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PROJECT HISTORY-2021
ANNUITY DISCLOSURE MODEL REGULATION (#245)

1. Description of the Project, Issues Addressed, etc.

The Annuity Disclosure Model Regulation (#245) was revised to address its application to participating income annuities.

2. Name of Group Responsible for Drafting the Model and States Participating

The Annuity Disclosure (A) Working Group of the Life Insurance and Annuities (A) Committee was responsible for drafting the revisions.

States Participating:

- Mike Yanacheak, Chair, Iowa
- Chris Struk, Florida
- Julie Holmes and Craig VanAalst, Kansas
- Adewole Odumade, Maryland
- John Robinson, Minnesota
- Frank Stone, Oklahoma
- Sarah Neil/Matt Gendron, Rhode Island
- Doug Danzeiser/Phil Reyna, Texas

3. Project Authorized by What Charge and Date First Given to the Group

In 2016, the Life Insurance and Annuities (A) Committee adopted a charge for the Annuity Disclosure (A) Working Group to: “Review and revise, as necessary, Section 6—Standards for Annuity Illustrations in the Annuity Disclosure Model Regulation (#245) to take into account the disclosures necessary to inform consumers in light of the product innovations currently in the marketplace.”

At the 2017 Summer National Meeting, the Executive (EX) Committee and Plenary adopted a Request for NAIC Model Law Development “to revise Section 6—Standards for Illustrations in the Annuity Disclosure Model Regulation (#245) to address issues identified by the Working Group related to innovations of annuity products currently in the marketplace that are not addressed or addressed adequately in the current standards.”

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The Annuity Disclosure (A) Working Group met six times to discuss an issue identified under its charge: that the model prohibits the illustration of “non-guaranteed elements,” which could be construed to include participating income annuities because of the formula used to calculate the dividend scale.

New York Life had been working with state insurance regulators since 2015 to develop language for inclusion in Model #245 to allow for the illustration of participating income annuities. The Working Group heard presentations explaining the issue and discussed a proposal forwarded by New York Life. The Working Group reviewed, discussed and revised the proposal. All drafts and comments were posted on the NAIC website. On March 2, 2018, the Working Group adopted draft revisions addressing participating income annuities.

5. A General Description of the Due Process (e.g., exposure periods, public hearings or any other means by which widespread input from industry, consumers and legislators was solicited)

The Annuity Disclosure (A) Working Group met Nov. 22, 2016; Dec. 14, 2017; March 9, 2017; April 13, 2017; Feb. 15 2018; March 2, 2018; and June 4, 2018. All drafts and comments were posted on the NAIC website. The Working Group adopted the revisions addressing participating income annuities on March 2, 2018, and the Life Insurance and Annuities (A) Committee adopted the revisions during the 2018 Summer National Meeting. These revisions were adopted and held by the Committee pending resolution of an additional issue that the Working Group identified. The Working Group did not end up
making any additional revision to the model. During the 2021 Spring National Meeting, the Committee agreed to disband the Working Group once these revisions to Model #245 were considered by the Membership.

6. A Discussion of the Significant Issues (e.g., items of some controversy raised during the due process and the group’s response)

During its Feb. 15 meeting, the Working Group discussed concerns that the American Academy of Actuaries (Academy) raised with the participating income annuity proposal. The Academy was concerned that the proposal deviated from the current standard in its use of projected improvements and that it did not apply the change consistently across product types. New York Life explained that the proposal was purposefully narrow in scope to address a particular issue with a particular product; only participating income annuities include the potential for additional income in the form of dividends based on the divisible surplus of the company. New York Life also worked with Missouri to revise the proposal to include additional disclosures about future rate assumptions, and it included a requirement that consumers are shown an additional, more conservative illustrated scale when current interest rates are less than the long-term interest rates.

7. Any Other Important Information (e.g., amending an accreditation standard)

None.

W:\National Meetings\2021\Summer\Plenary\Att 3 Model245_combined_final.pdf
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☑️ New Model Law or □ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:
   Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:
   Jolie Matthews jmatthews@naic.org

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   The Subgroup has a charge to consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs).

4. Does the model law meet the Model Law Criteria? ☑️ Yes or □ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☑️ Yes or □ No (Check one)
      If yes, please explain why

      The proposed new model would provide a consistent approach among the states for providing a regulatory scheme for these entities to address, for some states, a potential regulatory gap.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☑️ Yes or □ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
   ☐ 1 ☑️ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)
   High Likelihood Low Likelihood

   Explanation, if necessary: The current subgroup would target completion of a model within one year.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption the new model.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: Some states have already implemented laws and/or regulations establishing a regulatory scheme for these entities, which may or may not be consistent with the provisions in the proposed new model. For those states with laws or regulations not consistent with the new model’s provisions, the issue will be whether these states will want to re-open those laws or regulations after adoption the new model.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No. However, the U.S. Department of Health and Human Services (HHS) has proposed rules on rebating safe harbors. In addition, the HHS and/or other federal government agencies currently are considering proposing further federal policy guidance in the areas concerning PBMs and prescription drug pricing transparency and disclosure. In developing the new NAIC model, the Subgroup most likely will be discussing the same or similar issues.
[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.

B. The purpose of this Act is to:

   (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;

   (2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;

   (3) Provide for powers and duties of the commissioner; and

   (4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

   (1) Receiving payments for pharmacist services;

   (2) Making payments to pharmacists or pharmacies for pharmacist services; or

   (3) Both paragraphs (1) and (2).

B. “Commissioner” means the insurance commissioner of this state.
Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.

D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.

E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:

   (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;

   (2) Disbursing or distributing rebates;

   (3) Managing or participating in incentive programs or arrangements for pharmacist services;

   (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

   (5) Developing and maintaining formularies;

   (6) Designing prescription benefit programs; or

   (7) Advertising or promoting services.

G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.

H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.

I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.

J. (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.

   (2) “Pharmacy benefit manager” does not include:

      (a) A health care facility licensed in this state;

      (b) A health care professional licensed in this state;

      (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or
Section 4. Applicability

A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialing, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10 of this Act providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.

C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.

B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third-party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of $\[X\].

E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

F. (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this Act shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of $\[X\] and completion of a renewal application on a form prescribed by the commissioner.

(2) Such renewal fee and application shall be received by the commissioner on or before \([x]\) days prior to the anniversary of the effective date of the pharmacy benefit manager’s initial or most recent license.
Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

1. The nature of treatment, risks or alternative thereto;
2. The availability of alternate therapies, consultations, or tests;
3. The decision of utilization reviewers or similar persons to authorize or deny services;
4. The process that is used to authorize or deny healthcare services or benefits; or
5. Information on financial incentives and structures used by the insurer.

B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

1. The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
2. Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
   a. Marks as confidential any document in which the information appears; or
   b. Requests confidential treatment for any oral communication of the information.

D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:

1. Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
2. Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.

E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person’s cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.

2. Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person’s health benefit plan.

Section 7. Enforcement

A. The commissioner shall enforce compliance with the requirements of this Act.

B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.
Drafting Note: States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#8390).

Drafting Note: States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

(2) The information or data acquired during an examination under paragraph (1) is:

(a) Considered proprietary and confidential;

(b) Not subject to the [Freedom of Information Act] of this state;

(c) Not subject to subpoena; and

(d) Not subject to discovery or admissible in evidence in any private civil action.

C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner’s duties to determine compliance with this Act.

D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

Drafting Note: If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

Section 8. Regulations

The commissioner may promulgate regulations relating to pharmacy benefit managers that are not inconsistent with this Act.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have six (6) months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.
PROJECT HISTORY-2021

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

1. Description of the Project, Issues Addressed, etc.

In 2018, after the full NAIC membership adopted the revisions to the Health Carrier Prescription Drug Benefit Management Model Act (#22), there was consensus for the NAIC to explore whether to develop a new model regulating pharmacy benefit managers (PBMs). The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to discuss the issue. In 2019, the Subgroup decided to move forward with a 2019 charge to “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers.” The charge also states, “[t]he Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

In March 2019, the Subgroup adopted a Request for NAIC Model Law Development to work on the proposed new PBM model. The Task Force and the Health Insurance and Managed Care (B) Committee both adopted the Request for NAIC Model Law Development at the 2019 Spring National Meeting. The Executive (EX) Committee adopted the request at the 2019 Summer National Meeting. Based on its work plan, the Subgroup met 12 times throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated. The Subgroup’s goal was to have its members all equally educated on these issues before it started drafting a model.

Following these informational meetings, the Subgroup determined that it had received sufficient information to move forward with drafting the proposed model. In November 2019, the Subgroup established an ad hoc technical drafting group to develop an initial draft for the full Subgroup’s review. The ad hoc technical drafting group met in December 2019 and January 2020. Due to the COVID-19 pandemic, the Subgroup was unable to meet to discuss the ad hoc technical drafting group’s draft until July 2020. During that meeting, the Subgroup discussed the initial draft and formally exposed the draft for public comment until Sept. 1, 2020. Following the end of the public comment deadline, the Subgroup met Oct. 22, 2020; Oct. 8, 2020; Oct. 1, 2020; Sept. 24, 2020; and Sept. 14, 2020, to discuss the Sept. 1, 2020, comments received on the proposed new model. During its Oct. 29, 2020, meeting, the Subgroup adopted the new model and forwarded it to the Task Force for its consideration.

As adopted by the Subgroup, at its core, the PBM model is a PBM licensing model. Sections 1–4 of the proposed PBM model set out the model’s purpose, scope, and definitions. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals. Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices includes language related to gag clauses and information-sharing for the purposes of enforcement. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model act. Section 8—Regulations provides that the commissioner may promulgate regulations relating to PBMs that are not inconsistent with the model act. Section 8 also includes a drafting note to Section 8 to providing state statutory citations for 15 topic areas that some states might want to consider when developing their state legislation regulating PBMs. Section 9 and Section 10 provide, respectively, for the severability of the model act’s provisions and an effective date.

The Task Force met during the 2020 Fall National Meeting to consider the new PBM model. Given some issues with the proposed PBM model, particularly issues concerning a proposed drafting note for Section 8, the Task Force deferred acting on the PBM model and exposed it for an additional 30-day public comment period. Following the end of the public comment period, the Task Force met March 1 to discuss the comments received. During this meeting, the Task Force extensively discussed the comments received on the Section 8 drafting note and the potential impact of the U.S. Supreme Court’s decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA) on the draft PBM model. The Task Force adopted the PBM model March 18 and forwarded it to the Health Insurance and Managed Care (B) Committee for its consideration. The Committee deferred acting on the proposed PBM model during its meeting at the Spring National Meeting. The Committee extensively discussed the proposed Section 8 drafting note during a meeting June 22. Following that discussion, the Committee adopted the PBM model without the Section 8 drafting note to address concerns about the precedent of including optional sections the states could consider in adopting an NAIC model. In addition, in making this decision, the Committee considered that the Task Force had adopted a new charge for the Subgroup to develop a white paper that would explore the PBM business practices highlighted in the drafting note, including current and emerging state laws on these practices.
2. **Name of Group Responsible for Drafting the Model and States Participating**

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed new model. The members of the Subgroup were: Alabama, Alaska, Arkansas, California, District of Columbia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Oregon chaired the Subgroup. Nebraska was vice chair of the Subgroup.

3. **Project Authorized by What Charge and Date First Given to the Group**

The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018. In 2019, the Task Force adopted a charge for the Subgroup to, “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

4. **A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)**

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

5. **A General Description of the Due Process (e.g., exposure periods; public hearings; or any other means by which widespread input from industry, consumers, and legislators was solicited)**

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

6. **A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group’s response)**

There was one significant item of controversy raised and ultimately resolved during the drafting process. The item of controversy concerned the proposed drafting note to Section 8. The proposed drafting note provided state statutory citations for 15 topic areas reflecting current PBM business practices that some states might want to consider when developing their state legislation regulating PBMs. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup took this approach as a compromise between some states that wanted the PBM model to focus only on the licensing and registration by state departments of insurance (DOIs) and other states that wanted to go further to include substantive provisions related to these PBM business practices. The 15 topic areas are those areas where the Subgroup found, at this time, a lack of national consensus to include in the proposed PBM model. During the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee discussion of the PBM model, concerns were raised about the potential of a lack of uniformity in adoption by the states, which is a key component of the NAIC model law development procedures, if states selected different provisions to include in their state law in implementing the PBM model. Given this concern, some stakeholders suggested that the options approach in the Section 8 drafting note was not the appropriate approach to take and instead suggested that the Task Force consider a charge to the Subgroup to develop a white paper that would examine current and emerging state laws related to the PBM business practices outlined in the drafting note. Following its adoption of the PBM model, during its June 15 meeting, the Task Force adopted such a charge for the Subgroup. During its June 22 meeting, the Committee decided to delete the Section 8 drafting note, given the adoption of the Subgroup charge to develop a white paper and the issues related to the drafting note.
Another issue that arose was whether to defer adoption of the PBM model because of the Rutledge decision, which upheld an Arkansas law regulating certain PBM business practices. Those suggesting deferring the PBM model adoption asserted that the Rutledge decision supported state efforts to enact laws regulating PBM business practices, and the PBM model should be revised to include substantive provisions related to these PBM business practices. The Task Force decided to move forward with the PBM model, as drafted by the Subgroup, because of the different interpretations of the Rutledge decision as it relates to Employee Retirement Income Security Act of 1974 (ERISA) preemption of state laws regulating PBM business practices. To address this issue, the Task Force included in its charge to the Subgroup to develop a white paper language requiring the Subgroup to also examine the impact of the Rutledge decision on states seeking to enact laws regulating certain PBM business practices. In its discussions related to this issue, the Committee supported addressing this issue through the white paper.

The Subgroup also received comments concerning Section 6. Some commenters suggested that the gag clause provision in this section should mirror the federal gag clause language. The Subgroup did not accept that suggestion.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.
GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

Drafting Note: The receivership laws of most states address the coordination of receiverships involving multiple states. Typically, these laws provide that a domiciliary receiver appointed in another state has certain rights and protections, such as the following:

- The domiciliary receiver is vested with the title to the insurer’s assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

In many states’ laws, these provisions may apply only if the domiciliary state is a “reciprocal state.” Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago. These definitions may be inconsistent with laws in other states, and they may be more prescriptive than the Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws. As a result, the assets of a receivership estate might not be protected outside of the domiciliary state, and the receiver may be forced to defend litigation in multiple forums.

The provisions described above are intended to promote judicial economy, which benefits all participants in the receivership process. This guideline provides a statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of these provisions. Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Definition of Reciprocal State for Receivership

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner or comparable insurance regulatory official.
PROJECT HISTORY-2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

1. Description of the Project, Issues Addressed, etc.

The Receivership and Insolvency (E) Task Force has an active and ongoing charge, which was adopted in each year of this project by the Executive (EX) Committee and Plenary, that reads as follows:

Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

In 2020, the Task Force finalized its Macroprudential Initiative (MPI) study, which began in 2019, and addressed the referral from the Financial Stability (EX) Task Force to evaluate receivership and guaranty fund laws and practices in the context of the MPI. The Task Force surveyed state insurance regulators and interested parties on each of the key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receivership of insurers operating in multiple states. While a receivership of a multi-jurisdictional insurer would not likely have a material impact on financial stability or the broader financial markets, this project highlighted areas of the receivership process that may need attention, including laws related to full faith and credit of stays and injunctions.

The Task Force discussed the effect of whether a stay or injunction entered into a receivership court is honored in another state. This has been the subject of a lot of litigation, and receivers have expressed concern about this issue. The receivership laws of most states address the coordination of receiverships involving multiple states. However, in many states’ laws, these provisions may apply only if the domiciliary state is a “reciprocal state.” Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago.

The Task Force drafted this Guideline as an alternative to address how states define “reciprocal state.” This Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership and Insolvency (E) Task Force was responsible for drafting the Guideline. The 2020 and 2021 members of the Task Force were:

2020: Texas (Chair); District of Columbia (Vice Chair); Alaska; American Samoa; Arkansas; California; Colorado; Connecticut; Florida; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; North Carolina; Oklahoma; Pennsylvania; Rhode Island; South Carolina; Tennessee; and Utah.

2021: Texas (Chair); Louisiana (Vice Chair); American Samoa; Arizona; Colorado; Connecticut; Florida; Hawaii; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; New Mexico; North Carolina; Northern Mariana Islands; Oklahoma; Pennsylvania; Rhode Island; South Carolina; and Utah.

3. Project Authorized by What Charge and Date First Given to the Group.

As described in paragraph 1, on its Oct. 7, 2020, meeting, the Task Force agreed to draft a guideline to address this issue, which was identified through the results of the MPI study and the subsequent survey regarding key provisions of receivership and guaranty fund laws that states should consider adopting into their laws.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The Guideline was drafted by Task Force members: Florida; Maine; Texas; and Patrick Cantilo (Cantilo and Bennett LLP), an interested party. This drafting group met Oct. 19, 2020, and considered language contained in both the Florida and Maine laws. Rather than identifying a list of specific key provisions in law that would be required for a state to be defined as “reciprocal,” the drafting group agreed to use the same criteria used by the NAIC Financial Regulation Standards and Accreditation Program.
Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws, which requires a state to have a “receivership scheme,” will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws, and it should avoid unnecessary litigation regarding the recognition of a state as a reciprocal state.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

On Nov. 19, 2020, the Task Force met to release the draft Guideline for a 42-day public comment period ending Dec. 31, 2020. The exposure was distributed by email to members, interested state insurance regulators, and interested parties of the Task Force; and it was posted to the NAIC website.

The Task Force did not receive any comments.

The Task Force adopted the Guideline on March 12, 2021.

The Financial Condition (E) Committee adopted the Guideline on April 13, 2021.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response).

There were no issues of significance raised during the exposure periods or during meetings.

7. List the key provisions of the model (sections considered most essential to state adoption).

The Guideline provides the following definition, as well as an explanatory drafting note:

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner or comparable insurance regulatory official.

8. Any Other Important Information (e.g., amending an accreditation standard).

The Guideline will not be considered for any accreditation standard.
MEMORANDUM

TO: NAIC Plenary

FROM: Scott White, Financial Condition (E) Committee

DATE: June 29

RE: Agenda item 2019-24: Levelized and Persistency Commission

This memorandum summarizes both 1) the adopted changes to SSAP No. 71—Policy Acquisition Costs and Commissions, 2) and an overview of the key points of the levelized commission agenda item 2019-24 which were adopted into the changes to SSAP No. 71.

The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15, 2021, adopted revisions (see illustrated revisions page 5) which are effective Dec. 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the revisions as adopted by the Working Group with a vote of 41 members in favor and two opposed (LA and OK). On April 13, 2021, the Financial Condition (E) Committee adopted theses same revisions to SSAP No. 71 with a vote of 11-3 (Mississippi, New Mexico and South Carolina dissenting).

Overview

• Acquisition Costs: Acquisition costs are expenses incurred in the acquisition of new and renewal insurance contracts. These are costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). It is a foundational concept for statutory accounting principles (SAP) that acquisition costs including commissions are expensed as incurred. This is because incurred costs are not available to pay policyholder claims. Both U.S. generally accepted accounting principles (GAAP) and SAP would calculate acquisition costs in a similar manner. GAAP treatment capitalizes acquisition costs and expenses them over time to match revenue and expenses. This is one of the major financial reporting differences between SAP and GAAP. These differences are intentional because SAP is measuring the ability to pay policyholder claims using the foundational principles of conservatism, consistency and recognition. GAAP, on the other hand, is focused on matching revenue to expenses.
• **Funding Agreement:** A funding agreement is using a third-party to pay commission costs on the insurer’s behalf, with the insurer repaying the third-party over time plus interest. To ensure consistent and conservative treatment, and appropriate recognition, SSAP No. 71 requires that the full amount of the funding agreement liability be recognized upfront by the insurer plus interest and fees owed to date. This is because the substance of the agreement is a LOAN. That is, the third-party is paying an insurer’s acquisition commission obligation and accepting repayment over time (e.g., over 3-8 years).

• **Persistency Commission Versus Loan with a Contingency Element:** A normal persistency commission is one in which additional commission is earned over time, when a policy is renewed or remains in force. A distinct difference is that persistency commission occurs subsequent to an initial sales commission. The triggering event is the continuation (or renewal) of a policy. An additional amount is owed if the policy persists overtime. A persistency commission is typically a much smaller payment than initial sales commission. For example, a small percentage if the policy is in force in years 2-10.

Note: Although traditional persistency commission is not required to be recognized before the triggering event (e.g., renewal), earlier comments from industry noted that they could be inadvertently scoped in with the initially exposed revisions. The adopted edits addressed this concern and are clear that the recognition of commission is based on the triggering event, which is the policy action, such as initial issuance or renewal.

The practice under dispute represents initial sales commission that is not being recognized by a limited number of insurers. With these designs, the insurer has an agreement to reimburse a third-party in the future (who has paid the commission cost to the agent on the insurer’s behalf) plus interest and fees. The third-party agreement notes that the insurer does not have to pay the future installments if the policy lapses. *(The impacted insurers have noted that this practice inserts a “persistency” element into the initial sales commission already incurred. This is actually a LOAN with a contingency element.)* Note: Insurers are required to recognize the full initial commission cost when a policy is issued. If a policy is cancelled, at that time, an insurer can derecognize the liability to repay the third party.

**Disputed practice:** Those few insurers that are not recognizing the full liability under the funding agreement (to repay the parties who are paying acquisition costs on their behalf) are not following the long-standing guidance in SSAP No. 71. These limited companies are only recognizing a fraction of the acquisition commission expense, which results in misleading financial statements, and presents a better financial position than actually exists (as the company has unrecorded liabilities for commissions already paid on their behalf). SSAP No. 71 requires recognition of the full liability amount of such an
agreement, even if repayment is not guaranteed. The small number of insurers have asserted that their reporting is a decades-long practice. However, the SSAP No. 71 guidance that requires full accrual of the liability was adopted in 1998 and is based on even earlier statutory accounting guidance which notes that, “The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.” The Working Group discussions identified that not recognizing the full liability appears to have been practiced by only a small minority of companies, which supports that the majority of industry is reporting correctly.

- **Lapse** - Lapse risk is a risk identified in Model 791 Life and Health Reinsurance, as a significant insurance risk therefore it cannot be transferred to a non-insurance entity. However, some employing the disputed practice have tried to assert that it has been transferred to the funding agent.

- **Overview of Edits**: Revisions clarify that an insurance entity cannot use third-party structures to recharacterize and delay recognition of liabilities for initial sales commission owed, regardless of how a third-party arrangement is structured with regards to the timing of the payment from the insurers. This guidance clarifies that it is the writing of the insurance contract that obligates the insurer and recognition of expense shall occur consistently among insurers. SSAP No. 71 does not require advanced recognition for expected renewals or normal persistency metrics. When an insurance policy is issued, renewed or when metrics are met that require additional commission, then SSAP No. 71 consistently requires expense recognition for all insurers.

- **Substantive / Nonsubstantive** - The determination of a change as substantive or nonsubstantive is based on whether the edits reflect original intent (nonsubstantive) or incorporates new accounting concepts (substantive). Throughout the discussion process, it has been reiterated that the edits simply clarify the original intent of SSAP No. 71. As such, the change was classified as nonsubstantive. The impact to companies or the number of companies that have incorrectly applied accounting guidance is not a factor in determining whether a clarifying edit is substantive or nonsubstantive. However, the incorrect application only seems to involve a limited number of linked-companies, with other entities following the original intent of SSAP No. 71, which supports that the changes are nonsubstantive and consistent with original intent. The March 15 Working Group discussion affirmed the nonsubstantive classification of the revisions was consistent with the policy statement.

- **Correction of Error / Change in Accounting Principle**: An earlier comment from an impacted company identified that there is a process concern as the edits to SSAP No. 71 are classified as a change in accounting principle and not a correction of error. *(Under
SSAP No. 3—Accounting Changes and Correction of Errors, a mistake in the application of accounting principles is a correction of an error.) The edits proposed in July 2020 were to classify changes required from misapplication of SSAP No. 71 as a correction of error. However, in response to comments, the Working Group agreed to designate the impact as a change in accounting principle. This provision was provided to assist companies in reflecting the change. Both processes require the impact to be recognized to unassigned funds (surplus). If reported as a correction of an error, then an entity may be subject to filing amended financial statements for periods in which the error was reflected. As a change in accounting principle, then the entity calculates the change as a cumulative effect to the Jan. 1 balance in the current year financials.

- **Use of Funding Agreements:** SSAP No. 71 does not prohibit the use of funding agreements or the use of third parties to pay commission expense to selling agents. SSAP No. 71 simply requires consistent recognition of commission expense based on policy issuance or renewal. The involvement of third parties and funding agreements to front commission owed to selling agents is not a free service. These third-parties require fees and interest from these financing arrangements; which presumably exceeds the costs of commission only. The long-standing guidance in SSAP No. 71 requires recognition of the full amount of unpaid principal and interest accrued to date in these arrangements. One comment raised during the discussion was that the clarified guidance would hurt policyholders. This comment was never fully substantiated, but it was noted that failing to report expenses in line with SSAP No. 71 would result with inappropriate financial positions – which could hurt policyholders. Additionally, it was noted that if the process to defer expense recognition was sanctioned, then all insurers would have to engage in these arrangements to prevent competitive disadvantages with reporting.

- **Payments to the Direct Agent:** Some of the comments received from the impacted companies (or their representatives) have tried to indicate that the timing (and how) the initial sales commission is paid to the direct selling agent by the third-party should not impact the recognition of commission expense by the insurer. These comments were made because it has been highlighted that in the known situations, the third-party agents have already paid the direct selling agent the owed commission. Although the third-party payment to the direct selling agent substantiates that a commission was owed from policy issuance, the payment to the direct agent is not the triggering event. (Meaning, even if a third-party was to revise their agreements with direct agents to delay payment, this will not change that the insurer owes commission expense from policy issuance. The initial sales commission is triggered by policy issuance.)

- **Consistent Application Across Companies:** SSAP No. 71 is a “common area” SSAP and applies to all entities regardless of their line of business or product offerings. Some comments made to regulators have implied that certain large companies are permitted processes that are not in line with SSAP No. 71. It is speculated that these comments are
trying to compare commission expenses from renewals (which are not required until policy renewal occurs) to the process engaged by these companies in which they have not recognized commission expense from the initial issuance of policies. This goes back to these impacted companies mischaracterizing these financing arrangements as “persistency” commission. These timing arrangements do not alter the requirement to recognize commission expense with the issuance of a policy. Because many of these funding agreements were mischaracterized, it was noted that the disputed practice is difficult to identify on financial examinations and audits. One Working Group member shared that they had dealt with an issue like this previously when $16 million of off-balance sheet commission liabilities was identified after a third party funding agent applied to the liquidator for reimbursement.

- **Impacted Companies:** Throughout the discussion, key industry representatives continued to highlight that the impacted companies were less “than 10” and likely “5 or less.” The impacted companies were requested to reach out to domiciliary states to provide information. However the impact for these few companies is expected to be material. A consumer representative also voiced concerns about the illusory surplus and unlevel playing field such arrangements create. Because of the unfair competitive advantages that are perceived, the Working Group was not in favor of grandfathering the practices. However the Working Group did discuss that companies could have discussions with their domiciliary states regarding obtaining a permitted practice for phasing in the financial impact. A permitted practice approach was favored because the impact to the affected companies may vary.

**Effective Date:** Although nonsubstantive revisions are generally effective upon adoption, the Working Group ultimately determined to have a Dec. 31, 2021 effective date. Two of the industry commenters (Guggenheim and interested parties (Delaware Life)) stated support for an effective date no sooner than Dec. 31, 2021 at the March meeting. Annual 2020 effective dates were previously deferred. While some members of the Working Group supported an effective date earlier in 2021, it was discussed that a year end 2021 effective date would allow insurers, to assess the impact and review contracts, and additionally allow the issue to be fully through the NAIC committee process. During the March meeting, the National Council of Insurance Legislators (NCOIL) comments were supportive of a later effective date or an extended phase-in period. The Working Group determined that a year-end 2021 effective date was preferred because of the competitive issues and because the revisions were viewed as a clarification of long-standing guidance. The Working Group also reiterated its prior comments that the limited number of companies seeking phase in application could seek a permitted practice and that the permitted practices disclosures would provide regulatory transparency.
Adopted Revisions to SSAP No. 71 (new text from the prior exposure is shown as shaded):

2. Acquisition costs are those costs that are incurred in the acquisition of new and renewal insurance contracts and include those costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). Acquisition costs and commissions shall be expensed as incurred. Determination of when acquisition costs and commissions have been incurred shall be made in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported.

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent’s license with the reporting entity is not maintained with respect to the payment stream.

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party to the direct selling agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is
payable to a third party related to levelized commissions. Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions. The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless of if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.

Effective Date and Transition
7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. The nonsubstantive revisions adopted March 15, 2021 regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter.
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☐ New Model Law or ☑ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

Receivership Law (E) Working Group

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

- **Insurance Holding Company System Regulatory Act (#440)**
- **Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)**

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- **The Insurance Holding Company System Model Act (#440)** requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The **Insurance Holding Company System Model Regulation (#450)**, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.
The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450 Consistency with any revisions to Model 440

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)

If yes, please explain why:

While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?

☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood Low Likelihood

Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  

(Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: See previous discussion.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  

(Check one)

High Likelihood  Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

The Insurance Holding Company System Model Act (§440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

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Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

A. Transactions Within an Insurance Holding Company System

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(f) The insurer’s surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs.
If an insurer subject to this Act is deemed by the commissioner to be in a hazardous financial condition as defined by [insert citation for Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer’s discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the commissioner required the deposit or the bond.

In determining whether a deposit or a bond is required, the commissioner should consider whether concerns exist with respect to the affiliated person’s ability to fulfill the contract(s) or agreement(s) if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding, and a deposit or bond is necessary, the commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s).

Drafting Note: This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and actuarial services, data management, investment portfolio management and support and policy and policyholder services. (Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements). The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond, (deposit vs. bond to be determined by the insurer) and in specifying an amount, the commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action, including supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.

All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons’ records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer’s business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer’s business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to [the receivership act of the state].
(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer’s admitted assets as of the 31st day of December next preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer’s liabilities, or the projected reinsurance premium or a change in the insurer’s liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer’s surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer’s admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;
(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer’s surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

Drafting Note: When reviewing the notification required to be submitted pursuant to Section 5A(2)(f), the commissioner should examine prior and existing investments of this type to establish that these investments separately or together with other transactions, are not being made to contravene the dividend limitations set forth in Section 5B. However, an investment in a controlling person or in an affiliate shall not be considered a dividend or distribution to shareholders when applying Section 5B of this Act.

(g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer’s policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.

(4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation’s voting securities.

(6) Supervision, seizure, conservatorship or receivership proceedings.

(a) Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to Subsection 5A(2)(d) shall be subject to the jurisdiction of any supervision, seizure, conservatorship or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing and overseeing the affiliate’s obligations under the agreement or contract to perform services for the insurer that:

(i) Are an integral part of the insurer’s operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment or any other similar functions; or

(ii) Are essential to the insurer’s ability to fulfill its obligations under insurance policies.

(b) The commissioner may require that an agreement or contract pursuant to Subsection 5A(2)(d) for the provision of services described in (i) and (ii) above specify that the affiliate consents to the jurisdiction as set forth in this Subsection 5A(6).
an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Subsection 5A(6)(b) gives the commissioner discretion to require documentation of an affiliate’s consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a commissioner may require such provision, the commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrants requirement of such a provision.

B. Dividends and Other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

1. Ten percent (10%) of the insurer’s surplus as regards policyholders as of the 31st day of December next preceding; or
2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer’s own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner’s approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.

Drafting Note: The following Subsection C entitled “Management of Domestic Insurers Subject to Registration” is optional and is to be adopted according to the needs of the individual jurisdiction.

C. Management of Domestic Insurers Subject To Registration.

1. Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.

2. Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).

3. Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.
(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer’s annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than $300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer’s surplus as regards policyholders is reasonable in relation to the insurer’s outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) The extent to which the insurer’s business is diversified among several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer’s insured risks;

(5) The nature and extent of the insurer’s reinsurance program;

(6) The quality, diversification and liquidity of the insurer’s investment portfolio;

(7) The recent past and projected future trend in the size of the insurer’s investment portfolio;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer’s reserves; and

(10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.
PROJECT HISTORY-2021

REVISIONS TO

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)
AND INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)

RECEIVERSHIP

1. Description of the Project, Issues Addressed, etc.

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

"Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership."

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.
3. **Project Authorized by What Charge and Date First Given to the Group.**

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

4. **A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.**

   In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

5. **A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).**

   On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

   On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

   On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI’s proposed edit was accepted.

   All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

   All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

   The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

   The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

   The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response).**

   There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5A.1(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties’ revisions.
7. **List the key provisions of the model (sections considered most essential to state adoption).**

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- **Section 5A(1) of Model #440**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- **Section 5A(6) of Model #440**
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- **Section 19 of Model #450**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

8. **Any Other Important Information (e.g., amending an accreditation standard).**

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

*W:/National Meetings/2021/Summer/Plenary/13_MO440-combined_final.pdf*
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is:  
☐ New Model Law  or  ☒ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

   Receivsership Law (E) Working Group

2. NAIC staff support contact information:

   Jane Koenigsmann  
jkoenigsmann@naic.org  
816-783-8145

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   - Insurance Holding Company System Regulatory Act (#440)  
   - Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)

   In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

   The Financial Stability Board’s (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

   - The Insurance Holding Company System Model Act (#440) requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The Insurance Holding Company System Model Regulation (#450), Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
   - The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

   However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

   One potential solution is to revise the definition of “insurer” under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.
The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450
The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450 Consistency with any revisions to Model 440

4. Does the model law meet the Model Law Criteria? ☒ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☒ Yes or ☐ No (Check one)

   If yes, please explain why:

   While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☒ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval? ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

   High Likelihood Low Likelihood

   Explanation, if necessary:
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood ☒ Low Likelihood ☐

Explanation, if necessary: See previous discussion.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)

High Likelihood ☒ Low Likelihood ☐

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

The Insurance Holding Company System Model Act (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION
WITH REPORTING FORMS AND INSTRUCTIONS

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Section 16. Amendments to Form B
Section 17. Alternative and Consolidated Registration
Section 18. Disclaimers and Termination of Registration
Section 19. Transactions Subject to Prior Notice - Notice Filing (Form D)
Section 20. Enterprise Risk Report
Section 21. Group Capital Calculation
Section 22. Extraordinary Dividends and Other Distributions
Section 23. Adequacy of Surplus

Form A  Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer
Form B  Insurance Holding Company System Annual Registration Statement
Form C  Summary of Changes to Registration Statement
Form D  Prior Notice of a Transaction
Form E  Pre-Acquisition Notification Form
Form F  Enterprise Risk Report

Section 19. Transactions Subject to Prior Notice - Notice Filing

A. An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

(1) Identify the person providing services and the nature of such services;

(2) Set forth the methods to allocate costs;

(3) Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
(4) Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

(5) State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

(6) Define books and records and data of the insurer to include all books and records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

(7) Specify that all books and records and data of the insurer are and remain the property of the insurer, and:
   (a) Are subject to control of the insurer;
   (b) Are identifiable; and
   (c) Are segregated from all other persons’ records and data or are readily capable of segregation at no additional cost to the insurer;

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

(8) State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

(9) Include standards for termination of the agreement with and without cause;

(10) Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;

(11) Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts] or seized by the commissioner under the State Receivership Act:
   (a) All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state]; and,
   (b) All records and data of the insurer shall be identifiable and segregated from all other persons’ records and data or readily capable of segregation at no additional cost to the receiver or the commissioner;

Drafting Note: The “at no additional cost to the receiver or the commissioner” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the receiver or the commissioner. Since records and data of the insurer are the property of the insurer, the receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

   (c) A complete set of all books and records and data of the insurer will immediately be made available to the receiver or the commissioner, shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner’s request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable; and,
Drafting Note: The fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

(d) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts] the State Receivership Act; and

(13) Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;

(14) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts] a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner, for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court; and,

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver’s authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer’s policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate’s commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).
PROJECT HISTORY-2021

REVISIONS TO

INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)
AND INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)

1. Description of the Project, Issues Addressed, etc.

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

“Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.”

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

2. Name of Group Responsible for Drafting the Model and States Participating.

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.
3. **Project Authorized by What Charge and Date First Given to the Group.**

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

4. **A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.**

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

5. **A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).**

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI’s proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response).**

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5A.1(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties’ revisions.
7. List the key provisions of the model (sections considered most essential to state adoption).

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- **Section 5A(1) of Model #440**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
  - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party’s ability to fulfill the contract in the event of a liquidation.
  - Premiums are the property of the insurer, with any right of offset subject to receivership law.

- **Section 5A(6) of Model #440**
  - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.

- **Section 19 of Model #450**
  - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
  - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
  - In the event of receivership (now including supervision and conservatorship):
    - The rights of the insurer extend to the receiver or guaranty fund.
    - The affiliate will make available essential personnel.
    - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
    - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

8. Any Other Important Information (e.g., amending an accreditation standard).

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

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Process for Evaluating Qualified and Reciprocal Jurisdictions
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I. Preamble

Purpose

The revised Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) (collectively, the Credit for Reinsurance Models) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes. In 2012, the NAIC Reinsurance (E) Task Force was charged to develop an NAIC process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. This charge was extended in 2019 to encompass the recognition of Reciprocal Jurisdictions in accordance with the 2019 amendments to the Credit for Reinsurance Models, including the maintenance of a list of recommended Reciprocal Jurisdictions. The purpose of the Process for Evaluating Qualified and Reciprocal Jurisdictions is to provide a documented evaluation process for creating and maintaining these NAIC lists.

Background

On November 6, 2011, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions serve to reduce reinsurance collateral requirements for certified reinsurers that are licensed and domiciled in Qualified Jurisdictions. Under the previous version of the Credit for Reinsurance Models, in order for U.S. ceding insurers to receive reinsurance credit, the reinsurance was required to be ceded to U.S.-licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. When considering revisions to the Credit for Reinsurance Models, the Reinsurance (E) Task Force contemplated establishing an accreditation-like process, modeled on the current NAIC Financial Regulation Standards and Accreditation Program, to review the reinsurance supervisory systems of non-U.S. jurisdictions. Under the revised Credit for Reinsurance Models, the approval of Qualified Jurisdictions is left to the authority of the states; however, the models provide that a list of Qualified Jurisdictions will be created through the NAIC committee process, and that individual states must consider this list when approving jurisdictions.

The federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), enacted in 2010, authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements; (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.

On September 22, 2017, the United States and the European Union (EU) entered into the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.
Reciprocal Jurisdictions

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions were intended to conform the Models to the relevant provisions of the Covered Agreements. The Covered Agreements would eliminate reinsurance collateral requirements for EU and UK reinsurers that maintain a minimum amount of own funds equivalent to $250 million and a solvency capital requirement (SCR) of 100% under Solvency II, among other conditions. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or UK or post reinsurance collateral. Under the revised Credit for Reinsurance Models, jurisdictions that are subject to in-force covered agreements are considered to be Reciprocal Jurisdictions, and reinsurers that have their head office or are domiciled in a Reciprocal Jurisdiction are not required to post reinsurance collateral if they meet all of the requirements of the Credit for Reinsurance Models.

Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but any other Qualified Jurisdiction also has a pathway to qualify for collateral elimination as a Reciprocal Jurisdiction States that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The NAIC has updated and revised this Process for Evaluating Qualified and Reciprocal Jurisdictions to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

1 The hypothetical possibility that a future covered agreement might not relate to reinsurance is addressed in Section 2F(1)(a)(i) of Model #785, which limits automatic Reciprocal Jurisdiction status to a covered agreement that “addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.”
II. Principles for the Evaluation of Non-U.S. Jurisdictions

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.

2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.

3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states’ approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.

4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.

6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models. Under the Credit for Reinsurance Model Law (as adopted by a state) the state must recognize the Reciprocal Jurisdiction status of jurisdictions subject to an in-force Covered Agreement.
7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section III.

8. Both Qualified Jurisdictions and Reciprocal Jurisdictions have agreed to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction, in accordance with the Credit for Reinsurance Models, as adopted by the state. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.

10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.
III. Procedure for Evaluation of Non-U.S. Jurisdictions

   a. Priority will be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
   b. Formal notification of the NAIC’s intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
   c. Relevant U.S. state and federal authorities will be notified of the NAIC’s decision to evaluate a jurisdiction.

2. Evaluation of Jurisdiction
   a. Evaluation Materials. The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Mutual Recognition of Jurisdictions (E) Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Mutual Recognition of Jurisdictions (E) Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
   b. The Mutual Recognition of Jurisdictions (E) Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Mutual Recognition of Jurisdictions (E) Working Group’s review at this stage will be focused on how the jurisdiction’s laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework and other factors set forth in the Evaluation Methodology.

2 The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.
c. After reviewing the Evaluation Materials, the Mutual Recognition of Jurisdictions (E) Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.

d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction’s laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.

e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction’s evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

   a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction’s Evaluation Materials.

   b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.

   c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.

   d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. Discretionary On-site Review

   a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction’s reinsurance supervisory system. Factors that the Mutual Recognition of Jurisdictions (E) Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.

   b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant
issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

i. Interviews with supervisory authority personnel.

ii. Review of organizational and personnel practices.

iii. Any additional information beneficial to gaining an understanding of document and communication flows.

c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction’s reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction’s demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction’s laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

6. Additional Information to be Considered as Part of Evaluation

The NAIC may also consider information from sources other than the jurisdiction under review. This information includes:

a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.

b. Public comments from interested parties.

c. Rating agency information.

d. Any other relevant information.

7. Preliminary Evaluation Report

a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).

b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction’s reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.
c. All workpapers and reports, including supporting documentation and data, produced as part of the evaluation process are the property of the NAIC and shall be maintained at the NAIC Central Office. In the event that the NAIC shall come into possession of any confidential information, the information shall be held subject to a confidentiality and information-sharing agreement, which will outline the appropriate actions necessary to protect the confidentiality of such information.

   a. The Mutual Recognition of Jurisdictions (E) Working Group’s review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.
   b. The Mutual Recognition of Jurisdictions (E) Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.
   c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.

   a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.
   b. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Mutual Recognition of Jurisdictions (E) Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.
   c. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination Regarding List of Qualified Jurisdictions
    a. Once the Mutual Recognition of Jurisdictions (E) Working Group has adopted its Final Evaluation Report, it will submit the summary of its findings and its recommendation to the Reinsurance (E) Task Force at an open meeting. Upon approval by the Reinsurance (E) Task Force, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the FIO, USTR and other relevant federal authorities for consultation purposes. Upon approval as a Qualified Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Qualified Jurisdictions. The NAIC will maintain the List of Qualified Jurisdictions on its public website and in other appropriate NAIC publications.
b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.

c. Upon final adoption of the Mutual Recognition of Jurisdictions (E) Working Group’s determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.

b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a “Lead State” designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the IAIS MMoU, or in a bilateral MOU between the Lead State and the Qualified Jurisdiction. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided the that Lead State share that information with the other states requesting the information only in a manner consistent with the terms governing the further sharing of information included, as applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.

c. If a Qualified Jurisdiction has not been approved by the IAIS as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.

d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Evaluation after Initial Approval

a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Mutual Recognition of Jurisdictions (E) Working Group to be appropriate. It shall include a review of the jurisdiction’s status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13.

b. Qualified Jurisdictions must provide the Mutual Recognition of Jurisdictions (E) Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of
the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Mutual Recognition of Jurisdictions (E) Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. U.S. ceding insurers may also initiate notice to the Mutual Recognition of Jurisdictions (E) Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

c. The Mutual Recognition of Jurisdictions (E) Working Group will monitor those jurisdictions that have been approved as Qualified or Reciprocal Jurisdictions by individual states, but are not included on the applicable NAIC List.

13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

a. In evaluating whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. Procedure for Evaluation of Non-U.S. Jurisdictions such as the Mutual Recognition of Jurisdictions (E) Working Group deems is appropriate. Specifically, the Mutual Recognition of Jurisdictions (E) Working Group will use processes and procedures outlined in paragraph 1 (Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction), paragraph 3 (NAIC Review of Evaluation Materials), paragraph 7 (Preliminary Evaluation Report), paragraph 8 (Review of Preliminary Evaluation Report), paragraph 9 (Opportunity to Respond to Preliminary Evaluation Report), paragraph 10 (NAIC Determination regarding List of Qualified Jurisdictions), paragraph 11 (Memorandum of Understanding) and paragraph 12 (Process for Evaluation after Initial Approval), as modified for use with applicants for Reciprocal Jurisdiction status.

b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it has undergone the Evaluation Methodology outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Mutual Recognition of Jurisdictions (E) Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Mutual Recognition of Jurisdictions (E) Working Group may base its determination on all relevant information, which may include factors not specifically included in this Process for Evaluating Qualified and Reciprocal Jurisdictions.

c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force covered agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal

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Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group shall undertake the following analysis in making its evaluation:

i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurer domiciled in that jurisdiction;

ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in a jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision by the Qualified Jurisdiction at the level of the worldwide parent undertaking of the insurance or reinsurance group;

iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and

v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than $250,000,000, and the required minimum solvency or capital ratio, as applicable.

d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

[Jurisdiction] is a Qualified Jurisdiction under the NAIC Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786), and is currently in good standing on the NAIC List of Qualified Jurisdictions. As the lead insurance regulatory supervisor for [Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:
- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction]. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.

- [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction’s worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].

- [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].

- [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than $250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.

- Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

e. The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination will be submitted for a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.

f. The Mutual Recognition of Jurisdictions (E) Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable
14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

a. If the Mutual Recognition of Jurisdictions (E) Working Group finds a Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Mutual Recognition of Jurisdictions (E) Working Group would then report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. The status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC. If a Qualified Jurisdiction is also a Reciprocal Jurisdiction subject to a Covered Agreement, the Mutual Recognition of Jurisdictions (E) Working Group and the NAIC will initiate communications and consult with FIO, USTR and any other relevant federal and/or international authorities before any action is taken with respect to that Qualified Jurisdiction’s status.

b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction’s status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Mutual Recognition of Jurisdictions (E) Working Group would report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will be addressed through the Joint Committee process established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement. The NAIC, individual state regulators and interested parties may raise these issues directly with FIO, USTR or other relevant federal authorities.

c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Mutual Recognition of Jurisdictions (E) Working Group of any applicable changes to their reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction’s status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction’s status on probation, or suspending or revoking its status.

d. If a Qualified or Reciprocal Jurisdiction’s status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC’s suspension or revocation
takes effect, it is expected that the same action will be taken by the respective states that have recognized
the jurisdiction as a Qualified or Reciprocal Jurisdiction.

e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status
as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year
period.

f. During the period in which a Qualified or Reciprocal Jurisdiction’s status has been suspended by a state,
any new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled
in that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security
posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as
a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was
already in force.

g. If a Qualified or Reciprocal Jurisdiction’s status is revoked by a state, then those Certified Reinsurers and/or
Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction no longer qualify for that status, which
generally obligates them to post one hundred percent (100%) collateral on all their liabilities assumed from
ceding insurers domiciled in that state. The state has the option to suspend a reinsurer’s certification
indefinitely, in lieu of revocation, in which case the obligation to post collateral applies prospectively to all
new, renewed and amended reinsurance agreements. If the reinsurer’s eligibility is revoked, it must be
granted at least three months after the effective date of the revocation to cure any deficiency in collateral,
unless exceptional circumstances make a shorter period is necessary for policyholder and other consumer
protection.

h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the
evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a
Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still
meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject
to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a
Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal
Jurisdiction.

15. Passporting Process for Certified and Reciprocal Jurisdiction Reinsurers

a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the
states, the NAIC has initiated a process called “passporting” under which the commissioner has the
discretion to defer to another state’s determination with respect to the requirements for both Certified
Reinsurers and Reciprocal Jurisdiction Reinsurers. Passporting is based upon individual state regulatory
authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process.
States are also encouraged to utilize the passporting process to reduce the amount of documentation filed
with the states and reduce duplicate filings.

b. The passporting process is facilitated through the Reinsurance Financial Analysis (E) Working Group
(ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers
and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect
to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth
in the ReFAWG Procedures Manual.
c. Section 9C(7) of the Credit for Reinsurance Model Regulation (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than $250 million] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 either by providing the information required by Section 9C(7) itself, or by providing an assuming insurer domiciled in that Reciprocal Jurisdiction with a document confirming the required information, which the assuming insurer would file annually. With either filing method, in lieu of filing the required information directly with the domiciliary states of each of the reinsurer’s U.S. ceding companies, the information may be filed with either the Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process in satisfaction of their respective filing requirements.
IV. Evaluation Methodology

The Evaluation Methodology was developed to be consistent with the provisions of the NAIC Credit for Reinsurance Models. It is intended to provide an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. Although the methodology includes a comparison of the jurisdiction’s supervisory system to a number of key elements from the NAIC Accreditation Program, it is not intended as a prescriptive assessment under the NAIC Accreditation Program. Rather, the NAIC Accreditation Program simply provide the framework for the outcomes-based analysis. The NAIC will evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the jurisdiction and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of a Qualified Jurisdiction is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

The Evaluation Methodology consists of the following:

- Section A: Laws and Regulations
- Section B: Regulatory Practices and Procedures
- Section C: Jurisdiction’s Requirements Applicable to U.S.-Domiciled Reinsurers
- Section D: Regulatory Cooperation and Information Sharing
- Section E: History of Performance of Domestic Reinsurers
- Section F: Enforcement of Final U.S. Judgments
- Section G: Solvent Schemes of Arrangement

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.
Section A: Laws and Regulations

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation. A jurisdiction’s effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction’s regulatory system by gathering and undertaking a review of the most recent FSAP Report, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will simultaneously invite each jurisdiction (or its designee) to provide information relative to Section A (and other sections, as relevant) to assist the NAIC in evaluating its laws and regulations. The NAIC will review this information in conjunction with Appendix A, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix A is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction is requested to address the following information, which the NAIC will consider, at a minimum, in determining whether the outcomes achieved by the jurisdiction’s laws and regulations meet an acceptable level of effectiveness for the jurisdiction to be included on the NAIC List of Qualified Jurisdictions:

1. Confirmation of the jurisdiction’s most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.

2. Confirmation of the jurisdiction’s ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.

3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.

4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to

3 The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction’s reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.
minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

Section B is intended to facilitate an evaluation of whether the jurisdiction effectively employs baseline regulatory practices and procedures to supplement and support enforcement of the jurisdiction’s financial solvency laws and regulations described in Section A. This evaluation methodology recognizes that variation may exist in practices and procedures across jurisdictions due to the unique situations each jurisdiction faces. Jurisdictions differ with respect to staff and technology resources that are available, as well as the characteristics of the domestic industry regulated. A determination of effectiveness may be achieved using various financial solvency oversight practices and procedures. This evaluation is not intended to be prescriptive in nature.

The NAIC will utilize the information provided by the jurisdiction as outlined under Section A in completing this section of the evaluation. The NAIC will review this information in conjunction with Appendix B, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix B is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction should also provide any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC’s evaluation process in order to address, on an outcomes basis, the key elements described within Appendix B.

Section C: Jurisdiction’s Requirements Applicable to U.S. Domiciled Reinsurers

The jurisdiction is requested to describe and explain the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. supervisory authority to reinsurers licensed and domiciled in the U.S.

Section D: Regulatory Cooperation and Information-Sharing

The Credit for Reinsurance Models require the supervisory authority to share information and cooperate with the U.S. state insurance regulators with respect to all certified reinsurers domiciled within their jurisdiction. The jurisdiction is requested to provide an explanation of the supervisory authority’s ability to cooperate, share information and enter into an MOU with U.S. state insurance regulators and confirm that they are willing to enter into an MOU. This should include information with respect to any existing MOU with U.S. state and/or federal authorities that pertain to reinsurance. Both the jurisdiction and the states may rely on the IAIS MMoU to satisfy this requirement, and any states that have not yet been approved by the IAIS as a signatory to the MMoU may rely on an MOU entered into by a Lead State with the jurisdiction until such time that the state has been approved as a signatory to the IAIS MMoU. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

Section E: History of Performance of Domestic Reinsurers

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:
a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than $250,000,000.

b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.

c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).

d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

Drafting Note: The NAIC will determine the appropriate time period for review on a case-by-case basis with respect to this information.

Section F: Enforcement of Final U.S. Judgments

The NAIC has previously collected information from a number of jurisdictions with respect to enforcement of final U.S. judgments. The jurisdiction is also requested to provide a current description or explanation of any restrictions with respect to the enforcement of final foreign judgments in the jurisdiction. Based on the foregoing information, the NAIC will make an assessment of the effectiveness of the ability to enforce final U.S. judgments in the jurisdiction. This will include a review of the status, interpretations, application and enforcement of various treaties, conventions and international agreements with respect to final judgments, arbitration and choice of law. The Mutual Recognition of Jurisdictions (E) Working Group will monitor the enforcement of final U.S. judgments and the Qualified Jurisdiction is requested to notify the NAIC of any developments in this area.

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.
V. Appendices: Specific Guidance with Respect to Section A and Section B

It is important to note that Part IV, Section A: Laws and Regulations, and Part IV, Section B: Regulatory Practices and Procedures, are derived from the NAIC Financial Regulation Standards and Accreditation Program, which is intended to establish and maintain standards to promote sound insurance company financial solvency regulation among the U.S. states. As such, the NAIC Accreditation Program requires the states to employ laws, regulations and administrative policies and procedures substantially similar to the NAIC accreditation standards in order to be considered an accredited state.

However, it is not the intent of the Evaluation Methodology to require applicant jurisdictions to meet the standards required by the NAIC for accreditation. Instead, Section A and Section B (and their corresponding appendices) are intended to provide a framework to facilitate an outcomes-based evaluation by the NAIC and state insurance regulators of the effectiveness of the jurisdiction’s supervisory authority. This framework consists of a description of the jurisdiction’s laws, regulations, practices and procedures applicable to the supervision of its domestic reinsurers. The amount of detail provided within these appendices should not be interpreted as specific requirements that must be met by the applicant jurisdiction. Rather, the information is intended to provide direction to the applicant jurisdiction in an effort to facilitate a complete response and increase the efficiency and timeliness of the evaluation process.
Appendix A: Laws and Regulations

1. Examination Authority
Does the jurisdiction have the authority to examine its domestic reinsurers? This description should address the following:
   a. Frequency and timing of examinations and reports.
   b. Guidelines for examination.
   c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.
   d. Whether the jurisdiction has the authority to have complete access to the reinsurer’s books and records and, if necessary, the records of any affiliated company.
   e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.
   f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement
Does the jurisdiction have the authority to require domestic reinsurers to maintain a minimum level of capital and surplus to transact business? This description should address the following:
   a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.
   b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.
   c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures
Does the jurisdiction have the authority to require domestic reinsurers to file appropriate financial statements and other financial information? This description should address the following:
   a. Description of the accounting and reporting practices and procedures.
   b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action
Does the jurisdiction have the authority to order a reinsurer to take corrective action or cease and desist certain practices that, if not corrected or terminated, could place the reinsurer in a hazardous financial condition? This description should address the following:
   a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.
   b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.
5. **Regulation and Valuation of Investments**

What authority does the jurisdiction have with respect to regulation and valuation of investments? This description should address the following:

a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.

b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. **Holding Company Systems**

Does the jurisdiction have laws or regulations with respect to supervision of the group holding company systems of reinsurers? This description should address the following:

a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.

b. Whether the jurisdiction has access to consolidated financial information of a reinsurer’s ultimate controlling person.

c. Whether the jurisdiction has the authority to review integrity and competency of management.

d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.

e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
   i. Change in control of domestic reinsurers.
   ii. Dividends and other distributions to shareholders of the reinsurer.
   iii. Material transactions with affiliates.

7. **Risk Management**

Does the jurisdiction have the authority to require its domestic reinsurers to maintain an effective risk-management function and practices? This description should address the following:

a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.

b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer’s capital and surplus.

c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.

d. Whether the jurisdiction has corporate governance requirements for reinsurers.
8. **Liabilities and Reserves**

Does the jurisdiction have standards for the establishment of liabilities and reserves (technical provisions) resulting from reinsurance contracts? This description should address the following:

a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).

b. Liabilities related to catastrophic occurrences.

c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. **Reinsurance Ceded**

What are the jurisdiction’s requirements with respect to the financial statement credit allowed for reinsurance retroceded by its domestic reinsurers? This description should address the following:

a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.

b. Collateral requirements applicable to reinsurance contracts.

c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).

d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.

e. Affiliated reinsurance transactions and concentration risk.

f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. **Independent Audits**

Does the jurisdiction require annual audits of domestic reinsurers by independent certified public accountants or similar accounting/auditing professional recognized in the applicant jurisdiction? This description should address the following:

a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.

b. Contents of annual audited financial reports.

c. Requirements for selection of auditor.

d. Allowance of audited consolidated or combined financial statements.

e. Notification of material misstatements of financial condition.

f. Supervisor’s access to auditor’s workpapers.

g. Audit committee requirements.

h. Requirements for reporting of internal control-related matters.

11. **Receivership**

Does the jurisdiction have a receivership scheme for the administration of reinsurers found to be insolvent? This should include a description of any liquidation priority afforded to policyholders and the liquidation priority of reinsurance obligations to domestic and non-domestic ceding insurers in the context of an insolvency proceeding of a reinsurer.
12. Filings with Supervisory Authority

Does the jurisdiction require the filing of annual and interim financial statements with the supervisory authority? This description should address the following:

a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.

b. The use of supplemental data to address concerns with specific companies or issues.

c. Filing format (e.g., electronic data capture).

d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

Does the jurisdiction have a regulatory framework for the regulation of reinsurance intermediaries?

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction’s laws and regulations with respect to its reinsurance supervisory system.
Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

What are the jurisdiction’s practices and procedures with respect to the financial analysis of its domestic reinsurers? Such description should address the following:

a. Qualified Staff and Resources
   The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.

b. Communication of Relevant Information to/from Financial Analysis Staff
   The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).

c. Supervisory Review
   How the jurisdiction’s internal financial analysis process provides for supervisory review and comment.

d. Priority-Based Analysis
   How the jurisdiction’s financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.

e. Depth of Review
   How the jurisdiction’s financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.

f. Analysis Procedures
   How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.

g. Reporting of Material Adverse Findings
   The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.

h. Early Warning System/Stress Testing
   Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.
2. Financial Examinations

What are the jurisdiction’s practices and procedures with respect to the financial examinations of its domestic reinsurers? Such description should address the following:

a. Qualified Staff and Resources
The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.

b. Communication of Relevant Information to/from Examination Staff
The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).

c. Use of Specialists
Whether the supervisory authority’s examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.

d. Supervisory Review
Whether the supervisory authority’s procedures for examinations provide for supervisory review.

e. Examination Guidelines and Procedures
Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.

f. Risk-Focused Examinations
Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?

g. Scheduling of Examinations
Whether the supervisory authority’s procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.

h. Examination Reports
Description of the format in which the supervisory authority’s reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.

i. Action on Material Adverse Findings
What are the jurisdiction’s procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. Information Sharing

Does the jurisdiction have a process for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with U.S. state regulatory officials, provided that the recipients are required, under their law, to maintain its confidentiality?
4. **Procedures for Troubled Reinsurers**

What procedures does the jurisdiction follow with respect to troubled reinsurers?

5. **Organization, Licensing and Change of Control of Reinsurers**

What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:

a. **Licensing Procedure**
   Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.

b. **Staff and Resources**
   The educational and experience requirements for staff responsible for evaluating company licensing.

c. **Change in Control of a Domestic Reinsurer**
   Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.

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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. One state has enacted this model.

Life Insurance and Annuities (A) Committee

- 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 these 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. NAIC staff are not aware of any state activity regarding 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. NAIC staff are not aware of any state activity regarding 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. NAIC staff are not aware of any state activity regarding this model.

- Adoption of the Limited Long-Term Care Insurance Model Act (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.

- Adoption of the Limited Long-Term Care Insurance Model Regulation (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted 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.

- Adoption of the Travel Insurance Model Act (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted 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. 38 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. Three states have enacted this model.

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