

## EXECUTIVE (EX) COMMITTEE AND PLENARY

Executive (EX) Committee and Plenary, Dec. 16, 2021, Minutes

Adopted the Establishment of the Innovation, Cybersecurity, and Technology (H) Committee and its Charges (Attachment One)

Adopted the Proposed NAIC 2022 Budget (Attachment Two)

Adopted the Proposed NAIC 2022 Committee Charges (Attachment Three)

Adopted the 2022 Generally Recognized Expense Table (GRET) (Attachment Four)

Adopted Revisions to the *Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index* (AG 25) (Attachment Five)

Adopted the Travel Insurance Market Conduct Annual Statement (MCAS) Blank (Attachment Six)

Adopted the Short-Term, Limited-Duration (STLD) MCAS Blank (Attachment Seven)

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Adopted the *ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* (Attachment Ten)

Expose the 2020 Revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) (Attachment Eleven)

Report on States' Implementation of NAIC-Adopted Model Laws and Regulations (Attachment Twelve)

## Draft Pending Adoption

Draft: 1/4/22

Executive (EX) Committee and Plenary  
San Diego, California  
December 16, 2021

The Executive (EX) Committee and Plenary met in San Diego, CA, Dec. 16, 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 (AZ); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro represented by Dave Lonchar (DE); John F. King (GA); Michelle B. Santos (GU); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox (MI); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Chris Nicolopoulos (NH); Marlene Caride (NJ); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown represented by 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 Mark Dietzler (WA); Mark Afable (WI); Allan L. McVey represented by Tonya Gillespie (WV); and Jeff Rude (WY).

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

Commissioner Altmaier reported that the Executive (EX) Committee met Dec. 14 and adopted the Dec. 12 report from the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.

The Committee adopted the report of the Executive (EX) Committee, which met Dec. 7, Oct. 26, and Oct. 12 and took the following action: 1) approved the proposed NAIC 2022 budget and recommended that it be considered by the full membership during the joint meeting of the Executive (EX) Committee and Plenary during the Fall National Meeting; 2) approved the 2021 NAIC Staffing Request Fiscal; 3) approved the release of the proposed NAIC 2022 budget for public review and comment; 4) approved the release of the 2021 NAIC Staffing Request Fiscal for public comment; and 5) reappointed Commissioner Mais to the International Association of Insurance Supervisors (IAIS) Executive Committee for a two-year term.

The 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 Committee adopted its 2022 proposed charges.

The Committee received a status report on the NAIC *State Ahead* strategic plan implementation.

The 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 *Life Insurance Disclosure Model Regulation* (#580); 3) the *Mortgage Guaranty Insurance Model Act* (#630); 4) the *Nonadmitted Insurance Model Act* (#870); and 5) the new Pet Insurance Model Act.

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

Director Farmer made a motion, seconded by Director Lindley-Myers, to adopt the Dec. 14 report of the Executive (EX) Committee (*see NAIC Proceedings – Fall 2021, Executive (EX) Committee*). The motion passed unanimously.

### 2. Approved the Establishment of the Innovation, Cybersecurity, and Technology (H) Committee and its Charges

Commissioner Godfread reported that, in proposing the formation of a new committee, NAIC members recognized the importance of raising visibility and prioritizing and organizing the work of the NAIC and its Members, relating to innovation, technology and cybersecurity. The intention is to provide more consistency and collaboration and ensure the coordination of

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related workstreams. Further, it will help to provide clarity and understanding regarding related activities taking place in other committees and workstreams.

In terms of process, an ad hoc drafting group put together proposed charges for a new NAIC letter committee, the Innovation, Cybersecurity, and Technology (H) Committee. Superintendent Dwyer chaired the ad hoc group and Commissioner Birrane and Director Daniels served as vice chairs.

The ad hoc group put out a draft for comment and held a public comment meeting on Nov. 19. The ad hoc drafting group considered another draft based on comments received on Nov. 30. The final version was completed and posted on the NAIC website.

Also included in the meeting materials is a bylaw amendment to include the new Committee in the NAIC structure.

Commissioner Godfreed made a motion, seconded by Commissioner Lara, to amend the NAIC Bylaws to add an additional letter committee, the Innovation, Cybersecurity, and Technology (H) Committee and adopt its charges (Attachment One). The motion passed unanimously.

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

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

### 4. Adopted the Proposed NAIC 2022 Budget

Director Cameron presented the proposed NAIC 2022 budget for approval by the membership. This is the final step of a process that began in May and included meetings with NAIC officers, the Executive (EX) Committee, members, and interested parties.

Director Cameron provided a brief overview of the budget as approved by the joint session of the Executive (EX) Committee and Internal Administration (EX1) Subcommittee held on Dec. 7, which immediately followed the 2022 Budget Public Hearing. The proposed budget includes \$126.4 million in operating revenues and operating expenses of \$136.3 million. The proposed budget also includes three fiscals, each representing an investment of at least \$100,000 supporting a major regulatory or operational project. The proposed fiscals are in alignment with the members' priorities as outlined in the NAIC's strategic plan, *State Ahead*, and continue to enhance the important regulatory support the NAIC provides to its members. There were limited price changes in the budget.

After the inclusion of a forecasted \$2.4 million in investment income, the proposed NAIC 2022 budget reflects a reduction in net assets of \$7.5 million. At the end of 2022, the NAIC's net asset balance is expected to be \$169 million. Based on projected 2021 financial results and with approval of the proposed NAIC 2022 budget, the liquid operating reserve ratio will be approximately 120% at the end of 2021 and 117% at the end of 2022. These ratios are slightly higher than normal and reflect the lower travel and meeting costs the NAIC has experienced during the past 21 months.

During the public exposure period, the NAIC received one comment letter from the National Association of Mutual Insurance Companies (NAMIC). The nature of the comment letter was not financially oriented, but it was geared toward the regulatory policies maintained by the NAIC.

Director Cameron made a motion, seconded by Director Farmer, to adopt the proposed NAIC 2022 budget (Attachment Two). The motion passed unanimously.

### 5. Adopted the Proposed NAIC 2022 Committee Charges

Director Cameron reported that the proposed NAIC 2022 committee charges reflect the proposed work of the NAIC committee system. These charges should be viewed as a living document that will evolve as issues develop throughout the year. The charges have been exposed for public comment, discussed in open forum, and adopted by each of the letter committees. Amendments to previously posted committee charges are as follows: 1) on Dec. 15, the Life Insurance and Annuities (A) Committee voted to disband its Life Insurance Illustration Issues (A) Working Group; and 2) on Dec. 15, the Property and Casualty Insurance (C) Committee made two revisions to its original charges posted on Nov. 19. The first change adds a new charge for the Statistical Data (C) Working Group. The Working Group will implement the expedited reporting and publication

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of average auto and homeowners premiums in the NAIC's annual Auto and Homeowners Reports. The second change adds a new charge for the Title Insurance (C) Task Force to review current rate regulation practices.

Director Cameron made a motion, seconded by Commissioner Mais, to adopt the proposed NAIC 2022 committee charges (Attachment Three). The motion passed unanimously.

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

Commissioner Caride reported that the Life Insurance and Annuities (A) Committee met Dec. 15. During this meeting, the Committee: 1) adopted its Summer National Meeting minutes; 2) adopted the report of the Life Actuarial (A) Task Force; and 3) adopted the report of the Accelerated Underwriting (A) Working Group, including its Dec. 6 minutes. During this meeting, the Working Group discussed comments received on the latest draft of the accelerated underwriting educational report.

The Committee received a memorandum from the Life Actuarial (A) Task Force and the Valuation Analysis (E) Working Group on the Financial Sector Assessment Program (FSAP) recommendation.

The Committee also: 1) adopted *Actuarial Guide XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies With Guaranteed Increasing Death Benefits Based on an Index* (AG 25); 2) adopted the 2022 Generally Recognized Expense Table (GRET); 3) adopted the Life Actuarial (A) Task Force's 2022 proposed charges; and 4) adopted its 2022 proposed charges, including removal of the Life Insurance Illustration Issues (A) Working Group and a charge through the adoption of the Working Group "chair report."

### 7. Adopted the 2022 Generally Recognized Expense Table (GRET)

Commissioner Caride reported that as in previous years, the Society of Actuaries (SOA) Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year. The SOA followed the same methodology in developing the 2022 GRET as for the 2021 GRET.

Commissioner Caride also noted that the 2022 GRET was adopted by the Life Insurance and Annuities (A) Committee during its Dec. 15 meeting.

Commissioner Caride made a motion, seconded by Commissioner King, to adopt the 2022 GRET (Attachment Four). The motion passed unanimously.

### 8. Adopted Revisions to the Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index (AG 25)

Commissioner Caride reported that the revisions to AG 25 include a fix that removes the fixed 4% nonforfeiture rate floor to align AG 25 with the NAIC *Valuation Manual*. The revisions apply to pre-need funeral policies and other small dollar policies, with guaranteed increasing death benefits tied to a cost-of-living index.

Commissioner Caride also noted that AG 25 was adopted by the Life Insurance and Annuities (A) Committee during its Dec. 15 meeting.

Commissioner Caride made a motion, seconded by Commissioner Mulready, to adopt the revisions to AG 25 (Attachment Five). The motion passed unanimously.

### 9. 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 Dec. 15. During this meeting, the Committee adopted its Summer National Meeting minutes.

The Committee adopted the report of the Consumer Information (B) Subgroup, which met Dec. 2, Oct. 20, Oct. 14, and Aug. 24. During these meetings, the Subgroup took the following action: 1) adopted claims process-related guides; i.e., appeals process, medical necessity, explanation of benefits (EOBs), claims filing, and billing codes and claims; 2) adopted updates to the "Frequently Asked Questions about Health Care Reform" document; and 3) adopted a consumer-facing brief, "New Protections Against Surprise Medical Bills," on balance billing.

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The Committee adopted the report of the Health Innovations (B) Working Group, which met Dec. 11 and Nov. 7. During these meetings, the Working Group took the following action: 1) heard presentations related to its charges from the Special (EX) Committee on Race and Insurance on issues related to telehealth, alternative payment models, and their impacts on health disparities; 2) heard a presentation on using state rate review authority to limit premium growth; 3) heard a presentation on state policy considerations with enhanced premium tax credits; and 4) 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 its task forces: 1) the Health Actuarial (B) Task Force; 2) the Regulatory Framework (B) Task Force; and 3) the Senior Issues (B) Task Force.

The Committee adopted its 2022 proposed charges and its task forces' 2022 proposed charges.

The Committee heard an update from Jeff Wu (Center for Consumer Information & Insurance Oversight—CCIO) on the Biden administration's federal legislative and administrative initiatives and priorities. The update 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 discussed its work on developing guidance documents for state insurance departments to use as part of their outreach efforts to providers and consumers on the NSA.

The Committee heard a presentation on the Kaiser Family Foundation's (KFF's) summary findings from its 2021 Employer Health Benefits Survey.

The Committee heard an update on the work of the Special (EX) Committee on Race and Insurance Workstream Five. The Workstream met Dec. 3, Nov. 18, Oct. 14, Sept. 9, and Aug. 26. During these meetings, the Workstream discussed and considered revisions to its "Principles for Data Collection" document. The Workstream also discussed and released a draft outline for its proposed white paper on provider networks, provider directories, and cultural competency for a public comment period ending Nov. 8. The Workstream plans to meet Dec. 20 to consider final revisions to the "Principles for Data Collection" document, and if finalized, it will forward the document to the Special Committee for its consideration.

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

Commissioner Schmidt reported that the Property and Casualty Insurance (C) Committee met Dec. 15. During this meeting, the Committee: 1) adopted its Nov. 10 minutes, which included the following action: a) adopted its Summer National Meeting minutes; and 2) adopted the Pet Insurance Model Act.

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 its 2022 proposed charges with the following revisions: 1) an additional charge for the Title Insurance (C) Task Force to "[r]eview current rate regulation practices"; and 2) an additional charge for the Statistical Data (C) Working Group to "[i]mplement the expedited reporting and publication of average auto and average homeowners premium portions of the annual *Auto Insurance Database and Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance*."

The Committee also: 1) heard a presentation related to auto insurance premium refunds resulting from reduced driving during the pandemic; and 2) heard a federal update related to flood insurance, federal spending bills, auto insurance, and cannabis legislation.

Commissioner Altmaier noted that due to the need for additional discussion, the Plenary would not be considering the Pet Insurance Model Act for adoption at this meeting.

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

Commissioner Richardson reported that the Market Regulation and Consumer Affairs (D) Committee met Dec. 15. During this meeting, the Committee: 1) adopted its Summer National meeting minutes; 2) adopted its 2022 proposed charges, which did not include any substantial changes from the 2021 charges. Its charges noted that further direction from the Executive (EX) Committee may result in the Privacy Protections (D) Working Group being moved to the new Innovation, Cybersecurity, and Technology (H) Committee; 3) adopted new title in-force and title claims standardized data requests (SDRs) to be included in the reference documents of the *Market Regulation Handbook* (Handbook). A state may use these two SDRs to determine if a company follows appropriate procedures with respect to the issuance and underwriting of title policies and the handling of claims; 4) adopted revisions to Chapter 24—Conducting the Health Exam of the Handbook to provide additional guidance that market conduct examiners should review complaints regarding quality of care; and 5) adopted revisions to Chapter 25—Conducting the Medicare Supplement Exam of the Handbook to provide more specific cross-references to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

The Committee received the Privacy Protections (D) Working Group’s “Exposure Draft on Consumer Data Privacy Protections,” dated Dec. 7, which includes the following: 1) a summary of consumer privacy protections provided by the *Health Information Privacy Model Act* (#55), the *NAIC Insurance Information and Privacy Protection Model Act* (#670), and the *Privacy of Consumer Financial and Health Information Regulation* (#672); 2) a summary of the General Data Protection Regulation (GDPR) and recently adopted state consumer privacy protection laws; 3) a summary of the Working Group’s discussion on data transparency, consumer control of data, consumer access to data, data accuracy, and data ownership and portability; and 4) a recommendation that Model #670 and Model #672 be revised to modernize their applicability to the current technology-based insurance market.

The Committee received an update regarding the Market Conduct Examination Guidelines (D) Working Group’s coordination with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group to update the mental health parity-related chapter of the Handbook to ensure it reflects the current mental health parity compliance requirements set forth in federal guidance enacted in December 2020.

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.

### 12. Adopted the Travel Insurance Market Conduct Annual Statement (MCAS) Blank

Commissioner Richardson noted that on July 27, the Market Regulation and Consumer Affairs (D) Committee, adopted the Travel Insurance Market Conduct Annual Statement (MCAS) blank.

The Travel Insurance blank collects underwriting, claims, and lawsuit information on the Travel Insurance coverages of: trip cancellation; trip interruption; trip delay; baggage loss or delay; emergency medical and dental; and emergency transportation and repatriation.

Each of these coverages is broken out by domestic and international travel. For consistency purposes and, where possible, the definitions used in this MCAS blank were drawn from the *Travel Insurance Model Act* (#632).

Because travel insurance is represented by a small number of companies and the policies are generally small in amount, there is no premium threshold for reporting. All companies that are licensed for any travel insurance product within any of the participating MCAS jurisdictions are required to report.

Companies will report their travel insurance data beginning in 2023 for travel insurance activity during the 2022 data year.

Commissioner Richardson made a motion, seconded by Commissioner McClain, to adopt the Travel Insurance MCAS blank (Attachment Six). The motion passed with New York abstaining.

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### 13. Adopted the Short-Term, Limited-Duration (STLD) MCAS Blank

Commissioner Richardson reported that on July 27, the Market Regulation and Consumer Affairs (D) Committee adopted the Short-Term Limited-Duration (STLD) MCAS blank. This is the product of a large group of state insurance regulators, industry, and consumer representatives who put in many hours of work.

This new blank collects data on policy administration; prior authorizations; claims administration; consumer complaints and lawsuits; and marketing and sales. The data will be reported in three categories according to whether the product is sold through an association and, if sold through an association, whether the association is situated in the jurisdiction where the product is sold. Additionally, data will be collected for products with a term of less than or equal to 90 days, less than or equal to 180 days, and 181–364 days.

The STLD MCAS has a reporting threshold of \$50,000 in premium within the jurisdiction, and the product is reported according to the residency of the individual insured. Companies will report their data to participating MCAS states beginning in 2023 and will cover their STLD insurance activity for the 2022 data year.

Commissioner Richardson made a motion, seconded by Director Lindley-Myers, to adopt the STLD MCAS blank (Attachment Seven). The motion passed with New York abstaining.

### 14. Adopted the Regulatory Information Retrieval System (RIRS) Coding Structure Changes

Commissioner Richardson noted that during the Summer National Meeting, the Market Information Systems (D) Task Force and the Market Regulation and Consumer Affairs (D) Committee adopted Regulatory Information Retrieval System (RIRS) Coding Structure Changes. These coding changes address deficiencies of the current coding structure, are designed to render greater coherency to the data structure, and make the RIRS more compatible with other market information systems (MIS).

The RIRS Coding Structure Changes include: 1) a new field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment; 2) a new field to link related RIRS records; 3) a new Line of Business field; and 4) revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to create a more logical data structure.

The coding changes were reviewed by representatives of the Financial Analysis Solvency Tools (E) Working Group and the state producer licensing directors. Their feedback was incorporated into the proposal. The proposal was also reviewed with the state “back-office” system vendors. The vendors do not anticipate any additional cost to states to implement the necessary system changes.

Commissioner Richardson made a motion, seconded by Director Cameron, to adopt the RIRS Coding Structure Changes (Attachment Eight). The motion passed unanimously.

### 15. Received the Report of the Financial Condition (E) Committee

Commissioner White reported that the Financial Condition (E) Committee met Dec. 13. During this meeting, the Committee adopted its Nov. 19 and Summer National Meeting minutes, which included the following action: 1) adopted a response to a referral received from the Financial Regulation and Accreditation Standards (F) Committee regarding captive insurers; 2) received a response from the chair of the Valuation Analysis (E) Working Group related to principle-based reserving (PBR) and a recommendation from the International Monetary Fund (IMF) related to its FSAP; 3) received a request from the chair of the Capital Adequacy (E) Task Force about a proposed new working group related to investment risks; and 4) adopted its 2022 proposed charges.

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 Receivership 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 Mutual Recognition of Jurisdictions (E) Working Group; the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; the National Treatment and Coordination (E) Working Group; the Restructuring Mechanisms (E) Working Group; and the Risk-Focused Surveillance (E) Working Group.

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The Committee also: 1) adopted the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation*; and 2) adopted the *ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers*.

The Committee received and discussed a request from a consumer representative to take on a project to examine and identify investment practices of insurers that may disproportionately affect communities of color.

The Committee discussed a proposed project to consider a revised approach to the risk-based capital (RBC) requirements for structured securities and other asset-backed securities (ABS).

### 16. Adopted the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation*

Commissioner White noted that in late 2020, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implemented Group Capital Calculation (GCC) filing requirements but also set forth the requirements for a group-wide capital assessment in accordance with the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (Covered Agreement).

The GCC allows exemptions for certain insurance groups based on non-U.S. jurisdictions that do not require a GCC for U.S. groups in their countries or otherwise recognize the GCC in their country.

The Mutual Recognition of Jurisdictions (E) Working Group was charged by the Financial Condition (E) Committee with creating a process to determine whether other jurisdictions “recognize and accept” the NAIC GCC.

Commissioner White made a motion, seconded by Director Fox, to adopt the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* (Attachment Nine). The motion passed unanimously.

### 17. Adopted the *ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers*

Commissioner White reported that the *ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* was created to aid in the implementation of the 2019 revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786). Under this process, the Reinsurance Financial Analysis (E) Working Group will assist the states in reviewing reinsurers to determine whether they have met the requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

The final document was initially exposed for public comment on June 17 and on Sept. 17. The comments received were discussed by the Reinsurance (E) Task Force at the Summer National Meeting and the Reinsurance Financial Analysis (E) Working Group on a regulator-only call on Aug. 25.

Additionally, NAIC staff communicated with staff from the Federal Insurance Office (FIO) during the drafting process. We incorporated certain non-substantive revisions suggested by the FIO into the final draft, which was exposed on Nov. 11 for 21 days, and no comments were received.

Commissioner White made a motion, seconded by Director Lindley-Myers, to adopt the *ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* (Attachment Ten). The motion passed unanimously.

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

Superintendent Dwyer reported that the Financial Regulation Standards and Accreditation (F) Committee met Dec. 12 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 Hawaii, Kansas, and South Carolina.

The Financial Regulation Standards and Accreditation (F) Committee did not meet in open session at the Fall National meeting.

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### 19. Exposes the 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards

Superintendent Dwyer reported that at the Summer National Meeting, the Financial Regulation Standards and Accreditation (F) Committee voted to recommend exposure of a referral to include the 2020 revisions to Model #440 and Model #450 as an update to the accreditation standards for all states effective Jan. 1, 2026. The revisions implement a GCC for the purpose of group solvency supervision and a liquidity stress test (LST) for macroprudential surveillance. After Committee approval at the Summer National Meeting, the next step in the process, consistent with the standard process outlined in the accreditation manual, is for the Executive (EX) Committee and Plenary to consider approval of the exposure during the subsequent Fall National Meeting.

The exposure includes a recommendation by the Committee for a revised approach to the GCC significant elements, which allows a commissioner to grant exemptions to qualifying groups meeting the standards set forth in Model #450, Sections 21A and 21B, without the requirement to file at least once. This revision was in response to comment letters received during an initial exposure period in the spring.

Consistent with the accreditation procedures for adoption of new Part A standards, the Committee recommends a one-year public exposure period beginning Jan. 1, 2022, and a proposed effective date of Jan. 1, 2026.

Superintendent Dwyer encourages all states with a group affected by the Covered Agreement to adopt the GCC revisions to Model #440 and Model #450 for those groups effective Nov. 7, 2022. The Committee also encourages states with a group affected by the LST to adopt the relevant revisions to Model #440 as soon as possible.

Superintendent Dwyer made a motion, seconded by Commissioner McClain, to expose the 2020 revisions to Model #440 and Model #450 as an update to the Accreditation Standards (Attachment Eleven). The motion passed with Texas dissenting.

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

Commissioner Anderson reported that the International Insurance Relations (G) Committee met Dec. 15. During this meeting, the Committee: 1) adopted its Summer National Meeting minutes; 2) adopted its 2022 proposed charges; and 3) discussed international efforts on insurer culture.

The Committee heard an update on recent activities and priorities of the IAIS, including: 1) implementation assessment activities related to the holistic framework for systemic risk; 2) the comparability assessment process for the aggregation method (AM); 3) publication of the Global Monitoring Exercise (GME); and 4) publication of three supporting material documents: a) an *Issues Paper on Insurer Culture*; b) a *Revised Application Paper on Supervisory Colleges*; and c) a *Revised Application Paper on Combating Money Laundering and Terrorist Financing*.

The Committee heard an update on international activities, including: 1) recent virtual meetings and events with international regulators; 2) plans for the 2022 NAIC International Fellows Programs; 3) recent meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; 4) recent meetings of the Sustainable Insurance Forum (SIF); and 5) a recently held virtual webinar of the European Union (EU)-U.S. Dialogue Project.

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

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

### 22. Heard the Results of the 2022 NAIC Zone Officer Election

The Executive (EX) Committee and Plenary received the results of the 2022 zone officer elections. Midwest Zone: Commissioner Glen Mulready, Chair (OK); Commissioner Doug Ommen, Vice Chair (IA); and Director Anita G. Fox, Secretary (MI). Northeast Zone: Commissioner Gary D. Anderson, Chair (MA); Commissioner Kathleen A. Birrane, Vice Chair (MD); and Commissioner Trinidad Navarro, Secretary (DE). Southeast Zone: Commissioner Scott A. White, Chair (VA); Commissioner Carter Lawrence, Vice Chair (TN); and Commissioner James J. Donelon, Secretary (LA). Western Zone: Director Lori K. Wing-Heier, Chair (AK); Commissioner Michael Conway, Vice Chair (CO); and Commissioner Andrew R. Stolfi, Secretary (OR).

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### 23. Elected the 2022 NAIC Officers

The Plenary adjourned into Executive Session to conduct NAIC officer elections for 2022. The membership elected the 2022 NAIC officers: Director Dean L. Cameron, President (ID); Director Chlora Lindley-Myers, President-Elect (MO); Commissioner Andrew N. Mais, Vice President (CT); and Commissioner Jon Godfread, Secretary-Treasurer (ND).

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

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**Innovation, Cybersecurity and Technology (H) Committee Draft Charges**  
*Post-Public Comments Meeting*  
*December 1, 2021*

**2022 Proposed Charges**

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

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

**Ongoing Support of NAIC Programs, Products or Services**

1. The **Innovation, Cybersecurity, and Technology (H) Committee** will:
  - A. Provide forums, resources, and materials for the discussion of insurance sector developments in cybersecurity and data privacy to educate state insurance regulators on how these developments affect consumer protection, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
  - B. Discuss emerging issues related to cybersecurity, including cybersecurity event reporting, and consumer data privacy protections. Monitor and advise on the cybersecurity insurance market, including rating, underwriting, claims, product development, and loss control. Report on the cyber insurance market, including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.
  - C. Coordinate with various subject matter expert (SME) groups on insurer and producer internal cybersecurity. Discuss emerging developments; best practices for risk management, internal control, and governance; and how state insurance regulators can best address industry cyber risks and challenges. Work with the Center for Insurance Policy and Research (CIPR) to analyze cybersecurity related information from various data sources.
  - D. Provide forums, resources, and materials for the discussion of innovation and technology developments in the insurance sector, including the collection and use of data by insurers, producers, and state insurance regulators; as well as new products, services, and distribution platforms. Educate state insurance regulators on how these developments affect consumer protection, data privacy, insurer and producer oversight, marketplace dynamics, and the state-based insurance regulatory framework.
  - E. Discuss emerging technologies and innovations related to insurance; and insurers, producers, state insurance regulators, licensees, or vendors; and the potential implications of these technologies for the state-based insurance regulatory structure—including reviewing new products and technologies affecting the insurance sector, and associated regulatory implications.
  - F. Consider and coordinate the development of regulatory guidance and examination standards related to innovation, cybersecurity, data privacy, the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance, and technology, including drafting and revising model laws, white papers, and other recommendations as appropriate.

Consider best practices related to cybersecurity event tracking and coordination among state insurance regulators, and produce guidance related to regulatory response to cybersecurity events to promote consistent response efforts across state insurance departments.

- G. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity including the *Insurance Data Security Model Law (#668)*, the *NAIC Insurance Information and Privacy and Privacy Protection Model Act (#670)*, the *Privacy of Consumer Financial and Health Information Regulation (#672)*, and the *Unfair Trade Practices Act (#880)* rebating language and providing assistance to state insurance regulators as needed.
  - H. Coordinate with other NAIC committees and task forces, as appropriate, and evaluate and recommend certifications, continuing education, and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.
  - I. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.
2. The **Big Data and Artificial Intelligence (H) Working Group** will:
- A. Research the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommendations to the Innovation, Cybersecurity, and Technology (H) Committee including potential recommendations for development of model governance for the use of big data and AI including ML for the insurance industry.
  - B. Review current audit and certification programs and/or frameworks that could be used to oversee insurers' use of consumer and non-insurance data, and models using intelligent algorithms, including AI. If appropriate, issue recommendations and coordinate with the appropriate subject matter expert (SME) committees on the development of or modifications to model laws, regulations, handbooks, and regulatory guidance, regarding data analysis, marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
  - C. Assess data and regulatory tools needed for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data, algorithms, and machine learning, including AI/ML in underwriting, rating, claims and marketing practices. This assessment shall include a review of currently available data and tools, as well as recommendations for development of additional data and tools, as appropriate. Based on this assessment, propose a means to include these tools in existing and/or new regulatory oversight and monitoring processes to promote consistent oversight and monitoring efforts across state insurance departments.
3. The **Speed to Market (H) Working Group** will:
- A. Consider proposed System for Electronic Rates and Forms Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board (SAB), likely originating from the SERFF Product Steering Committee (PSC). Upon approval and acquisition of any needed funding, direct the SAB to implement the project. Receive periodic reports from the SAB, as needed.
  - B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
  - C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:

1. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.
  2. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.
  3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.
  4. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.
  - D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.
  - E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
    1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states' participation in, and the industry's usage of, the Compact.
    2. Receive periodic reports from the Compact, as needed.
4. **The E-Commerce (H) Working Group** will:
- A. Examine e-commerce laws and regulations; survey states regarding federal Uniform Electronic Transactions Act (UETA) exceptions; and work toward meaningful, unified recommendations. The Working Group will also examine whether a model bulletin would be appropriate for addressing some of the identified issues and draft a proposed bulletin if determined appropriate.
5. **The Cybersecurity (H) Working Group** will:
- A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices and breaches with the potential to affect the insurance industry.
  - B. Interact with and support state insurance departments responding to insurance industry cybersecurity events.
  - C. Promote communication across state insurance departments regarding cybersecurity risks and events.
  - D. Oversee the development of a regulatory cybersecurity response guidance document to assist state insurance regulators in the investigation of insurance cyber events.
  - E. Coordinate NAIC committee cybersecurity work including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology Examination (E) Working Group.
  - F. Advise on the development of cybersecurity training for state insurance regulators.

- G. Work with the Center for Insurance Policy and Research (CIPR) to analyze publicly available cybersecurity related information.
- H. Support the states with implementation efforts related to the adoption of *Insurance Data Security Model Law* (#668).
- I. Engage with federal and international supervisors and agencies on efforts to manage and evaluate cybersecurity risk.

*Adopted by the Executive (EX) Committee and Plenary, Dec. 16, 2021*

Bylaw Amendment to Establish the Innovation, Cybersecurity, and Technology (H) Committee

Article VI, Section 2 (h):

(h) Innovation, Cybersecurity and Technology (H) Committee. This Standing Committee shall consider issues related to cybersecurity, innovation, data security and privacy, and emerging technology issues.

## Executive Summary NAIC 2022 Budget



NATIONAL ASSOCIATION OF  
INSURANCE COMMISSIONERS

### About the NAIC

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

Through the NAIC, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight activities. NAIC staff supports these efforts and represents the collective domestic and international views of state insurance regulators.

NAIC members, together with the central resources of the association, form the national system of state-based insurance regulation in the U.S. NAIC members are elected or appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents/brokers in their respective jurisdictions.

The NAIC's annual budget supports the many valuable services and benefits provided to state insurance regulators, insurance consumers, and the insurance industry. Each year, the budget is developed with the goal of enabling the membership to accomplish its key strategic priorities.

As the year 2021 dawned, so too did the realization that the many challenges faced in 2020 remained, as well as their impact to the insurance industry. The NAIC remained focused on providing the necessary leadership, resources, and direction to assist its membership in addressing the largest health crisis of our time, in addition to natural disasters and economic uncertainty.

Over the past four years, the NAIC has utilized its strategic plan, *State Ahead*, as a compass. The plan articulated a comprehensive vision for the future of state insurance regulation and outlined how the NAIC could help the membership stay ahead of the curve in a rapidly evolving marketplace. Many of the initiatives identified in the plan have been implemented or are nearing completion, such as the migration of systems to the Cloud, improved analytical capabilities via regulatory dashboards, and the establishment of an enterprise data asset management program. The goal in 2022 is to evaluate and expand the plan as *State Ahead 2.0*, which will serve as a roadmap for initiatives planned in 2023 and beyond.

To accomplish this goal, the 2022 budget incorporates funding to complete current *State Ahead* initiatives and establish *State Ahead 2.0*. It recognizes the need for key internal resources to be added to ensure adequate staffing levels for important regulatory and operational needs. The budget also demonstrates a firm commitment to technology advancements and the modernization of insurance regulation in areas such as innovation, cybersecurity, and international standard-setting.

The budget continues the NAIC's commitment to support the variety of programs, products, and services in the financial solvency and market regulatory arenas. The NAIC offers a wide range of publications, data, and information systems; accreditation reviews; and many other services to assist state insurance regulators in achieving their fundamental insurance regulatory goals in a timely and cost-effective manner.

## Support of the Membership

The mission of the NAIC is to assist the state insurance regulators in serving the public interest and achieving its goals of protecting the public interest; promoting a competitive marketplace; facilitating the fair and equitable treatment of insurance customers; ensuring the reliability, solvency, and financial stability of insurers; and supporting and improving state insurance regulation. Leveraging NAIC technology solutions, regulatory tools, and staff resources allow member states to achieve these goals at a significant cost savings. Without these options, many systems would be cost-prohibitive for the states to implement on their own. Without membership in the NAIC, the amount of state funding required to provide or access similar types of services and data the NAIC provides — often at no extra charge — would far exceed what a state pays in member dues to the NAIC.

## A Focus on Consumers

The NAIC provides a multi-channel approach to reach and assist consumers in making informed decisions on insurance matters. These multi-pronged marketing communications campaigns include consumer education pieces, mobile apps, and targeted social campaigns. In 2022, the NAIC will expand its efforts to provide departments of insurance with greater access to these tools.

## Valuable Products and Services

The NAIC seeks to support its mission through a wide variety of products and services offered to both the insurance industry and state regulators. NAIC web-based systems automate, standardize, and streamline regulatory processes by transmitting data and facilitating regulatory transactions between insurers, consumers, and state insurance regulators.

The NAIC is committed to maintaining and enhancing these systems to provide high-quality service to all stakeholders. The 2022 budget includes two technology-based fiscals, one of which allows additional states to take advantage of a proven back-office platform and the other to lay the foundation for a successful modernization of a critical data collection platform.

## Building the Budget

The NAIC strives for transparency in its budget process as well as in its operations. The budget process gets underway in May each year, when department managers evaluate current-year revenues and expenses to assess the year-end picture, then propose a budget for the following year based on their operational objectives and member initiatives. Managers carefully focus on variances between the current year's budget and projected results and anticipated business needs for the coming year. This process includes a review of all projects, products, programs, services, committee charges, and

### By the Numbers

NAIC products and services make life easier.

- ▶ **System for Electronic Rates & Forms Filing (SERFF)** – 578,185 transactions processed in 2020
- ▶ **Online Premium Tax for Insurance (OPTins)** – 151,623 transactions processed in 2020
- ▶ **State Based Systems (SBS)** – back-office services licensed to 33 jurisdictions in 2020
- ▶ **Professional Designation Program** – 1,528 designations awarded since the program's inception in October 2006 through year-end 2020
- ▶ **Center for Insurance Policy and Research (CIPR) Key Research Issues** – 185 briefs currently available online including NAIC key initiatives and topics ranging from cybersecurity and innovation to natural catastrophe risk and resiliency

technology initiatives in light of the NAIC’s mission and the membership’s strategic priorities, particularly those outlined in *State Ahead*. NAIC senior management reviews each department budget in detail with its division director to adjust according to the strategic and financial needs of the association and ultimately consolidates all requests into a single, comprehensive budget.

Following the extensive development and internal review process, the budget is presented to the NAIC Officers, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee, and the full NAIC membership before being released for public review and comment. To ensure transparency, a public hearing is held to receive public comments before final consideration and adoption by the NAIC Executive (EX) Committee and Plenary.

**State Ahead Continues to Guide**

*State Ahead* enabled the NAIC to build on existing strengths as a nexus for innovation and provide a hub of resources for insurance departments to draw upon.

**Progress on Initiatives by Year**

- 2018 – 18 completed
- 2019 – 25 completed
- 2020 – 17 completed
- 2021 – 2 completed with 31 in progress and on schedule for completion in 2021/2022
- 2022 – 2 planned to begin

### Expected Results for 2021

Based on actual operating results (before adding investment income) through June 30, 2021, the NAIC projects a net negative operating margin of \$2.5 million compared to a budgeted net negative operating margin of \$13.2 million, an improvement of nearly \$10.8 million. Investment income is projected to be \$11.9 million, resulting in a net asset increase of nearly \$9.4 million.

As a result of the continuation of the COVID-19 pandemic, 2021 saw a virtual only or hybrid approach to several meetings, including the Summer National Meeting and the Insurance Summit, causing travel, meetings, and Grant/Zone spending to be significantly lower than budget.

Additional information regarding 2021 projected variances is included throughout the detailed footnotes of the budget.

### 2022 Budget

The 2022 budget demonstrates NAIC’s continued strong focus on prudent financial management, which is critically important in these unprecedented times. The 2022 budget also assumes the majority of meetings will be offered in a hybrid format.

The 2022 NAIC operating budget (before adding investment income) reflects revenues of \$126.4 million and expenses of \$136.3 million, which represent a 7.8% and a 4.4% increase, respectively, from the 2021 budget, resulting in nearly \$10.0 million in projected expenses over revenues. Viewed in relation to the 2021 projected totals, which continue to be significantly impacted by the pandemic, the 2022 budget represents an operating revenue increase of 3.4% and operating expense increase of 9.3%. Additional information about the 2022 budget is included throughout the detailed footnotes of the budget.

**State Ahead 2.0 is on the horizon**

**The next phase of *State Ahead* will support key regulatory priorities in upcoming years.**

- Financial Solvency, including macroprudential surveillance and principle-based reserving
- Long-term care insurance
- Consumer data privacy protections
- Climate/natural catastrophes risk and resiliency
- Big data and artificial intelligence
- Race and Insurance

A fiscal impact statement (fiscal) is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of \$100,000 or more either in the current budget or within the following few years' budgets or requires more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact of the initiative; and an assessment of the risks. The total financial impact of the three fiscals included in the 2022 budget is \$2.8 million in expenses with \$312,627 in revenues. Additional information about each initiative is included in the various fiscal sections of the budget.

The 2022 budget includes \$2.4 million in investment income from the NAIC's Long-Term Investment Portfolio. Investment income is composed of interest and dividends earned reduced by investment management fees – investment gains and losses are not projected nor included in the budget.

Combining budgeted results from operations with budgeted investment income, the 2022 budget has a reduction in net assets of \$7.5 million.

### Preparing for the Unknown

The budget includes all known activities anticipated to occur in 2022. However, as 2021 has proven to be a year that deviated from the expected, situations will likely arise during 2022 that require additional funding. In such an event, a funding request is prepared and presented to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee for consideration. Funding for any approved project comes from the Regulatory Modernization and Initiatives Fund, established in 2005 to manage requests that arise following the adoption and implementation of an annual budget. The Fund is based on 1.5% of the NAIC's projected consolidated net assets as of December 31, 2022, or \$2.5 million with the inclusion of fiscals.

### Ensuring Financial Stability

The NAIC's operating reserve is designed to ensure the financial stability of the NAIC in the event of emerging business risks and uncertainties and to absorb new priority initiatives pursued by NAIC membership. The association's reserve status is of paramount consideration in the budgeting process, as is strong and prudent financial management of the NAIC's assets.

### 2022 Fiscal Impact Statements

- ▶ **Financial Data Repository (FDR) Modernization Pre-Work** – FDR is a centralized warehouse storing 10 years of annual and quarterly financial statements filed by 4,500+ insurers. Today, the FDR system is over 20 years old, and the technologies used at that time no longer align with current NAIC development tools, making it difficult and time consuming to support. This fiscal requests professional services to assist staff in laying the groundwork for the full modernization effort. In 2022, changes will be made to migrate reporting to Tableau, leverage other applications' functionality where feasible, document current processes, and analyze requirements for the new system.
  - 2022 expense of \$384K for professional services
- ▶ **SBS State Implementations 2022** – The NAIC has transitioned 31 licensed states to the new updated SBS platform, known as SOLAR, and interest in utilizing SBS remains strong among many of the remaining states. With several new and pending licenses added to existing commitments, the SBS team's implementation workload would be five states in 2022. Meeting this demand would require staff hours that surpass the current staffing capacity, requiring professional services to assist staff. Continuing Education revenue earned from the implementations of these states will offset a portion of the expense.
  - 2022 revenue of \$313K, with professional services expense of \$1.7M
- ▶ **2022 NAIC Staffing Requests** – Urgent priority business needs and current capacity of NAIC staff require six new positions be added in the areas of market regulation analysis, macroprudential surveillance, product ownership, and cybersecurity.
  - 2022 salary/benefits expense of \$715K

<b>Operating Reserve</b>	
2020 Audited	119.1%
2021 Projected	120.2%
2022 Proposed	117.3%

In July 2015, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved a report from an independent financial advisory firm which established the NAIC's liquid operating reserve target range of 83.4% to 108.2%. This range was the result of a comprehensive review of current and future identified risks and an evaluation of comparable organizations. This report recognized the increased level of uncertainty facing the NAIC and anticipated future investments which would be required to enhance the association's information

technology and technical infrastructure, represented by many elements of the 2022 budget. A review of the NAIC's risk profile is currently in progress and is expected to be finalized in early 2022.

### **Contact Information**

The NAIC appreciates the opportunity to present this 2022 budget and believes it provides a comprehensive review of the NAIC's business and financial operations for the current and upcoming fiscal year. A summary of the 2022 budget's key components is included in the budget overview.

Please feel free to contact Jim Woody, Chief Financial Officer, at [jwoody@naic.org](mailto:jwoody@naic.org), or Carol Thompson, Senior Controller, at [cthompson@naic.org](mailto:cthompson@naic.org), should you have any questions or need additional information.

**NAIC** NATIONAL ASSOCIATION OF  
INSURANCE COMMISSIONERS  
**2022 BUDGET WITH FISCAL IMPACT STATEMENTS**  
**REVENUE AND EXPENSE BY LINE**

Description	Reference	2021					2022				
		2020 Actual	6/30/2021 Actual	12/31/2021 Projected	2021 Budget	2021 Projected Variance	2022 Budget	Increase (Decrease) from 2021 Budget	%	Increase (Decrease) from 2021 Projected	%
Member Assessments	R1	\$2,110,951	\$1,056,497	\$2,114,813	\$2,114,816	(\$3)	<b>\$2,119,592</b>	\$4,776	0.2%	\$4,779	0.2%
Database Fees	R2	31,938,729	32,919,745	32,919,745	32,416,728	503,017	<b>33,451,037</b>	1,034,309	3.2%	531,292	1.6%
Publications and Insurance Data Products	R3	17,207,317	11,202,809	17,109,749	17,048,190	61,559	<b>17,491,032</b>	442,842	2.6%	381,284	2.2%
Valuation Services	R4	30,706,807	9,473,302	28,921,400	28,743,095	178,305	<b>29,167,475</b>	424,380	1.5%	246,075	0.9%
Transaction Filing Fees	R5	13,202,789	8,178,615	14,748,424	14,335,946	412,478	<b>15,725,225</b>	1,389,279	9.7%	976,801	6.6%
National and Major Meetings	R6	784,139	332,505	1,732,455	2,805,910	(1,073,455)	<b>2,681,132</b>	(124,778)	-4.4%	948,677	54.8%
Education and Training	R7	327,132	150,785	364,146	365,663	(1,517)	<b>410,940</b>	45,277	12.4%	46,794	12.9%
Administrative Services and License Fees	R8	20,724,524	12,195,205	24,348,777	19,320,684	5,028,093	<b>25,298,173</b>	5,977,489	30.9%	949,396	3.9%
Other	R9	131,990	(52,280)	(40,280)	97,900	(138,180)	<b>58,360</b>	(39,540)	-40.4%	98,640	-244.9%
<b>Total Operating Revenues</b>		<b>117,134,378</b>	<b>75,457,183</b>	<b>122,219,229</b>	<b>117,248,932</b>	<b>4,970,297</b>	<b>126,402,966</b>	<b>9,154,034</b>	<b>7.8%</b>	<b>4,183,738</b>	<b>3.4%</b>
Salaries	E1	56,718,567	28,754,962	58,404,049	58,329,280	74,769	<b>61,605,459</b>	3,276,179	5.6%	3,201,410	5.5%
Temporary Personnel	E2	684,900	340,570	697,027	919,738	(222,711)	<b>1,004,460</b>	84,722	9.2%	307,433	44.1%
Payroll Taxes	E3	3,873,262	2,330,640	4,120,328	4,064,077	56,251	<b>4,441,272</b>	377,195	9.3%	320,944	7.8%
Employee Benefits	E4	11,306,966	6,694,240	12,680,835	12,809,855	(129,020)	<b>12,576,793</b>	(233,062)	-1.8%	(104,042)	-0.8%
Employee Development	E5	580,404	229,560	664,648	916,414	(251,766)	<b>1,041,530</b>	125,116	13.7%	376,882	56.7%
Professional Services	E6	16,826,066	4,712,759	17,071,890	18,051,538	(979,648)	<b>17,414,489</b>	(637,049)	-3.5%	342,599	2.0%
Computer Services	E7	4,844,689	2,691,867	5,792,816	5,332,992	459,824	<b>6,233,024</b>	900,032	16.9%	440,208	7.6%
Travel	E8	614,614	57,088	2,306,453	4,954,661	(2,648,208)	<b>4,881,551</b>	(73,110)	-1.5%	2,575,098	111.6%
Occupancy and Rental	E9	4,461,064	2,109,554	4,625,182	4,677,735	(52,554)	<b>4,722,460</b>	44,725	1.0%	97,278	2.1%
Computer Hardware and Software Maintenance	E10	5,167,370	3,362,452	6,926,950	6,509,233	417,717	<b>7,303,735</b>	794,502	12.2%	376,785	5.4%
Depreciation and Amortization	E11	4,012,527	2,000,037	4,098,263	4,245,378	(147,115)	<b>4,042,863</b>	(202,515)	-4.8%	(55,400)	-1.4%
Operational	E12	1,382,038	390,140	1,294,736	1,658,762	(364,026)	<b>1,796,506</b>	137,744	8.3%	501,770	38.8%
Library Reference Materials	E13	306,260	175,855	301,843	336,213	(34,370)	<b>370,242</b>	34,029	10.1%	68,399	22.7%
National and Major Meetings	E14	728,761	263,714	2,953,126	3,840,723	(887,597)	<b>4,898,774</b>	1,058,051	27.5%	1,945,648	65.9%
Education and Training	E15	20,289	23,847	33,663	272,638	(238,975)	<b>265,063</b>	(7,575)	-2.8%	231,400	687.4%
Grant and Zone	E16	167,799	97,028	1,742,037	2,409,072	(667,035)	<b>2,405,956</b>	(3,116)	-0.1%	663,919	38.1%
Other	E17	1,107,722	856,316	987,125	1,152,660	(165,535)	<b>1,265,531</b>	112,871	9.8%	278,406	28.2%
<b>Total Operating Expenses</b>		<b>112,803,298</b>	<b>55,090,629</b>	<b>124,700,971</b>	<b>130,480,969</b>	<b>(5,779,998)</b>	<b>136,269,708</b>	<b>5,788,739</b>	<b>4.4%</b>	<b>11,568,737</b>	<b>9.3%</b>
Revenues Over/(Under) Expenses before Investment Income		4,331,080	20,366,554	(2,481,742)	(13,232,037)	10,750,295	<b>(9,866,742)</b>	3,365,295		(7,385,000)	
Investment Income	II1	12,611,828	8,682,075	11,866,474	1,759,818	10,106,656	<b>2,400,115</b>	640,297		(9,466,359)	
Revenues Over/(Under) Expenses		<b>\$16,942,908</b>	<b>\$29,048,629</b>	<b>\$9,384,732</b>	<b>(\$11,472,219)</b>	<b>\$20,856,951</b>	<b>(\$7,466,627)</b>	<b>\$4,005,592</b>		<b>(\$16,851,359)</b>	

A detailed analysis of each line item is included in the Revenue Detail, Expense Detail, and Investment Income Detail sections.

**NAIC** NATIONAL ASSOCIATION OF  
 INSURANCE COMMISSIONERS  
**2022 BUDGET**  
**FISCAL IMPACT STATEMENTS**

		2022 Budget			
<u>Fiscal Impact Number</u>	<u>Description</u>	<u>Capital Expenditures</u>	<u>Revenues</u>	<u>Expenses</u>	<b>Net Impact 2022 Budget</b>
	Total Revenues Over/(Under) Expenses Before Fiscals and Investment Income	\$469,961	\$126,090,339	\$133,474,340	<b>(\$7,384,001)</b>
1	Financial Data Repository (FDR) Modernization Pre-Work			384,000	<b>(384,000)</b>
2	SBS State Implementations 2022		312,627	1,696,750	<b>(1,384,123)</b>
3	2022 NAIC Staffing Request			714,618	<b>(714,618)</b>
	Total Fiscal Revenues Over/(Under) Expenses		312,627	2,795,368	<b>(2,482,741)</b>
	Investment Income		2,400,115		<b>2,400,115</b>
	Total Revenues Over/(Under) Expenses	<u>\$469,961</u>	<u>\$128,803,081</u>	<u>\$136,269,708</u>	<b>(\$7,466,627)</b>



Date: December 2, 2021

To: All NAIC Members and Interested Parties

From: Dean Cameron, Idaho Director of Insurance and NAIC-President Elect  
Michael Consedine, NAIC Chief Executive Officer  
Andy Beal, NAIC Chief Operating Officer and Chief Legal Officer  
Jim Woody, NAIC Chief Financial Officer

Re: Summary of Comments on the Proposed 2022 NAIC Budget

In response to the Executive (EX) Committee's and Internal Administration (EX1) Subcommittee's request for comment on the NAIC's proposed 2022 budget, the NAIC received one comment letter on the proposed budget after it was released for public comment on October 27, 2021, from the National Association of Mutual Insurance Companies (NAMIC) (Attachment One). This memorandum summarizes the letter's comments and includes the NAIC's response to each comment.

A Public Hearing will be held December 7th to discuss these comments. Participation instructions for public hearing teleconference can be accessed at [http://www.naic.org/about\\_budget.htm](http://www.naic.org/about_budget.htm).

#### **NAIC's Commitment to Innovation, Cybersecurity, and Technology**

1. NAMIC noted the NAIC is focused on providing support to its members by modernizing its tools and systems by the largely implemented State Ahead initiatives and the focus on establishing State Ahead 2.0. NAMIC also noted approximately 50 percent of the NAIC's staff is in information technology or technical services with a request for two additional staff members for the cybersecurity team. NAMIC agreed that protection of the sensitive data collected from states and industry participants is a high priority.

**NAIC Response:** The NAIC appreciates NAMIC's support of the NAIC's focus on continuing to provide outstanding service to state regulators by updating its tools and systems in a thoughtful and systematic manner. The two new cybersecurity positions as well as two technology-related fiscals – one to expand the NAIC's State Based Systems platform to several new states and the other to lay the groundwork to modernize the Financial Data Repository system – are examples of the NAIC's commitment to make prudent investments in technology that are of benefit to state-based insurance regulation. The NAIC will continue to make additional investments in its systems over the coming years to ensure the systems provide a high level of value to regulators, industry and consumers in a secure manner.

**Consider Initiatives that Streamline Existing Regulatory Tools**

2. NAMIC highlighted NAIC’s history of developing long-lasting model regulation and guidance with flexibility to be modified in response to changes in the insurance regulatory environment. NAMIC cited several instances of guidance brought forth decades before that have stood the test of time. However, NAMIC would like the NAIC to undertake an independent study to audit the current state of insurance regulations to identify opportunities to eliminate redundancies, resolve conflicting guidance, and gain efficiencies. The organization would also like the NAIC to consider making such a review an ongoing process. The reorganization of the Financial Analysis Handbook and Financial Condition Examiners Handbook, brought about from a systemic review of the pertinent regulation by the Risk-Focused Surveillance (E) Working Group between 2014 and 2018 was given as a positive example.

**NAIC Response:** NAMIC rightly notes that many companies are taking the opportunity, post-pandemic, to review their operations to determine the best path forward to doing business. The NAIC has begun its own review of internal operations, looking to preserve what worked well before the pandemic when staff worked collaboratively in the office and combine it with efficiencies gained during the pandemic as staff and regulators worked remotely. Turning attention to NAMIC’s recommendation of an independent review of NAIC model laws and guidance, along with a methodology for ongoing evaluation as new model laws and guidance are considered and adopted, would fit well with the plans to develop State Ahead 2.0 in 2022.

**Embrace Collaborative Work to Promote Transparency and Create Efficiencies**

3. NAMIC recognizes the significant value provided by the NAIC to its members by providing an organized and coordinated approach to the many challenges that occurred during the pandemic. However, NAMIC cautions the NAIC to continue to be collaborative and transparent as it seeks to address difficult and sensitive subjects, especially those that could be considered outside the bounds of insurance supervision. The organization asks the NAIC and the members to give all parties – including stakeholders such as NAMIC – the opportunity to participate in a meaningful way. One such way would be for the association to perform analysis exercises more frequently in joint sessions, with the goal of creating efficiencies.

**NAIC Response:** The NAIC values NAMIC’s thoughtful recommendation to work collaboratively, thereby promoting better transparency, developing deeper expertise, and utilizing regulators, industry, and staff more efficiently. The NAIC strives for transparency in its operations, budget process, and regulatory activities. Working collaboratively with stakeholders has long been a focus of the NAIC as well. One of the pillars of the State Ahead strategic plan was to put into place resources supporting a collaborative regulatory environment that fosters stable financial markets and reliable and affordable insurance products. As the members work in 2022 toward developing the next phase of the NAIC’s long-term strategic plan, State Ahead 2.0, NAMIC’s recommendation will be taken into account as collaboration and transparency continue to a high priority to the membership.

### **Concluding Comments**

The NAIC takes a holistic approach to the development of its annual budget, which involves input from NAIC staff, NAIC officers, the Executive Committee, and all of the NAIC's members. To provide transparency to the public, the NAIC publishes a copy of its proposed budget on its website before the budget is approved and welcomes input and comments from interested parties, which are addressed in writing and in an open Public Hearing. This process ensures that State insurance regulators, supported by the NAIC, are committed to protecting policyholders as well as ensuring the financial solvency of the insurance industry in a cost-effective and financially prudent manner, while minimizing the impact to industry where possible. The NAIC continuously seeks opportunities to reduce operating costs while providing world-class support to its members, regulators, interested parties, and insurance customers.



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20 F Street N.W., Suite 510 | Washington, D.C. 20001

November 19, 2021

Jim Woody  
Chief Financial Officer  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

**Re: NAMIC Comments – Proposed 2022 NAIC Budget**

Dear Mr. Woody:

On behalf of the National Association of Mutual Insurance Companies (NAMIC),<sup>1</sup> thank you for the opportunity to provide comments regarding the Proposed 2022 NAIC Budget. NAMIC is a long supporter of the NAIC in its efforts to develop regulatory tools and guidance, as well as to develop model regulations that promote a strong and stable state-based regulatory system. Our comments today focus on three central themes that harmonize around the notion that a focused state-based regulatory system remains the best path toward regulatory modernization. Those themes include: (1) support for NAIC’s commitment to innovation, cybersecurity, and technology; (2) consideration of initiatives that streamline existing regulatory tools; and (3) collaboration to promote transparency and create efficiencies.

**Innovation, Cybersecurity, and Technology**

All stakeholders have a responsibility to be good stewards of data governance. NAMIC commends the NAIC for their commitment in this area. As demonstrated by the largely implemented State Ahead initiatives and the additional investments that establish State Ahead 2.0, the NAIC is demonstrating their responsibility to support the states through the modernization of tools and technology to advance state insurance regulation. As noted in the budget, approximately 50% of NAIC staff is in the information technology group or in technical services, and two new cybersecurity full-time positions will be added to that count going forward. NAMIC shares the NAIC’s view in making the protection of the sensitive data they collect from states and industry participants a high priority.

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<sup>1</sup> The National Association of Mutual Insurance Companies is the largest property/casualty insurance trade group with a diverse membership of more than 1,500 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner’s insurance market and 53 percent of the auto market. Through our advocacy programs NAMIC promotes public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.



In addition to the investments in State Ahead 2.0 and the addition of two new IT professionals, two technology-based fiscals are being proposed in the 2022 budget. This includes the modernization of the data collection tool that stores annual and quarterly financial statements and is leveraged by state financial analysts to conduct solvency reviews. This also includes significant investments in the State-Based System (SBS) to expand and transition to a new platform to improve the regulatory processes resulting in cost-savings for the states. NAMIC appreciates the support the NAIC provides to the states and continuous efforts to keep its systems and technology modernized for the future.

#### Consider Initiatives That Streamline Existing Regulatory Tools

The NAIC has an established track record for developing long-lasting model regulation and guidance. For example, the early stages of the development of the Insurance Holding Company System Regulatory Act dates back to 1966, and yet it was recently amended to incorporate the Group Capital Calculation in 2020. The Risk-Based Capital formula established its roots nearly 30 years ago and codification of statutory accounting was now 20 years ago. And while these regulations and guidance have stood the test of time, it is because the system that supports it is adaptable enough to continuously tweak, amend, and add to the regulations to respond to an evolving insurance regulatory environment.

However, what often gets overlooked when new regulations come online is a robust evaluation of what they are replacing or trying to improve upon. This results in years and layers of regulations piling-on top of other antiquated regulations. It is critical to regularly and systematically consider and eliminate the areas that have become redundant and/or conflicting with new or existing regulations. Not only could efficiencies be gained by going back to evaluate this situation, but a **process should be put in place to consider the question of duplication/inconsistency as a matter of course**. A concrete example of the NAIC systematically addressing redundancy in regulation occurred recently over a four-year time (2014-2018) when the Risk-Focused Surveillance (E) Working Group adopted a charge to “review existing examination and analysis procedures to identify and eliminate redundant efforts in collecting and reviewing insurer information for solvency monitoring purposes.” The result of this charge was a complete reorganization of the Financial Analysis Handbook and significant changes to the Financial Condition Examiners Handbook. The clarity gained through this deliberate process benefits regulators and insurers alike.

While we have certainly come a long way since the NAIC embarked upon the Solvency Modernization Initiative back in 2008; in fact, the aforementioned Holding Company Act has undergone three separate and significant amendment processes in that time, but what has not occurred in that time is a pause to take stock of everything that has changed. Again, NAMIC thinks now would be that appropriate time, given companies, regulators, and consumers are all currently doing a similar exercise themselves. Companies are looking throughout their operations at how they are going to do business going forward in a post-pandemic world. Regulators too are trying to navigate how best to do their jobs in an increasingly remote and technologically advanced world. Consumers as well are evaluating their choices and figuring out what they value, and we all know consumer demands are constantly evolving. Therefore, **NAMIC suggests the NAIC embark upon a similar initiative as SMI where all NAIC model acts, regulations, workstreams and guidance manuals are independently surveyed and reviewed**



www.namic.org

to determine their utility and to promote regulatory efficiency as we navigate together the next set of challenges on the horizon.

Our members would certainly appreciate an effort to look at all the good work that the NAIC has accomplished over the years and juxtapose that against where we have come from. An audit of what was trying to be solved back then versus what has been implemented since, such as ORSA, CGAD, MAR, GCC, group supervision, etc. and include an assessment of what was accomplished and what could have been done differently. The NAIC has an opportunity, as it has amassed significant resources since the adoption of these tools. Understanding that the NAIC has an outsized liquid operating reserve that exceeds the recommended range, NAMIC thinks it would be prudent to use the savings (from the reduced spending due to the pandemic) to conduct an independent study. It would be a prudent use of the significant reserves amassed and an investment in a more cohesive and understandable set of regulatory tools for the next generation.

#### Embrace Collaborative Work to Promote Transparency and Create Efficiencies

The NAIC certainly demonstrated its value throughout the pandemic, as we witnessed the association respond with the urgency and agility that was needed. NAMIC members appreciated how organized and coordinated the NAIC and its members were. NAIC Immediate Past President, Director Ray Farmer, often said about his year as NAIC President, “2020 has not been the year we planned, but it is the year we got.” This epitomizes how adaptive the NAIC has become. As we have all learned, it is entirely impossible to foresee every challenge or obstacle around the corner.

NAMIC respectfully shares a note of caution, particularly as the NAIC ventures into conversations that include difficult and sensitive subjects outside the bounds of insurance supervision. **It is important for the NAIC to maintain the ability to be nimble while at the same time intentionally embracing a collaborative spirit and robust transparency.** NAMIC encourages the NAIC and its members to work together to find common ground and to be as inclusive as possible – including with stakeholders – to give everyone an opportunity to participate meaningfully.

Again, as we move toward a post-pandemic world, it presents a unique opportunity for organizations to take stock of where they are going. Given the speed the NAIC has grown in recent years, **analysis exercises should be more frequent and aimed at looking to create efficiencies.** The NAIC has committed itself in years past to restructuring and/or reducing the number of subgroups, working groups, and task forces. On the other hand, with each new evolving risk seems to come more specialized and technical groups producing an environment that creates silos, potentially resulting in inefficient methods to solving common problems. These barriers can be overcome through a more collaborative effort, one that brings together various groups to solve common problems. By combining certain groups or conducting business in joint sessions, for example, this can result in better transparency, development of deeper expertise, and more efficient use of regulators, industry, and NAIC staff time. Further, new issues eventually mature and short-term ad hoc efforts accomplish their discrete purposes. While as new issues emerge, there may be a need for a limited deep dive on an aspect of an issue, after some initial understanding is gained, it may be worth asking whether less splintering of attention and more focused effectiveness may be achieved by consolidating and or sunseting such narrow efforts.



[www.namic.org](http://www.namic.org)

**Conclusion**

As always NAMIC appreciates the opportunity to provide comments on the NAIC's proposed budget. Being a strong supporter of the state-based system of insurance regulation, our intent is not to be critical but rather to offer constructive ideas, because NAMIC values the mission of the NAIC. NAMIC believes the NAIC is positioned very well and has an opportunity to make progress in a number of areas. NAMIC supports the commitments made to innovation, cybersecurity, and technology, and encourages NAIC leadership to consider streamlining existing regulatory tools and to embrace a more collaborative and transparent work environment.

Thank you for your consideration of these comments on this matter of importance to insurers and policyholders. NAMIC looks forward to the responses and discussions during the coming year.

A handwritten signature in black ink that reads "Jonathan Rodgers".

Jonathan Rodgers  
Director of Financial and Tax Policy  
National Association of Mutual Insurance Companies

Draft: 12/15/21

**NAIC 2022 Proposed Committee Charges**

**EXECUTIVE (EX) COMMITTEE**

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

**Ongoing Support of NAIC Programs, Products or Services**

1. The **Executive (EX) Committee** will:
  - A. Identify the goals and priorities of the organization and make recommendations to achieve such goals and priorities based on input of the membership. Make recommendations by the 2022 Commissioners Conference.
  - B. Create/terminate task force(s) and/or Executive (EX) Committee-level working groups to address special issues and monitor the work of these groups. Create necessary task force(s) and/or Executive (EX) Committee-level working groups throughout 2022 as necessary.
  - C. Submit reports and recommendations to NAIC members concerning the activities of its subcommittee and the standing committees. Submit a report at each national meeting.
  - D. Consider requests from NAIC members for friend-of-the-court briefs.
  - E. Establish and allocate functions and responsibilities to be performed by each NAIC zone.
  - F. Pursuant to the Bylaws, oversee the NAIC offices to assist the organization and the individual members in achieving the goals of the organization.
  - G. Conduct strategic planning on an ongoing basis.
  - H. Plan, implement and coordinate communications and activities with the Federal Insurance Office (FIO).
  - I. Plan, implement and coordinate communications and activities with other state, federal, local and international government organizations to advance the goals of the NAIC and promote understanding of state insurance regulation.
  - J. Review and approve requests for the development of model laws and/or regulations. Coordinate the review of existing model laws and/or regulations.
  - K. Select NAIC national meeting sites five and six years in advance of the meeting date to ensure efficient and economical locations and facilities.
  - L. Review and revise, as necessary and appropriate, the criteria and categories for registrants at NAIC national meetings.

NAIC Support Staff: Andrew J. Beal/Kay Noonan

### CLIMATE AND RESILIENCY (EX) TASK FORCE

The mission of the Climate and Resiliency (EX) Task Force is to serve as the coordinating NAIC body for discussion and engagement on climate-related risk and resiliency issues, including dialogue among state insurance regulators, industry, and other stakeholders.

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Climate and Resiliency (EX) Task Force** will:
  - A. Consider appropriate climate risk disclosures within the insurance sector, including:
    1. Evaluation of the Climate Risk Disclosure Survey.
    2. Evaluation of alignment with other sectors and international standards.
    3. Evaluation of financial regulatory approaches to climate risk and resiliency in coordination with other relevant committees, task forces, and working groups, such as the Financial Condition (E) Committee and the Financial Stability (E) Task Force.
    4. Evaluation of the use of modeling by carriers and their reinsurers concerning climate risk.
    5. Evaluation of how rating agencies incorporate climate risk into their analysis and governance.
    6. Evaluation of the potential solvency impact of insurers' exposures, including both underwriting and investments, to climate-related risks.
    7. Evaluation and development of climate risk-related disclosure, stress testing, and scenario modeling.
  - B. Consider innovative insurer solutions to climate risk and resiliency, including:
    1. Evaluation of how to apply technology and innovation to the mitigation of storm, wildfire, other climate risks, and earthquake.
    2. Evaluation of insurance product innovation directed at reducing, managing, and mitigating climate risk and closing protection gaps.
  - C. Identify sustainability, resilience, and mitigation issues and solutions related to the insurance industry.
  - D. Consider pre-disaster mitigation and resiliency and the role of state insurance regulators in resiliency.

NAIC Support Staff: Jennifer Gardner

### **GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL**

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

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

#### **Ongoing Support of NAIC Programs, Products or Services**

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

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb/Brooke Stringer

### **LONG-TERM CARE INSURANCE (EX) TASK FORCE**

Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, the mission of the Long-Term Care Insurance (EX) Task Force is to: 1) further develop and implement a coordinated national approach for reviewing LTCI rates; 2) monitor and evaluate the rate review process; 3) evaluate and recommend options to help consumers manage the impact of rate increases; and 4) monitor work performed by other NAIC groups to review the financial solvency of long-term care (LTC) insurers.

#### **Ongoing Support of NAIC Programs, Products or Services**

1. The **Long-Term Care Insurance (EX) Task Force** will:
  - A. Once adopted by the NAIC Executive (EX) Committee and Plenary, monitor, and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document. Monitor state insurance department rate review actions subsequent to implementation of the MSA Framework and MSA rate review recommendations.
  - B. Complete an evaluation and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
  - C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers.
  
2. The **Long-Term Care Insurance Multistate Rate Review (EX) Subgroup** will:
  - A. Finalize the development of the MSA rate review process as outlined in the MSA Framework document which outlines a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Implement the MSA rate review process once adopted by the NAIC Executive (EX) Committee and Plenary.
  - B. Evaluate the progress of the MSA rate review process and provide ongoing maintenance and enhancements, as deemed necessary.
  - C. The Subgroup should complete its charges by the 2022 Fall National Meeting.
  
3. The **Long-Term Care Reduced Benefit Options (EX) Subgroup** will:
  - A. Complete an evaluation and/or recommendation of options to help consumers manage the impact of rate increases. This includes:
    1. Finalizing development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options.
    2. The potential development of mechanisms to help regulators and consumers objectively compare reduced benefit options (RBOs), including comparison of accepting a rate increase and retaining current benefits to electing an offered RBOs.
    3. Finalizing the Consumer Notices Checklist for RBOs.
  - B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding evaluation of RBOs.
  - C. The Subgroup should complete its charges by the 2022 Fall National Meeting.

NAIC Support Staff: Jeff Johnston/Jane Koenigsman

### 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.

**SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE** *(Continued)*

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.
- I. 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.

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine

### INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

#### Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Andrew J. Beal/Jim Woody

### INFORMATION SYSTEMS (EX1) TASK FORCE

The mission of the Information Systems (EX1) Task Force is to: 1) provide regulator-based technology expertise to the Internal Administration (EX1) Subcommittee; and 2) support committee activities and objectives by monitoring projects that provide technical services or systems for state-based insurance regulation, as prioritized by the Executive (EX) Committee.

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Information Systems (EX1) Task Force** will:
  - A. Serve as the Internal Administration (EX1) Subcommittee's project-independent technology monitor and consultant. This involves monitoring the development, deployment and operation of NAIC information technology (IT) systems and services for state insurance regulators and, based on this effort, providing reports and recommendations to the Subcommittee, as appropriate. To achieve this, the Task Force will receive regular portfolio and technical operational reports.
  - B. Provide consultation to NAIC technology staff, as well as the interpretation of intent and specific technology direction, where needed. For example, from time to time, NAIC technology staff may request approval of a specific technology approach, such as a proposal to drop support for a particular version of software. The Task Force will provide direction in such matters, either directly or through a working group. Task Force members will also communicate current and future state technology changes planned for their state to alert NAIC technology staff of potential impacts and requirements for NAIC systems and services used by state insurance regulators.
  - C. Review, with technical recommendations for the Subcommittee: 1) Fiscal Impact Statements Appendix A for all *State Ahead* projects, as well as others involving a technology component exceeding \$100,000 or 1,150 hours of technology staff development and which is not limited to the support of the internal operations; and 2) project requests that involve technology being submitted to the Subcommittee or directly to the Executive (EX) Committee.

NAIC Support Staff: Sherry Stevens/Keith Bollig

### **LIFE INSURANCE AND ANNUITIES (A) COMMITTEE**

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

#### **Ongoing Support of NAIC Programs, Products or Services**

1. The **Life Insurance and Annuities (A) Committee** will:
  - A. Monitor the activities of the Life Actuarial (A) Task Force.
2. The **Accelerated Underwriting (A) Working Group** will:
  - A. Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue; and, if appropriate, draft guidance for the states.
3. The **Annuity Suitability (A) Working Group** will:
  - A. Consider how to promote greater uniformity in the adoption of the *Suitability in Annuity Transactions Model Regulation* (#275) across NAIC member jurisdictions.
4. The **Life Insurance Online Guide (A) Working Group** will:
  - A. Develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.

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

### LIFE ACTUARIAL (A) TASK FORCE

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

#### Ongoing Support of NAIC Programs, Products and Services

1. The **Life Actuarial (A) Task Force** will:
  - A. Work to keep reserve, reporting and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the *Valuation Manual*, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
  - B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
    1. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements, as appropriate, for life insurance and annuities.
    2. Provide recommendations for guidance and requirements for accelerated underwriting, as needed.
    3. Evaluate and provide recommendations regarding the VM-21/AG 43 Standard Projection Amount, which may include continuing as a required floor or providing as disclosure. This evaluation is to be completed prior to year-end 2023.
    4. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
    5. Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues, and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
    6. Work with the selected vendor to develop and implement the new economic scenario generator (ESG) for use in regulatory reserve and capital calculations.
    7. Monitor international developments regarding life and health insurance reserving, capital and related topics. Compare and benchmark with PBR requirements.
2. The **Variable Annuities Capital and Reserve (E/A) Subgroup** of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
  - A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation and determine if additional revisions need to be made.
  - B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.
3. The **Experience Reporting (A) Subgroup** will:
  - A. Continue development of the experience reporting requirements within the *Valuation Manual*. Provide input, as appropriate, for the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.
4. The **Indexed Universal Life (IUL) Illustration (A) Subgroup** will:
  - A. Monitor the results and practices of IUL illustrations following implementation of *Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A)*. Provide recommendations for consideration of changes to *Life Insurance Illustrations Model Regulation (#582)* to the Life Actuarial (A) Task Force, as needed.
5. The **Longevity Risk (E/A) Subgroup** of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
  - A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2022 Summer National Meeting.
6. The **Valuation Manual (VM)-22 (A) Subgroup** will:
  - A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. Continue working with the Academy on a PBR methodology for non-variable annuities.

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

7. The **Guaranteed Issue (GI) Life Valuation (A) Subgroup** will:
  - A. Provide recommendations regarding valuation requirements for GI life business, including any appropriate mortality table(s) for valuation as well as nonforfeiture. Initial recommendations are to be provided to the Life Actuarial (A) Task Force by the 2022 Summer National Meeting.
  
8. The **Index-Linked Variable Annuity (A) Subgroup** will:
  - A. Provide recommendations and changes, as appropriate, to nonforfeiture, or interim value requirements related to index-linked variable annuities.

NAIC Support Staff: Reggie Mazyck/Jennifer Frasier

## HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
  - A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
  - B. Monitor the activities of the Health Actuarial (B) Task Force.
  - C. Monitor the activities of the Regulatory Framework (B) Task Force.
  - D. Monitor the activities of the Senior Issues (B) Task Force.
  - E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
  - F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
  - G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
  - H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.
2. The **Consumer Information (B) Subgroup** will:
  - A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
  - B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.
3. The **Health Innovations (B) Working Group** will:
  - A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
  - B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
  - C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
  - D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
  - E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

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

## HEALTH ACTUARIAL (B) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Health Actuarial (B) Task Force** will:
  - A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
  - B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
  - C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
  - D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
  - E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
2. The **Long-Term Care Actuarial (B) Working Group** will:
  - A. Assist the Health Actuarial (B) Task Force in completing the following charges:
    1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
    2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
    3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
3. The **Long-Term Care Pricing (B) Subgroup** will:
  - A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charge:
    1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
4. The **Long-Term Care Valuation (B) Subgroup** will:
  - A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charges:
    1. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
    2. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

NAIC Support Staff: Eric King

## 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 2022.
  - 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, report, and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
  - B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
  - C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
  - D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.
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 MHPAEA of 2008, 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. 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 v. 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.

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

- B. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). Based on issues identified in the white paper, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

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

## SENIOR ISSUES (B) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Senior Issues (B) Task Force** will:
  - A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
  - B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.
  - C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
  - D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
  - E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
  - F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Review the existing *Long-Term Care Insurance Model Act* (#640), the *Long-Term Care Insurance Model Regulation* (#641), the *Limited Long-Term Care Insurance Model Act* (#642), and the *Limited Long-Term Care Insurance Model Regulation* (#643) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving LTCI marketplace. Work with federal agencies, as appropriate.
  - G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.
  - H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.
2. The **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup** will:
  - A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
  - B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
  - C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

NAIC Support Staff: David Torian

## PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Property and Casualty Insurance (C) Committee** will:
  - A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
  - B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
  - C. Monitor the activities of the Surplus Lines (C) Task Force.
  - D. Monitor the activities of the Title Insurance (C) Task Force.
  - E. Monitor the activities of the Workers' Compensation (C) Task Force.
  - F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the *Quarterly Listing of Alien Insurers*. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
  - G. Monitor and review developments in case law and rehabilitation proceedings related to risk retention groups (RRGs). If warranted, make appropriate changes to the *Risk Retention and Purchasing Group Handbook*.
  - H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
    1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
    2. Review law changes and court decisions and, if warranted, make appropriate changes to the *Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators*.
    3. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.
  - I. Report on the cyber insurance market, including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.
  - J. Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
  - K. Provide a forum for discussing issues related to parametric insurance and consider the development of a white paper or regulatory guidance.
2. The **Cannabis Insurance (C) Working Group** will:
  - A. Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
  - B. Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
  - C. Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
  - D. Develop an appendix to the *Understanding the Market for Cannabis Insurance* white paper, providing updated information on cannabis-related insurance issues for adoption by the 2022 Summer National Meeting.
  - E. Collaborate with the Producer Licensing (D) Task Force to study whether cannabis-related convictions in states where cannabis is legalized for medical and/or recreational use are preventing individuals from being licensed as an agent or broker.
3. The **Catastrophe Insurance (C) Working Group** will:
  - A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
  - B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
  - C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
  - D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war, and natural disasters.
  - E. Consider revisions to the *Catastrophe Computer Modeling Handbook*.

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

- F. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC's Catastrophe Resource Center for state insurance regulators to better prepare for disasters.
  - G. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.
  - H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.
4. The **NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group** will:
- A. Assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization, and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.
5. The **Terrorism Insurance Implementation (C) Working Group** will:
- A. Coordinate the NAIC's efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury's (Treasury Department's) Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
  - B. Review and report on data collection related to insurance coverage for acts of terrorism.
6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
- A. Facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.
  - B. Assist other groups with drafting language included within consumer-facing documents.
  - C. Complete the drafting of regulatory best practices that serve to inform consumers of the reasons for significant premium increases related to P/C insurance products.
  - D. Update and develop web page and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*.
  - E. Study and evaluate ways to engage department of insurance (DOI) communication to more diverse populations, such as rural communities.

NAIC Support Staff: Aaron Brandenburg/Jennifer Gardner

## CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate, and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry. The Task Force's goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensure that P/C insurance rates are not excessive, inadequate, or unfairly discriminatory; and ensure that appropriate data regarding P/C insurance markets are available.

### Ongoing Support of NAIC Programs, Products or Services

1. The **Casualty Actuarial and Statistical (C) Task Force** will:
  - A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces, and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
    1. Property and Casualty Insurance (C) Committee – ratemaking, reserving, or data issues.
    2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
    3. Capital Adequacy (E) Task Force – P/C risk-based capital (RBC) report.
    4. Group Solvency Issues (E) Working Group and Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup – ORSA.
    5. Statutory Accounting Principles (E) Working Group – *Accounting Practices and Procedures Manual* (AP&P Manual), and review and provide comments on statutory accounting issues being considered under *Statement of Statutory Accounting Principles (SSAP) No. 65—Property and Casualty Contracts*.
    6. Speed to Market (EX) Working Group – P/C actuarial sections of the *Product Filing Review Handbook*.
  - B. Monitor national casualty actuarial developments and consider regulatory implications.
    1. Casualty Actuarial Society (CAS) – Statements of Principles and *Syllabus of Basic Education*.
    2. American Academy of Actuaries (Academy) – Standards of Practices, Council on Professionalism, and Casualty Practice Council.
    3. Society of Actuaries (SOA) – general insurance track's basic education.
    4. Federal legislation.
  - C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
  - D. Conduct the following predictive analytics work:
    1. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
    2. Review the completed work on artificial intelligence (AI) from other committee groups. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues in as far as these issues contain a Task Force component.
    3. With NAIC staff assistance, discuss guidance for the regulatory review of tree-based models and generalized additive models (GAM) used in rate filings.
2. The **Actuarial Opinion (C) Working Group** will:
  - A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
    1. *Financial Analysis Handbook*.
    2. *Financial Condition Examiners Handbook*.
    3. *Annual Statement Instructions—Property/Casualty*.
    4. Regulatory guidance to appointed actuaries and companies.
    5. Other financial blanks and instructions, as needed.
3. The **Statistical Data (C) Working Group** will:
  - A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators*.
  - B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
    1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance*.
    2. *Auto Insurance Database*.

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

3. *Competition Database Report.*
4. *Report on Profitability by Line by State.*
- C. Implement the expedited reporting and publication of average auto and average homeowners premium portions of the annual *Auto Insurance Database* and *Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance*.

NAIC Support Staff: Kris DeFrain/Jennifer Gardner/Libby Crews

## SURPLUS LINES (C) TASK FORCE

The mission of the Surplus Lines (C) Task Force is to: 1) monitor the surplus lines market and regulation, including the activity and financial condition of U.S. and alien surplus lines insurers by providing a forum for discussion of issues; and 2) develop or amend relevant NAIC model laws, regulations, and/or guidelines.

### Ongoing Support of NAIC Programs, Products or Services

1. The **Surplus Lines (C) Task Force** will:
  - A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
  - B. Review and analyze quantitative and qualitative data on U.S. domestic and alien surplus lines industry results and trends.
  - C. Monitor federal legislation related to the surplus lines market and ensure all interested parties remain apprised.
  - D. Develop or amend relevant NAIC model laws, regulations, and/or guidelines.
  - E. Oversee the activities of the Surplus Lines (C) Working Group.
2. The **Surplus Lines (C) Working Group** will:
  - A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
  - B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC *Quarterly Listing of Alien Insurers*.
  - C. Review and consider appropriate decisions regarding applications for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
  - D. Analyze renewal applications of alien surplus lines insurers on the NAIC *Quarterly Listing of Alien Insurers* and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.
  - E. Provide a forum for surplus lines-related discussion among jurisdictions.

NAIC Support Staff: Andy Daleo

### TITLE INSURANCE (C) TASK FORCE

The mission of the Title Insurance (C) Task Force is to study issues related to title insurers and title insurance producers.

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Title Insurance (C) Task Force** will:
  - A. Discuss and/or monitor issues and developments affecting the title insurance industry, and provide support and expertise to other NAIC committees, task forces, and/or working groups, or outside entities, as appropriate.
  - B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces, and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies.
  - C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information; education; and disclosure for mortgage lending, closing, and settlement services about the role of title insurance in the real estate transaction process.
  - D. Evaluate CPLs to ensure compliance with state regulation and requirements, consumer protection offered and excluded, and potential alternatives for coverage.
  - E. Review current rate regulation practices.

NAIC Support Staff: Anne Obersteadt

### WORKERS' COMPENSATION (C) TASK FORCE

The mission of the Workers' Compensation (C) Task Force is to study the nature and effectiveness of state approaches to workers' compensation and related issues, including, but not limited to: 1) assigned risk plans; 2) safety in the workplace; 3) treatment of investment income in rating; 4) occupational disease; 5) cost containment; and 6) the relevance of adopted NAIC model laws, regulations, and/or guidelines pertaining to workers' compensation.

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Workers' Compensation (C) Task Force** will:
  - A. Oversee the activities of the NAIC/International Association of Industrial Accident Boards and Commissions (IAIABC) Joint (C) Working Group.
  - B. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.
  - C. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.
  - D. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.
  - E. Discuss workers' compensation issues related to COVID-19.
2. The **NAIC/IAIABC Joint (C) Working Group** will:
  - A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible changes in light of the Working Group's recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

## MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Market Regulation and Consumer Affairs (D) Committee** will:
  - A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
  - B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
  - C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
  - D. Oversee the activities of the Antifraud (D) Task Force.
  - E. Oversee the activities of the Market Information Systems (D) Task Force.
  - F. Oversee the activities of the Producer Licensing (D) Task Force.
  - G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
  - H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
  - I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
  - J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
  - K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update, as needed.
2. The **Advisory Organization Examination Oversight (D) Working Group** will:
  - A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
  - B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
  - C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).
3. The **Market Actions (D) Working Group** will:
  - A. Facilitate interstate communication and coordinate collaborative state regulatory actions.
4. The **Market Analysis Procedures (D) Working Group** will:
  - A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
  - B. Discuss other market data collection issues and make recommendations, as necessary.
  - C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).
5. The **Market Conduct Annual Statement Blanks (D) Working Group** will:
  - A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
  - B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.

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

6. The **Market Conduct Examination Guidelines (D) Working Group** will:
  - A. Develop market conduct examination standards, as necessary, for inclusion in the *Market Regulation Handbook*.
  - B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
  - C. Develop updated standardized data requests, as necessary, for inclusion in the *Market Regulation Handbook*.
  - D. Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the *Market Regulation Handbook*.
  - E. Coordinate with the Innovation, Cybersecurity and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities' use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
  - F. Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
  - G. Discuss the role of market conduct examiners in reviewing insurers' corporate governance as outlined in the NAIC's *Corporate Governance Annual Disclosure Model Act* (#305) and *Corporate Governance Annual Disclosure Model Regulation* (#306).
  
7. The **Market Regulation Certification (D) Working Group** will:
  - A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states' compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.
  
8. The **Privacy Protections (D) Working Group** will:
  - A. Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the *NAIC Insurance Information and Privacy Protection Model Act* (#670) and the *Privacy of Consumer Financial and Health Information Regulation* (#672). *(Further direction from NAIC Executive (EX) Committee may result in this charge being moved to the new Innovation, Cybersecurity, and Technology (H) Committee.)*

NAIC Support Staff: Tim Mullen/Randy Helder

## ANTIFRAUD (D) TASK FORCE

The mission of the Antifraud (D) Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, through the detection, monitoring, and appropriate referral for the investigation of insurance crime, both by and against consumers. The Task Force will assist the insurance regulatory community by conducting the following activities: 1) maintaining and improving electronic databases regarding fraudulent insurance activities; 2) disseminating the results of research and analysis of insurance fraud trends, as well as case-specific analysis, to the insurance regulatory community; and 3) providing a liaison function between state insurance regulators, law enforcement (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 2022 Fall National Meeting.
3. The **Antifraud Technology (D) Working Group** will:
  - A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by 2022 Fall National Meeting.
  - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2022 Fall National Meeting.
4. The **Improper Marketing of Health Insurance (D) Working Group** will:
  - A. Coordinate with state insurance regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC committees, task forces, and working groups.
  - B. Review existing NAIC models and guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

NAIC Support Staff: Greg Welker/Lois E. Alexander

### MARKET INFORMATION SYSTEMS (D) TASK FORCE

The mission of the Market Information Systems (D) Task Force is to provide business expertise regarding the desired functionality of the NAIC Market Information Systems (MIS) and the prioritization of regulatory requests for the development and enhancements of the MIS.

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Market Information Systems (D) Task Force** will:
  - A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
  - B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2022 Summer National Meeting.
  - C. Analyze the data in the MIS. If needed, recommend methods to ensure better data quality. Complete by the 2022 Fall National Meeting.
  - D. Provide guidance on the appropriate use of the MIS and the data entered in them.
    1. Complaints Database System (CDS).
    2. Electronic Forums.
    3. Market Actions Tracking System (MATS).
    4. Market Analysis Profile.
    5. Market Analysis Prioritization Tool (MAPT).
    6. Market Analysis Review System (MARS).
    7. Market Conduct Annual Statement (MCAS).
    8. Regulatory Information Retrieval System (RIRS).
    9. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).
2. The **Market Information Systems Research and Development (D) Working Group** will:
  - A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
  - B. Assist the Task Force with tasks as assigned, such as:
    1. Analyze MIS data.
    2. Provide state users with query access to MIS data.
    3. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder

### PRODUCER LICENSING (D) TASK FORCE

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

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Producer Licensing (D) Task Force** will:
  - A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC's Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
  - B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
  - C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
  - D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
  - E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
  - F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC's Market Information Systems (MIS).
  - G. Monitor the state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.
  - H. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
  - I. Discuss how criminal convictions may affect producer licensing applicants and review the NAIC's *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* to create a more simplified and consistent approach in how states review 1033 waiver requests.
2. The **Producer Licensing Uniformity (D) Working Group** will:
  - A. Work closely with state producer licensing directors and exam vendors to ensure that: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
  - B. Provide oversight and ongoing updates, as needed, to the *State Licensing Handbook*.
  - C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
  - D. Review and update, as needed, the NAIC's uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.
3. The **Uniform Education (D) Working Group** will:
  - A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2022 Fall National Meeting.
  - B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations, as necessary, on preclicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards.

NAIC Support Staff: Tim Mullen/Greg Welker

## FINANCIAL CONDITION (E) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Financial Condition (E) Committee** will:
  - A. Monitor all of the changes to the annual/quarterly financial statement blanks and instructions, risk-based capital (RBC) formulas, *Financial Condition Examiners Handbook*, *Accounting Practices and Procedures Manual* (AP&P Manual), *Financial Analysis Handbook*, *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), NAIC model laws, NAIC accreditation standards, and other NAIC publications.
  - B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
  - C. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
  - D. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues industry subsequently escalates to the Committee.
2. The **Financial Analysis (E) Working Group** will:
  - A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
  - B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
  - C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
  - D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.
3. The **Group Capital Calculation (E) Working Group** will:
  - A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
  - B. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.
4. The **Group Solvency Issues (E) Working Group** will:
  - A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
  - B. Critically review and provide input and drafting to the IAIS Insurance Groups Working Group on other IAIS material dealing with group supervision issues.
  - C. Continually review and monitor the effectiveness of the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450), and consider revisions, as necessary, to maintain effective oversight of insurance groups.
  - D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), and make recommendations on its implementation in a manner appropriate for the U.S.
5. The **Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup** of the Group Solvency Issues (E) Working Group will:
  - A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the ORSA implementation.
  - B. Continually review and monitor the effectiveness of the *Risk Management and Own Risk and Solvency Assessment Model Act* (#505) and its corresponding *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual*; consider revisions as necessary.

**FINANCIAL CONDITION (E) COMMITTEE** *(Continued)*

6. The **Mortgage Guaranty Insurance (E) Working Group** will:
  - A. Develop changes to the *Mortgage Guaranty Insurance Model Act* (#630) and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to *Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance*, and develop an extensive mortgage guaranty supplemental filing. Finalize Model #630 by the 2022 Spring National Meeting.
7. The **Mutual Recognition of Jurisdictions (E) Working Group** will:
  - A. Oversee the process for evaluating jurisdictions and maintain a listing of jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC GCC.
  - B. Maintain the *NAIC List of Qualified Jurisdictions* and the *NAIC List of Reciprocal Jurisdictions* in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.
8. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
  - A. Continually review the *Annual Financial Reporting Model Regulation* (#205) and its corresponding implementation guide; revise as appropriate.
  - B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
  - C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
  - D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.
9. The **National Treatment and Coordination (E) Working Group** will:
  - A. Increase utilization and implementation of the *Company Licensing Best Practices Handbook*.
  - B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
  - C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
  - D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
  - E. Make necessary enhancements to promote electronic submission of all company licensing applications.
10. The **Restructuring Mechanisms (E) Working Group** will:
  - A. Evaluate and prepare a white paper that:
    1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
    2. Summarizes the existing state restructuring statutes.
    3. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
    4. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
    5. Identifies and addresses the legal issues associated with restructuring using a protected cell.
  - B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.
11. The **Long-Term Care Insurance Restructuring (E) Subgroup** of the Restructuring Mechanisms (E) Working Group will:
  - A. Identify and assess potential legal and regulatory issues arising from a corporate transaction that would seek to legally separate certain long-term care (LTC) policies from the general account of the issuing insurer. Report on the Subgroup's consideration of the issue, including a recommendation as to merits of an existing regulatory framework (e.g., Insurance Business Transfers state statutes) or a new regulatory framework, as contemplated by Workstream #2 of the Long-Term Care Insurance (EX) Task Force.

**FINANCIAL CONDITION (E) COMMITTEE** *(Continued)*

12. The **Restructuring Mechanisms (E) Subgroup** of the Restructuring Mechanisms (E) Working Group will:
  - A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.
  - B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.
  - C. Review the various restructuring mechanisms and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.
  
13. The **Risk-Focused Surveillance (E) Working Group** will:
  - A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
  - B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
  - C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
  - D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.
  
14. The **Valuation Analysis (E) Working Group** will:
  - A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination, which also may include consideration of asset adequacy analysis questions and issues.
  - B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis, including actuarial guidelines or other requirements making use of or relating to PBR, such as *Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation* (AG 38), *Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation* (AG 48), and the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
  - C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.
  - D. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the *Valuation Manual*.
  - E. Assist NAIC resources in the development of a standard asset/liability model portfolio used to calibrate company PBR models.
  - F. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
  - G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jensen

## ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Accounting Practices and Procedures (E) Task Force** will:
  - A. Oversee the activities of the Blanks (E) Working Group and the Statutory Accounting Principles (E) Working Group.
2. The **Blanks (E) Working Group** will:
  - A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
    1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
    2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
    3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
    4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
  - B. Continue to monitor state filing checklists to maintain current filing requirements.
  - C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the *Annual Statement Instructions*.
  - D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
  - E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
  - F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
  - G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
  - H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.
3. The **Statutory Accounting Principles (E) Working Group** will:
  - A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
  - B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
  - C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the *Valuation Manual* VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other *Valuation Manual* requirements. This process will include the receipt of periodic reports on changes to the *Valuation Manual* on items that require coordination.
  - D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

NAIC Support Staff: Robin Marcotte

### CAPITAL ADEQUACY (E) TASK FORCE

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

#### Ongoing Support of NAIC Programs, Products or Services

1. The **Capital Adequacy (E) Task Force** will:
  - A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
  - B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
  - C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.
2. The **Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group** will:
  - A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
  - B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present no later than June 30 for the current reporting year.
  - C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised *Accounting Practices and Procedures Manual (AP&P Manual)* to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
  - D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.
3. The **Longevity Risk (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
  - A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.
4. The **Variable Annuities Capital and Reserve (E/A) Subgroup**, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
  - A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
  - B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.
5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
  - A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
  - B. Continue to update the U.S. and non-U.S. catastrophe event list.
  - C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
  - D. Evaluate the RBC results inclusive of a catastrophe risk charge.
  - E. Refine instructions for the catastrophe risk charge.
  - F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
  - G. Evaluate other catastrophe risks for possible inclusion in the charge.

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

6. The **Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group** will:
  - A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
    1. Identifying and acknowledging uses that extend beyond the purpose of the *Risk-Based Capital (RBC) for Insurers Model Act* (#312).
    2. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action level.
    3. Documenting the modifications made over time to the formulas, including, but not limited to, an analysis of the costs in study and development, implementation (internal and external), assimilation, verification, analysis, and review of the desired change to the RBC formulas and facilitating the appropriate allocation of resources.

NAIC Support Staff: Jane Barr

## EXAMINATION OVERSIGHT (E) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Examination Oversight (E) Task Force** will:
  - A. Accomplish its mission using the following groups:
    1. Electronic Workpaper (E) Working Group.
    2. Financial Analysis Solvency Tools (E) Working Group.
    3. Financial Examiners Coordination (E) Working Group.
    4. Financial Examiners Handbook (E) Technical Group.
    5. Information Technology (IT) Examination (E) Working Group.
2. The **Electronic Workpaper (E) Working Group** will:
  - A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
  - B. Provide ongoing oversight to the transition of electronic workpaper work to the TeamMate+ application.
  - C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.
3. The **Financial Analysis Solvency Tools (E) Working Group** will:
  - A. Provide ongoing maintenance and enhancements to the *Financial Analysis Handbook* and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
  - B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
  - C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
  - D. Adjust the *Financial Analysis Handbook* and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.
4. The **Financial Examiners Coordination (E) Working Group** will:
  - A. Develop enhancements that encourage the coordination of examination activities regarding holding company groups.
  - B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
  - C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
  - D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).

**EXAMINATION OVERSIGHT (E) TASK FORCE** *(Continued)*

5. The **Financial Examiners Handbook (E) Technical Group** will:
  - A. Continually review the *Financial Condition Examiners Handbook* and revise, as appropriate.
  - B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the *Financial Condition Examiners Handbook*, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
  - C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
  - D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the *Financial Condition Examiners Handbook* related to the charges of these specific working groups.
  - E. Adjust the *Financial Condition Examiners Handbook* based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate PBR changes.
  
6. The **Information Technology (IT) Examination (E) Working Group** will:
  - A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C— Evaluation of Controls in Information Systems” sections of the *Financial Condition Examiners Handbook*.
  - B. Monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the *Financial Condition Examiners Handbook* or other tools, if deemed necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning

## 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.
  - F. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed.

NAIC Support Staff: Todd Sells/Tim Nauheimer

## RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Receivership and Insolvency (E) Task Force** will:
  - A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
  - B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
  - C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
  - D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
  - E. Provide ongoing review of the *Receiver's Handbook for Insurance Company Insolvencies* (Receiver's Handbook), other related NAIC publications, and the Global Receivership Information Database (GRID), and make any necessary updates.
  - F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
  - G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.
2. The **Receiver's Handbook (E) Subgroup** of the Receivership and Insolvency (E) Task Force will:
  - A. Review the Receiver's Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver's Handbook. Complete by the 2022 Fall National Meeting.
3. The **Receivership Financial Analysis (E) Working Group** will:
  - A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
  - B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) regarding potential or pending receiverships.
4. The **Receivership Law (E) Working Group** will:
  - A. Review and provide recommendations on any issues identified that may affect states' receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
  - B. Discuss significant cases that may impact the administration of receiverships.

NAIC Support Staff: Jane Koenigsman

## REINSURANCE (E) TASK FORCE

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

### Ongoing Support of NAIC Programs, Products or Services

1. The **Reinsurance (E) Task Force** will:
  - A. Provide a forum for the consideration of reinsurance-related issues of public policy.
  - B. Oversee the activities of the Reinsurance Financial Analysis (E) Working Group.
  - C. Monitor the implementation of the 2011, 2016 and 2019 revisions to the *Credit for Reinsurance Model Law* (#785); and the 2011 and 2019 revisions to the *Credit for Reinsurance Model Regulation* (#786) and the *Term and Universal Life Insurance Reserve Financing Model Regulation* (#787).
  - D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
  - E. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
  - F. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
  - G. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
  - H. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).
2. The **Reinsurance Financial Analysis (E) Working Group** will:
  - A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
  - B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
  - C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
  - D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
  - E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
  - F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
  - G. Ensure the public passporting website remains current.
  - H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

NAIC Support Staff: Jake Stultz/Dan Schelp

### **RISK RETENTION GROUP (E) TASK FORCE**

The mission of the Risk Retention Group (E) Task Force is to stay apprised of the work of other NAIC groups as it relates to financial solvency regulation and the NAIC Financial Regulation Standards and Accreditation Program. The Task Force may make referrals to the Financial Regulation Standards and Accreditation (F) Committee and/or other NAIC groups, as deemed appropriate.

#### **Ongoing Support of NAIC Programs, Products or Services**

1. The **Risk Retention Group (E) Task Force** will:
  - A. Monitor and evaluate the work of other NAIC committees, task forces and working groups related to risk retention groups (RRGs). Specifically, if any of these actions affect the NAIC Financial Regulation and Accreditation Standards Program, assess whether and/or how the changes should apply to RRGs and their affiliates.
  - B. Monitor and analyze federal actions, including any U.S. Government Accountability Office (GAO) reports. Consider any action necessary as a result of federal activity.
  - C. Monitor the impacts of recent tools and resources made available to domiciliary and non-domiciliary state insurance regulators pertaining to RRGs. Consider whether additional action is necessary, including educational opportunities, updating resources and further clarifications.

NAIC Support Staff: Becky Meyer/Sara Franson

## VALUATION OF SECURITIES (E) TASK FORCE

The mission of the Valuation of Securities (E) Task Force is to provide regulatory leadership and expertise to establish and maintain all aspects of the NAIC's credit assessment process for insurer-owned securities, as well as produce insightful and actionable research and analysis regarding insurer investments.

### Ongoing Support of NAIC Programs, Products or Services

1. The **Valuation of Securities (E) Task Force** will:
  - A. Review and monitor the operations of the NAIC Securities Valuation Office (SVO) and the NAIC Structured Securities Group (SSG) to ensure they continue to reflect regulatory objectives.
  - B. Maintain and revise the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to provide solutions to investment-related regulatory issues for existing or anticipated investments.
  - C. Monitor changes in accounting and reporting requirements resulting from the continuing maintenance of the *Accounting Practices and Procedures Manual*, as well as financial statement blanks and instructions, to ensure that the P&P Manual continues to reflect regulatory needs and objectives.
  - D. Consider whether improvements should be suggested to the measurement, reporting and evaluation of invested assets by the NAIC as the result of: 1) newly identified types of invested assets; 2) newly identified investment risks within existing invested asset types; or 3) elevated concerns regarding previously identified investment risks.
  - E. Identify potential improvements to the credit filing process, including formats and electronic system enhancements.
  - F. Provide effective direction to the NAIC's mortgage-backed securities modeling firms and consultants.
  - G. Coordinate with other NAIC working groups and task forces—including, but not limited to, the Capital Adequacy (E) Task Force, the Statutory Accounting Principles (E) Working Group and the Blanks (E) Working Group—to formulate recommendations and to make referrals to such other NAIC regulator groups to ensure expertise relative to investments, or the purpose and objective of guidance in the P&P Manual, is reflective in the guidance of such other groups and that the expertise of such other NAIC regulatory groups and the objectives of their guidance is reflected in the P&P Manual.
  - H. Identify potential improvements to the filing exempt process (the use of credit rating provider ratings to determine an NAIC designation) to ensure greater consistency, uniformity and appropriateness to achieve the NAIC's financial solvency objectives.
  - I. Implement policies to oversee the NAIC's staff administration of rating agency ratings used in NAIC processes, including staff's discretion over the applicability of their use in its administration of filing exemption.

NAIC Support Staff: Charles Therriault

## FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products and Services

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

NAIC Support Staff: Becky Meyer/Sara Franson

## INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

### Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ryan Workman/Nikhail Nigam

**NAIC/CONSUMER LIAISON COMMITTEE**

The mission of the NAIC/Consumer Liaison Committee is to assist the NAIC in its mission to support state insurance regulation by providing consumer views on insurance regulatory issues. The Liaison Committee provides a forum for ongoing dialogue between NAIC members and NAIC consumer representatives. The Liaison Committee's activities in 2022 will be closely aligned with the priorities of the NAIC Consumer Board of Trustees.

**NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE**

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

*Draft: 8/3/2021*

*Reaffirmed by the Executive (EX) Committee and Plenary – TBD*

*Reaffirmed by the Executive (EX) Committee – TBD*

*Reaffirmed by the Internal Administration (EX1) Subcommittee – Aug. 13, 2021*

*Reaffirmed by the Audit Committee – Aug. 10, 2021*

**2022 PROPOSED NAIC AUDIT COMMITTEE  
Committee Charter**

1. The **Audit Committee** will:
  - A. Provide continuous audit oversight, including:
    1. Provide an open avenue of communication between the independent auditor and the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee.
    2. Confirm and ensure the independence of the independent auditor.
    3. Inquire of management and the independent auditor about significant risks or exposures, and assess the steps management has taken to minimize such risk.
    4. Consider and review with the independent auditor:
      - a. Significant findings during the year, including the status of previous audit recommendations.
      - b. Any difficulties encountered in the course of audit work, including any restrictions on the scope of activities or access to required information.
      - c. The adequacy of internal controls, including computerized information system controls and security, as documented in the Statement on Auditing Standards (SAS) 115 letter from the independent auditor.
      - d. Related findings and recommendations of the independent auditor with management's responses, as documented in the SAS 114 letter from the independent auditor.
    5. Meet periodically with the independent auditor in separate executive sessions to discuss any matters the Committee believes should be discussed privately with the Committee.
    6. Report periodically to the Executive (EX) Committee and Internal Administration (EX1) Subcommittee on significant results of the foregoing activities.
    7. Instruct the independent auditor that the Executive (EX) Committee and Internal Administration (EX1) Subcommittee are the auditor's clients.
  - B. Provide continuous oversight of reporting policies, including:
    1. Advise financial management and the independent auditor that they are expected to provide a timely analysis of significant current financial reporting issues and practices.
    2. Inquire as to the auditor's independent qualitative judgments about the appropriateness, not just the acceptability, of the accounting principles and the clarity of the financial disclosure practices.
    3. Inquire as to the auditor's views about whether management's choices of accounting principles are conservative, moderate or aggressive from the perspective of income, asset and liability recognition, and whether those principles are common practices or minority practices.
    4. Inquire as to the auditor's views about how choices of accounting principles and disclosure practices may affect NAIC members, the insurance industry, and public views and attitudes.
  - C. Provide continuous oversight of financial management, including:
    1. Review the monthly consolidated financial statements, and receive regular reports from executive management on the financial operations of the association.
    2. Meet prior to, or at, each national meeting or more frequently, as circumstances require. The Committee may ask members of management or others to attend meetings and provide pertinent information, as necessary.
    3. Report on significant results of the foregoing activities to the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee on a regular basis.
  - D. Conduct scheduled audit activities, including:
    1. Recommend the selection of the independent auditor for approval by the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, approve the compensation of the independent auditor, and review and approve the discharge of the independent auditor.
    2. Review annually the audit scope and plan of the independent auditor with management and the independent auditor, including:
      - a. The independent auditor's audit of the financial statements, accompanying footnotes, and its report thereon.
      - b. Any significant changes required in the independent auditor's audit plans.
      - c. Any difficulties or disputes with management encountered during the course of the year under audit.
      - d. Other matters related to the conduct of the audit, which are to be communicated to the Committee under generally accepted auditing standards (GAAS).
    3. Review and approve needs-based funding allocations, as needed.

4. Review and update the Committee charter on at least an annual basis.
- E. Conduct other activities when necessary, including:
  1. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.
  2. Review and approve requests for any management consulting engagement to be performed by the independent auditor, and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.
  3. Conduct and/or authorize investigations into any matters within the Committee's scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.
  4. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

*Adopted by the Life Actuarial (A) Task Force, 9/16/21*  
*Adopted by the Life Insurance and Annuities (A) Committee, 12/15/21*  
*Adopted by the Executive (EX) Committee and Plenary, 12/16/21*

**TABLE 1**  
PROPOSED 2022 GRET FACTORS, BASED ON AVERAGE OF 2018/2019 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$183	\$1.00	46%	\$55	142	3,252	194
Career	212	1.20	53%	64	77	2,327	197
Direct Marketing	200	1.10	50%	60	23	875	72
Niche Marketing	151	0.90	37%	45	24	517	13
Other*	139	0.80	35%	42	109	786	70
* Includes companies that did not respond to this or prior year surveys					375		

**TABLE 2**  
CURRENT 2021 GRET FACTORS, BASED ON AVERAGE OF 2017/2019 DATA

Description	Acquisition per Policy	Acquisition per Unit	Acquisition per Premium	Maintenance per Policy	Companies Included	Average Premium Per Policy Issued During Year	Average Face Amt (000) Per Policy Issued During Year
Independent	\$166	\$0.90	42%	\$50	121	2,916	194
Career	214	1.20	54%	64	63	2,517	195
Direct Marketing	195	1.10	49%	59	15	2,933	119
Niche Marketing	137	0.80	34%	41	26	590	11
Other*	126	0.70	32%	38	67	836	29
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**APPENDIX A -- DISTRIBUTION CHANNELS**

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

1. **Independent** – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.
2. **Career** – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.
3. **Direct Marketing** – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet or other media. No direct field compensation is involved.
4. **Niche Marketers** – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.
5. **Other** – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.

**APPENDIX B – UNIT EXPENSE SEEDS**

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

The unit expense seeds used in the 2022 GRET and the 2021 GRET recommendations were based on the average of the 2006 through 2010 Annual SOA expense studies. These studies differentiated unit expenses by type of individual life insurance policy (term and permanent coverages). As neither the GRET nor the Annual Statement data provided differentiates between these two types of coverage, the unit expense seed was derived by judgment based this information. The following shows the averages derived from the Annual SOA studies and the seeds used in this study. Beginning with the 2020 Annual Statement submission this information will become more readily available.

2006-2010 (AVERAGE) CLICE STUDIES:

	Acquisition/ Policy	Acquisition/ Face Amount (000)	Acquisition/ Premium	Maintenance/ Policy
<b>Term</b>				
Weighted Average	\$149	\$0.62	38%	\$58
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<b>Permanent</b>				
Weighted Average	\$167	\$1.43	42%	\$56
Unweighted Average	\$303	\$1.57	49%	\$70
Median	\$158	\$1.30	41%	\$67

CURRENT UNIT EXPENSE SEEDS:

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

**TO:** Reggie Mazyck, NAIC  
**FROM:** Pete Miller, Experience Study Actuary, Society of Actuaries (SOA)  
Tony Phipps, Chair, SOA Committee on Life Insurance Company Expenses  
**DATE:** August 4, 2021  
**RE:** 2022 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

As in previous years, the Society of Actuaries expresses its thanks to NAIC staff for their assistance and responsiveness in providing Annual Statement expense and unit data for the 2022 GRET analysis for use with individual life insurance sales illustrations. The analysis is based on expense and expense related information reported on companies' 2019 and 2020 Annual Statements. This project has been completed to assist the Life Actuarial Task Force (LATF) in its consideration of potential revisions to the GRET that could become effective for calendar year 2022. This memo describes the analysis and resultant findings.

NAIC staff provided Annual Statement data for life insurance companies for calendar years 2019 and 2020. This included data from 776 companies in 2019 and 771 companies in 2020. This decrease resumes the trend of small decreases from year to year. Of the total companies, 375 were in both years and passed the outlier exclusion tests and were included as a base for the GRET factors (292 companies passed similar tests last year).

#### **APPROACH USED**

The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 2015<sup>1</sup>.

To calculate updated GRET factors, the average of the factors from the two most recent years (2019 and 2020 for those companies with data available for both years) of Annual Statement data was used. For each company an actual-to-expected ratio was calculated. Companies with ratios that fell outside predetermined parameters were excluded. This process was completed three times to stabilize the average rates. The boundaries of the exclusions have been modified from time to time; however, there were no adjustments made this year. Unit expense seed factors (the seeds for all distribution channel categories are the same), as shown in Appendix B, were used to compute total expected expenses. Thus, these seed factors were used to implicitly allocate expenses between acquisition and maintenance expenses, as well as among the three acquisition expense factors (on a direct of ceded reinsurance basis).

Companies were categorized by their reported distribution channel (four categories were used as described in Appendix A included below). There remain a significant number of companies for which no distribution channel was provided, as no responses to the annual surveys have been received from those companies. The characteristics of these companies vary significantly, including companies not currently writing new business or whose major line of business is not individual life insurance. Any advice or assistance from LATF in future

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<sup>1</sup> <https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf>

years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

Companies were excluded from the analysis if in either 2019 or 2020 (1) their actual to expected ratios were considered outliers, often due to low business volume, (2) the average first year and single premium per policy were more than \$40,000, (3) they are known reinsurance companies or (4) their data were not included in the data supplied by the NAIC. To derive the overall GRET factors, the unweighted average of the remaining companies’ actual-to-expected ratios for each respective category was calculated. The resulting factors were rounded, as shown in Table 1.

### THE RECOMMENDATION

The above methodology results in the proposed 2022 GRET values shown in Table 1. To facilitate comparisons, the current 2021 GRET factors are shown in Table 2. Further characteristics of the type of companies represented in each category are included in the last two columns in Table 1, including the average premium per policy issued and the average face amount (\$000s) per policy issued.

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In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2021 GRET were reviewed to ensure that a significant change was not made in this year's GRET recommendation.

The Independent, Niche Marketing and Other distribution channel categories experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed somewhat more than 10% because of rounding) from the corresponding 2021 GRET values. The volatility occurred due to incorrect NAIC data for 2018 for some companies, which caused their actual to expected ratios to be considered outliers and they were not included in the calculation. Over the next one to three years, the ten percent cap will allow this difference to be graded in so calculated GRET will be used for the final recommended GRET factors.

#### USAGE OF THE GRET

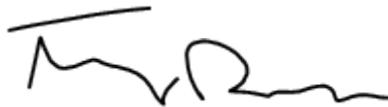
This year's survey, responded to by companies' Annual Statement correspondent, included a question regarding whether the 2021 GRET table was used in its illustrations by the company. Last year, 29% of the responders indicated their company used the GRET for sales illustration purposes, with similar percentage results by size of company; this contrasted with about 28% in 2019. This year, 31% of responding companies indicated that they used the GRET in 2020 for sales illustration purposes. The range was from 11% for Direct Marketing to 43% for independent. Based on the information received over the last several years, the variation in GRET usage appears to be in large part due to the relatively small sample size and different responders to the surveys.

We hope LATF finds this information helpful and sufficient for consideration of a potential update to the GRET. If you require further analysis or have questions, please contact Pete Miller at 847-706-3566.

Kindest personal regards,



Pete Miller, ASA, MAAA,  
Experience Study Actuary  
Society of Actuaries



Tony Phipps, FSA, MAAA  
Chair, SOA Committee on  
Life Insurance Company Expenses

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*Adopted by the Executive (EX) Committee and Plenary, Dec. 16, 2021*  
*Adopted by the Life Insurance and Annuities (A) Committee, Dec. 15, 2021*  
*Adopted by the Life Actuarial (A) Task Force, Dec.1, 2021*

## ACTUARIAL GUIDELINE XXV

### CALCULATION OF MINIMUM RESERVES AND MINIMUM NONFORFEITURE VALUES FOR POLICIES WITH GUARANTEED INCREASING DEATH BENEFITS BASED ON AN INDEX

#### A. Valuation - Text

For a policy where premiums are fixed in amount at issue which provides for whole life insurance with the amount of death benefit adjusted periodically with the Consumer Price Index or another cost of living index, the value of the minimum reserve at any time shall be based on the maximum valuation interest rate for the year of issue and an acceptable mortality table for life insurance statutory reserves and based on the death benefit and premium pattern adjusted as provided in the policy by reasonable annual increases based on the index. The present value of future benefits component shall be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit. If the policy provides for future premiums and such premiums are also adjusted periodically with the Consumer Price Index or another cost of living index, the present value of future premiums component shall likewise be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit. The assumption as to what is a reasonable annual increase in death benefits based on the index must not be less than the maximum valuation interest rate for the year of issue less:

1. 2.0% If the annual increase is limited to an annual and non-cumulative maximum of 0% through 5.0%
2. 1.5% If the annual increase is limited to an annual and cumulative maximum of 0% through 5.0%.
3. 1.5% If the annual increase is limited to an annual and non-cumulative maximum of 5.01% through 10.0%.
4. 1.25% If the annual increase is limited to an annual and cumulative maximum of 5.01% through 10.0%.
5. 1.0% For all other plans.

The term “annual and non-cumulative maximum” refers to a maximum where each annual increase is limited to the lower of the maximum or the increase in the index without carry forward of excess index increases.

The term “annual and cumulative maximum” refers to a maximum where each annual increase is limited to the lower of the maximum or the increase in the index with carry forward of excess index increases.

In no event shall the assumption as to an annual increase based on the index be less than 1.0%.

This guideline for valuation shall be effective immediately for policies issued on or after January 1, 1991.

#### B. Nonforfeiture – Text

The threshold amount shall be \$10,000 until December 31, 2009. For years beginning after December 31, 2009, the threshold amount for a calendar year shall be the product of \$10,000 and the ratio of 1) the index for June of the prior year to 2) 136.0 (the index as of June 30, 1991), rounded to the nearest \$25. If this calculation would result in an increase in the threshold amount of less than \$500, the unadjusted threshold amount from the prior year shall continue in effect for the next calendar year. In no calendar year shall the increase in threshold amount exceed 5% of the prior calendar year threshold amount.

The index used to determine the threshold amount for years beginning after December 31, 2009, shall be the Consumer Price Index for All Urban Consumers (CPI-U) as of June 30 of that year. If this index is no longer available, another index which, in the actuary’s opinion, reflects the change in general consumer prices for the year should be substituted.

I. FOR POLICIES WHERE ANY DEATH BENEFIT FOR ANY POLICY YEAR WOULD EXCEED THE THRESHOLD AMOUNT EVEN IN ABSENCE OF ANY ANNUAL INCREASES BASED ON THE INDEX

For a policy where premiums are fixed in amount at issue which provides for whole life insurance with the amount of death benefit adjusted periodically with the Consumer Price Index or another cost of living index, the value of the minimum nonforfeiture benefit at any time shall be based on the maximum nonforfeiture interest rate for the year of issue and an acceptable mortality table for life insurance nonforfeiture and based on the death benefit and premium pattern adjusted as provided in the policy by reasonable annual increases based on the index. The present value of future benefits component shall be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit. If the policy provides for future premiums and such premiums are also adjusted periodically with the Consumer Price Index or another cost of living index, the present value of future premiums component shall likewise be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit. The assumption as to what is a reasonable annual increase in death benefits based on the index must not be less than the maximum valuation interest rate for the year of issue less:

1. 2.0% If the annual increase is limited to an annual and non-cumulative maximum of 0% through 5.0%.
2. 1.5% If the annual increase is limited to an annual and cumulative maximum of 0% through 5.0%.
3. 1.5% If the annual increase is limited to an annual and non-cumulative maximum of 5.01% through 10.0%.
4. 1.25% If the annual increase is limited to an annual and cumulative maximum of 5.01% through 10.0%.
5. 1.0% For all other plans.

The term “annual and non-cumulative maximum” refers to a maximum where each annual increase is limited to the lower of the maximum or the increase in the index without carry forward of excess index increases.

The term “annual and cumulative maximum” refers to a maximum where each annual increase is limited to the lower of the maximum or the increase in the index with carry forward of excess index increases.

In no event shall the assumption as to an annual increase based on the index be less than 1.0%.

II. FOR POLICIES WHERE ANY DEATH BENEFIT FOR ANY POLICY YEAR WOULD NOT EXCEED THE THRESHOLD AMOUNT IN ABSENCE OF ANY ANNUAL INCREASES BASED ON THE INDEX

For a policy where premiums are fixed in amount at issue which provides for whole life insurance with the amount of death benefit adjusted periodically with the Consumer Price Index or another cost-of-living index, the unadjusted value of the minimum nonforfeiture benefit at any time shall be based on a level death benefit, an acceptable mortality table for life insurance nonforfeiture and a nonforfeiture interest rate equal to the greater of (a) and (b):

(a) The nonforfeiture interest rate defined in Section 3 of VM-02, Minimum Nonforfeiture Mortality and Interest, less:

1. 4.5% - 0 bp If the annual increase based on the index is limited to a maximum of 0% through 5.0%.
2. 4.25% - 25 bp If the annual increase based on the index is limited to a maximum of 5.01% through 10.0%.
3. 4.0% - 50 bp For all other plans.

(b) The Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under IRS Section 7702 (Life Insurance Contract Defined) of the U.S. Internal Revenue Code.

The present value of future benefits component shall be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit. If the policy provides for future premiums and such premiums are also adjusted periodically with the Consumer Price Index or another cost-of-living index, the present value of future premiums component shall likewise be further adjusted each year by the ratio of the then current amount of death benefit to the initially projected amount of death benefit.

For purposes of this guideline multiple policies on a single life shall be aggregated and only those policies aggregating not more than \$10,000 (or the threshold amount<sup>1</sup> after December 31, 2009), shall be considered under B.II.

This guideline for nonforfeiture shall be effective immediately for policies issued on or after January 1, 1991.

## BACKGROUND

A number of companies are marketing individual life insurance policies with guaranteed increasing death benefits tied into a consumer price index or another cost-of-living index and are for low initial amounts of insurance sold through funeral directors to provide for burial expenses. Some of the policies provide for graded death benefits such as the return of premium with or without interest for the early policy years or for a fixed scheduled increase in death benefits prior to the operation of the index. In some cases, there is a maximum on the increase for any year. The vast majority of such policies are single premium policies, but some are annual premium policies (generally limited payment). The annual premium may or may not be subject to adjustment with the index.

Since the changes in the index are not known at issue, but from past experience, increases within a given range can be expected with a high probability, it is necessary to assume some increases and then to continually adjust the present value of future benefits component and, if appropriate, the present value of future premiums component in the reserve and nonforfeiture calculation.

Theoretically the same assumed increases in the death benefits should be used for both valuation and nonforfeiture. This guideline so provides for policies where the amount of death benefit in any given policy year would exceed \$10,000 (or the threshold amount<sup>1</sup> after December 31, 2009), even if there were no increases based on the index. For practical purposes this may mean that such policies are not marketable for higher amounts as it is most likely that such policies will not qualify under the IRS Section 7702. The cash value accumulation test to qualify thereunder requires a minimum interest rate ~~of 4%~~ and an assumed level amount of death benefits.

In the case of policies for an initial amount of insurance of \$5,000 or less, the IRS rules provide an exception to the prohibition of assuming increasing death benefits. However, since many of the policies for very low amounts of initial face amount of insurance would require relatively high expenses if underwritten, many of the policies are issued with simplified underwriting or on a guaranteed issue basis with lower amounts of death benefits in the early policy years, some of the resulting annual increases are such as would disqualify many of the policies for the exception. Therefore, it is recommended that policies for low amounts of insurance be allowed to qualify under the cash value accumulation test by permitting the nonforfeiture values to be based on a level death benefit and ~~4% or higher interest~~ [an interest rate not less than the VM-02 nonforfeiture interest rate Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under IRS Section 7702](#) and requiring such values to be updated as increases based on the index take place. The amount in this guideline is set at \$10,000 (or the threshold amount<sup>1</sup> after December 31, 2009), to allow for future adjustments and for different patterns of benefits for low amounts.

For single premium policies, the value of nonforfeiture benefits based on a level death benefit and a net assumed nonforfeiture interest rate equal to the maximum nonforfeiture interest rate less an assumed increase based on the index and such factors then adjusted by the projected increases will approximate factors based on assumed increases and the maximum nonforfeiture interest rate. ~~However, the net interest rate is likely to be less than 4%. Thus, t~~ The procedure of assuming a level death benefit and a net assumed rate of not less than ~~4%~~ [the VM-02 nonforfeiture interest rate the Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under IRS Section 7702](#) for policies of low amounts of insurance is apt to produce lower cash values than the procedure for large amounts of insurance. Such lower values can be justified based upon the fact that the highly specialized market is prearranged funeral expenses for very small amounts of insurance per policy.

To emphasize the qualification with the IRS rules for the very low amounts of insurance, the nonforfeiture guideline for small amount policies is stated in terms of the net rate, a level death benefit and continual adjustment.

For solvency purposes, reserves should be conservative. The same rules apply for reserve regardless of the size of the policy. That is, lower reserves are not permitted for policies with very low amounts of insurance per policy.

Paragraph 5c(3) of the Model Standard Nonforfeiture Law states that unscheduled changes do not need to be taken into account until the time of the change. The changes guaranteed according to an index are a hybrid, i.e., the changes are scheduled but the amount of the change is not known until the index is determined. Thus, the changes must be recognized at issue. This guideline

is a hybrid with increases assumed at issue either explicitly or implicitly but with further adjustments made at the time the increase based on the index is determined.

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<sup>1</sup> In 2010, the actuarial guideline was modified to substitute a threshold amount for 10,000, such threshold being increased by the change in the CPI-U, the CPI for All Urban Consumers.

*Adopted by MCAS Blanks (D) Working Group, 5/26/2021*  
*Adopted by the Market Regulation and Consumer Affairs (D) Committee, 7/27/2021*  
*Adopted by Executive (EX) Committee and Plenary, 12/16/2021*

## Property & Casualty Market Conduct Annual Statement Travel Insurance Data Call & Definitions

**Line of Business:** Travel

**Reporting Period:** January 1, 2022 through December 31, 2022

**Filing Deadline:** April 30, 2023

### Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

### Schedule 1 – Interrogatories

ID	Description	Comment
1-01	Were there policies/certificates in force during the reporting period that provide travel insurance coverage?	Yes/No
1-02	Has the company had a significant event/business strategy that would affect data for this reporting period?	Yes/No
1-03	If yes, add additional comments	Comment
1-04	Has this block of business or part of this block of business been sold, closed or moved to another company during the reporting period?	Yes/No
1-05	If yes, add additional comments	Comment
1-06	How does the company treat subsequent supplemental or additional payments on previously closed claims?	Comment
1-07	Does the company use third party administrators (TPAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-08	If yes, provide the names and functions of each TPA.	Comment
1-09	Does the company use managing general agents (MGAs) for purposes of supporting the travel insurance business being reported?	Yes/No
1-10	If yes, provide the names and functions of each MGA.	Comment
1-11	Does the company use travel administrators for purposes of supporting the travel insurance business being reported?	Yes/No
1-12	If yes, provide the names and functions of each travel administrator.	Comment

1-13	Number of Travel Retailers offering and disseminating Travel Insurance on behalf of the Company at the end of the reporting period.	Comment
1-14	Additional state specific Claims comments (optional)	Comment
1-15	Additional state specific Lawsuit and Complaints comments (optional)	Comment
1-16	Additional state specific Underwriting comments (optional)	Comment

**Coverages**

<b>Trip Cancellation</b>
<b>Trip Interruption</b>
<b>Trip Delay</b>
<b>Baggage Loss/Delay</b>
<b>Emergency Medical/Dental</b>
<b>Emergency Transportation/Repatriation</b>
<b>Other</b>

**Other Breakouts:**

- 1) Each coverage listed is also broken out by Domestic vs. International coverage**
- 2) Emergency Medical/Dental coverage is also broken out by Primary vs. Excess/Secondary coverage**

**Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage**

Report the number of reserves/lines/features opened for each coverage part per claim.

ID	Description
2-17	Number of claims open at the beginning of the period
2-18	Number of claims opened during the period
2-19	Number of claims closed during the period, with payment
2-20	Number of claims closed during the period, without payment
2-21	Number of claims open at the end of the period
2-22	Median days to final payment
2-23	Number of claims closed with payment within 0-30 days
2-24	Number of claims closed with payment within 31-90 days
2-25	Number of claims closed with payment beyond 90 days
2-26	Number of claims closed without payment within 0-30 days
2-27	Number of claims closed without payment within 31-90 days
2-28	Number of claims closed without payment beyond 90 days
2-29	Dollar amount of claims closed with payment

### Schedule 3 – Lawsuits and Complaints

ID	Description
3-30	Number of lawsuits open at the beginning of the period
3-31	Number of lawsuits opened during the period
3-32	Number of lawsuits closed during the period
3-33	Number of lawsuits open at the end of the period
3-34	Number of lawsuits closed with consideration for the consumer
3-35	Number of complaints received directly from the DOI
3-36	Number of complaints received directly from any person or entity other than the DOI

### Schedule 4 – Underwriting

ID	Description
4-37	Number of individual policies in force at the beginning of the period
4-38	Number of group policies (other than blanket policies) in force at the beginning of the period
4-39	Number of blanket policies in force at the beginning of the period
4-40	Number of individuals insured under all policies at the beginning of the period
4-41	Number of individual policies and certificates from group policies cancelled by the consumer during the period
4-42	Number of individual policies and certificates from group policies expired during the period
4-43	Number of individual policies and certificates from group policies in force at end of the period
4-44	Dollar amount of direct premium written during the period for individual policies
4-45	Dollar amount of direct premium written during the period for group policies (other than blanket)
4-46	Dollar amount of direct premium written during the period for blanket policies

In determining what business to report for a particular jurisdiction, unless otherwise indicated in these instructions, all companies should follow the same methodology/definitions used to file the Financial Annual Statement (FAS) and its corresponding state pages. Specifically, the business to be reported is the direct business of the reporting company. Reinsurance ceded is not deducted and reinsurance assumed is not included.

**Participation Requirements:** All companies licensed and reporting any travel insurance within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

## **Definitions:**

**Travel Insurance** means insurance coverage for personal risks incident to planned travel.

Include:

- Interruption or cancellation of trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident, disability or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or
- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Exclude:

- major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

**Blanket Travel Insurance** means a policy of Travel Insurance issued to any Eligible Group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the Eligible Group without a separate charge to individual members of the Eligible Group.

## **Coverages**

For the following terms, the NAIC asks that the insurer use definitions that meet industry standards. To the extent the insurer's definitions differ from industry standards, the NAIC asks that the insurer provide those definitions.

**Trip Cancellation**  
**Trip Interruption**  
**Trip Delay**  
**Baggage Loss/Delay**  
**Emergency Medical / Dental**  
**Emergency Transportation/Repatriation**  
**Primary Coverage**  
**Excess/Secondary Coverage**

**Cancellations** – Includes all cancellations of the policies/certificates where the cancellation was executed during the reporting year regardless of the date of placement of the coverage.

**Claim** – A request or demand for payment of a loss that may be included within the terms of coverage of an insurance policy/certificate. Each claimant/insured reporting a loss is counted separately.

Exclude:

- An event reported for "information only."
- An inquiry of coverage if a claim has not actually been presented (opened) for payment.
- A potential claimant if that individual has not made a claim nor had a claim made on his or her behalf.

**Claims Closed With Payment** – Claims closed with payment where the claim was closed during the reporting period regardless of the date of loss or when the claim was received. The number of days to closure, however, should be measured as the difference between the date of the final payment and the date the claim was reported or between the date of the final payment and the date the request for supplemental payment was received. *See also "Date of Final Payment."*

Exclude:

- Claims where payment was made for company loss adjustment expenses if no payment was made to an insured/claimant.
- Claims that are closed because the amount claimed is below the insured's deductible.

Clarifications:

- If a claim is reopened for the sole purpose of refunding the insured's deductible, do not count it as a paid claim.
- For claims where the net payment is \$0 due to subrogation recoveries, report the number of claims in which any amount was paid to the insured; do not net the payment with subrogation recoveries when counting the number of paid claims.

Calculation Clarification:

- For each coverage identifier, the sum of the claims settled with payment across each closing time interval should equal the total number of claims closed with payment during the reporting period.

Handling additional payment on previously reported claim/subsequent supplemental payment for claims closed with payment during the reporting period:

- If a claim is reopened for a subsequent supplemental payment, count the reopened claim as a new claim. Calculate a separate aging on the supplemental payment from the time the request for supplemental payment was received to the date the final payment was made.

**Claims Closed Without Payment** – Claims closed with no payment made to an insured or third party. The number of days to closure is the difference between the date the claim was closed and the date the claim was reported and/or reopened. *See also "Date of Final Payment."*

Include:

- All claims that were closed during the reporting period regardless of the date of loss or when the claim was received.
- Claims where no payment was made to an insured/claimant even though payment was made for company loss adjustment expenses.
- A demand for payment for which it was determined that no relevant policy/certificate was in-force at the time of the loss if a claim file was set up and the loss was investigated.
- Claims that are closed because the amount claimed is below the insured's deductible.
- Claims closed because primary coverage was available elsewhere.

**Complaints Received Directly from any Person or Entity Other than the Department of Insurance** – any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the jurisdiction's insurance laws. An oral communication, which is subsequently converted to a written form in order to be analyzed and acted upon, will meet the definition of a complaint for this purpose.

Include:

- Any complaint regardless of the subject of the complaint (claims, underwriting, marketing, etc.)
- Complaints received from third parties

**Complaints Received Directly from the Department of Insurance** – All complaints:

- As identified by the DOI as a complaint.
- Sent or otherwise forwarded by the DOI to the reporting company.

**Date of Final Payment** – The date final payment was issued to the insured/claimant.

Calculation Clarification:

- If partial payments were made on the claim, the claim would be considered closed with payment if the final payment was made during the reporting period regardless of the date of loss or when the claim was received.
- Report a claim as "closed with payment" or "closed without payment" if it is closed in the company's claims system during the reporting period (even if the final payment was issued in a prior reporting period.)
- If a claim remains open at the end of the reporting period (even though a final payment has been issued) it should be reported as open. Only when the claim is closed in the company's claims system, would you report the days to final payment.

Example:

- A claim is open on 11/1/00 and final payment is made on 12/1/00. The claim is left open until 2/1/01 to allow time for supplemental requests.
  - The claim would be reported as open in the "00" MCAS submission and closed in the "01" MCAS submission.
  - The number of days to final payment would be calculated as 30 days and

reported in the "01" MCAS submission.

**Date the Claim was Reported** – The date an insured or claimant first reported his or her claim to either the company or insurance agent.

**Domestic Coverage:** Coverage for travel originating and contained within the United States including travel directly to and from mainland United States to Hawaii, Alaska and United States territories.

**Group Travel Insurance** means Travel Insurance issued to any Eligible Group as defined by state law.

**International Coverage:** Coverage for any travel other than Domestic.

**Premium Written During Period** – The total premium written before any reductions for refunds for travel insurance during the reporting period.

**In-force** – A master policy, individual policy, or certificate in effect during the reporting period.

**Lawsuit** – An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits in the Travel MCAS blank:

- Include only lawsuits brought by an applicant for insurance or a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies, count the number of policies involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each jurisdiction in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

**Lawsuits Closed During the Period with Consideration for the Consumer** – A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant or policyholder in

an amount greater than offered by the reporting company before the lawsuit was brought.

**Median Days to Final Payment** – The median value for all claims closed with payment during the period.

Calculation for losses with one final payment date during the reporting period:

- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:

- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:

- Subrogation payments.

Calculation Clarification / Example:

- To determine the Median Days to Final Payment you must first determine the number of days it took to settle each claim. This is the difference between the date the loss was reported to the company, or the date the request for supplemental payment was received, to the date of final payment. The Median Days to Final Payment is the median value of the number of days it took to settle all claims closed with payment during the period.

**Median** - A median is the middle value in a distribution arranged in numerical order (either lowest to highest or highest to lowest). If the distribution contains an odd number of elements, the median is the value above and below which lie an equal number of values. If the distribution contains an even number of elements, the median is the average of the two middle values. It is not the arithmetic mean (average) of all of the values.

Consider the following simple example of the number of days it took to settle each of the following seven claims:

	<b>Nbr 1</b>	<b>Nbr 2</b>	<b>Nbr 3</b>	<b>Nbr 4</b>	<b>Nbr 5</b>	<b>Nbr 6</b>	<b>Nbr 7</b>
<b>Days to Settle</b>	2	4	4	5	6	8	20

In this situation, the Median Days to Final Payment would be 5 because it is the middle value. There are exactly 3 values below the median (2, 4, & 4) and 3 values above the median (6, 8, & 20). If the data set had included an even number of values, then the median would be the average of the two middle values as demonstrated below.

	<b>Nbr 1</b>	<b>Nbr 2</b>	<b>Nbr 3</b>	<b>Nbr 4</b>	<b>Nbr 5</b>	<b>Nbr 6</b>
<b>Days to Settle</b>	2	4	5	6	8	20

$$\text{Median Days to Final Payment} = (5 + 6)/2 = 5.5$$

**The median should be consistent with the paid claim counts reported in the closing time intervals.**

Example: A carrier reports the following closing times for paid claims.

**Closing Time # of Claims**

< 30	22
31-60	13
61-90	18
91-180	11
181-365	12
>365	15

The sum of the claims reported across each closing time interval is 91, so that the median is the 46<sup>th</sup> claim. This claim falls into the closing time interval "61-90 days." Any reported median that falls outside of this range (i.e. less than 61 or greater than 90) will indicate a data error.

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

**NAIC Group Code** – The code assigned by the NAIC to identify those companies that are a part of a given holding company structure. A zero indicates that the company is not part of a holding company.

**Travel Retailer** means a business entity that makes, arranges or offers planned travel and may offer and disseminate Travel Insurance as a service to its customers on behalf of and under the direction of a Limited Lines Travel Insurance Producer.

*Adopted by MCAS Blanks (D) Working Group, 5/26/2021*

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, 7/27/2021*

*Adopted by Executive (EX) Committee and Plenary, 12/16/2021*

## **Short-Term Limited Duration Insurance Market Conduct Annual Statement Data Call & Definitions**

**Line of Business:** Short-Term Limited Duration Insurance

**Reporting Period:** January 1, 2022 through December 31, 2022

**Filing Deadline:** June 30, 2023

### **Contact Information**

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

### **Schedule 1 - Interrogatories**

1-01	List the states where your STLDI products are marketed	Comment
1-02	Does the company offer STLDI policies/certificates with up to a 90-day duration?	Yes/No
1-03	Does the company offer STLDI policies/certificates with 91- to 180-day duration?	Yes/No
1-04	Does the company offer STLDI policies/certificates with 181- to 364-day duration?	Yes/No
1-05	Number of STLDI forms offered to residents in this state	Comment
1-06	Number of STLDI forms offered in all states	Comment
1-07	Number of STLDI forms filed in this state	Comment
1-08	Number of STLDI forms filed in all states	Comment
1-09	List the states where your STLDI products are filed (provide SERFF tracking number and form number, if applicable). If a company issues the product in a state that does not require a filing, please identify the product and describe the basis for not filing	Comment
1-10	How many policy forms have waiting periods that apply to the entire policy/certificate?	Number
1-11	How many policy forms have waiting periods that apply per specific benefits?	Number
1-12	Do any waiting periods exceed the policy/certificate term?	Y/N
1-13	If the answer to #12 is yes, please explain	Comment
1-14	Does the company issue STLDI products through associations? If yes, list the associations	Yes/No

1-15	If #14 is yes, list the associations	Comment
1-16	If #14 is yes, do you have a contractual relationship with each Association?	Yes/No
1-17	If #14 is yes, does the contract cover the marketing of your product?	Yes/No
1-18	If #14 is yes, does the contract cover the collection of dues and fees?	Yes/No
1-19	If #14 is yes, does the contract cover commissions?	Yes/No
1-20	If #14 is yes, what other operational areas are covered in the contract?	Comment
1-21	Does the company issue STLDI products through trusts?	Yes/No
1-22	If #21 is yes, how many?	Comment
1-23	Does the company issue STLDI products through administrators?	Yes/No
1-24	If #23 is yes, how many?	
1-25	Does the company contract with third-party administrators for administrative services related to STLDI products?	Comment
1-26	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-27	If yes, does your delegation structure include claims related to STLDI products?	Yes/No
1-28	If yes, does your delegation structure include complaints related to STLDI products?	Yes/No
1-29	If yes, does your delegation structure include medical underwriting related to STLDI products?	Yes/No
1-30	If yes, does your delegation structure include pricing related to STLDI products?	Yes/No
1-31	If yes, does your delegation structure include producer appointments related to STLDI products?	Yes/No
1-32	If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLDI products?	Yes/No
1-33	Does your company audit Third parties to whom you have delegated responsibilities?	Yes/No
1-34	If # 33 is yes, please provide frequency of audits	Comment
1-35	Does the company offer renewals/reissues?	Yes/No
1-36	Are any renewals/reissues subject to optional or mandatory underwriting?	Yes/No
1-37	If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue	Comment
1-38	Are there limitations on the number renewals per individual?	Yes/No
1-39	Does your company offer renewal(s) without underwriting for an additional charge?	Yes/No
1-40	If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge	Comment
1-41	Are the limitations on renewals based on state, federal, or company rules?	Yes/No
1-42	Does your company distribute its product through independent agents?	Yes/No
1-43	Does your company distribute its products through captive agents?	Yes/No
1-44	Does your company distribute its products through its employees?	Yes/No
1-45	What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)	Comment

1-46	Additional State Specific Comments (optional)	Comment
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**Products**

<b>Product Identifiers</b>	<b>Explanation of Product Identifiers</b>
<b>STLDI &lt;=90</b>	<b>Short-Term Limited Duration Insurance not sold through an Association with a term less than or equal to 90 days</b>
<b>STLDI &lt; 180</b>	<b>Short-Term Limited Duration Insurance not sold through an Association with a term greater than 90 and less than or equal to 180 days</b>
<b>STLDI 181 - 364</b>	<b>Short-Term Limited Duration Insurance not sold through an Association with a term greater than 180 days and less than 364 days</b>
<b>STLDI Not Sitused &lt;=90</b>	<b>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term less than or equal to 90 days</b>
<b>STLDI Not Sitused &lt; 180</b>	<b>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 90 and less than or equal to 180 days</b>
<b>STLDI Not Sitused 181 - 364</b>	<b>Short-Term Limited Duration Insurance sold through an Association not sitused in this state with a term greater than 180 days and less than 364 days</b>
<b>STLDI Sitused &lt;=90</b>	<b>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term less than or equal to 90 days</b>
<b>STLDI Sitused &lt; 180</b>	<b>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 90 and less than or equal to 180 days</b>
<b>STLDI Sitused &gt;181 - 364</b>	<b>Short-Term Limited Duration Insurance sold through an Association sitused in this state with a term greater than 180 days and less than 364 days</b>

**Schedule 2 – Policy/Certificate Administration**

2-1	Net Written Premium
2-2	Earned premiums for Reporting Year
2-3	Number of Policies/Certificates in Force at the Beginning of the Period
2-4	Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period
2-5	Number of new policy/certificate applications received during the period
2-6	Number of new policy/certificates issued during the period

2-7	Number of new policies/certificates denied during the period
2-8	Number of Covered Lives on New Policies/Certificates Issued During the Period
2-9	Member months for policies/certificates newly issued during the period
2-10	Number of policy/certificate renewal/reissue applications received during the period
2-11	Number of policies/certificates renewed/reissued during the period
2-12	Number of policies/certificates non-renewed or denied at the option of insurer during the period
2-13	Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period
2-14	Number of renewals/reissues allowed?
2-15	Member months for policies/certificates renewed/reissued during the period
2-16	Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting
2-17	Number of Member Months of on Other Than New Policies/Certificates or Renewal/Reissued Policies/Certificates During the Period
2-18	Number of policy/certificate terminations and cancellations initiated by the policyholder/certificateholder
2-19	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Period
2-20	Number of policies/certificates cancelled during the free look period
2-21	Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-22	Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period
2-23	Number of policy/certificate terminations and cancellations due to non-payment of premium
2-24	Number of Lives on Policies/Certificates Cancelled Due to Non-Payment of Premium During the Period
2-25	Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period
2-26	Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-27	Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period
2-28	Number of rescissions
2-29	Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder
2-30	Number of insured lives impacted on terminations and cancellations due to nonpayment
2-31	Number of insured lives impacted by rescissions
2-32	Number of Policies/Certificates in Force at the End of the Period
2-33	Number of Covered Lives on Policies/Certificates in Force at the End of the Period

**Schedule 3 – Prior Authorizations**

3-1	Number of Prior Authorization Requests Pending at the Beginning of the Period
3-2	Number of prior authorizations requested during period
3-3	Number of prior authorizations approved during period
3-4	Number of prior authorizations denied during period
3-5	Number of claims where prior authorization penalties were assessed
3-6	Number of Prior Authorization Requests Pending at the End of the Period
3-7	Median Number of Days from Receipt of Prior Authorization Request to Decision
3-8	Average Number of Days from Receipt of Prior Authorization to Decision

**Schedule 4 – Claims Administration (Including Pharmacy)**

4-1	Number of Claims Pending at the Beginning of the Period
4-2	Number of claims received
4-3	Total number of claims denied, rejected or returned
4-4	Number of denied, rejected, or returned due to claims submission coding error(s)
4-5	Number of denied, rejected, or returned for lack of Prior Authorization
4-6	Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation
4-7	Number of denied, rejected, or returned as Not medically necessary
4-8	Number of denied, rejected, or returned as Subject to pre-existing condition exclusion
4-9	Number denied, rejected, or returned due to failure to provide adequate documentation
4-10	Number denied, rejected, or returned due to being within the waiting period
4-11	Number of denied, rejected, or returned (in whole or in part) because maximum \$ limit exceeded
4-12	Number of denied, rejected, or returned for Out-of-Network provider
4-13	Number of Claims Pending at End of Period
4-14	Median Number of Days from Receipt of Claim to Decision for Denied Claims
4-15	Average Number of Days from Receipt of Claim to Decision for Denied Claims
4-16	Median Number of Days from Receipt of Claim to Decision for Approved Claims
4-17	Average Number of Days from Receipt of Claim to Decision for Approved Claims
4-18	Number of Claim Decisions Appeals Pending At Beginning of Period
4-19	Number of Claim Decision Appeals Received During the Period
4-20	Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period
4-21	Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period
4-22	Number of Claim Decision Appeals Rejected and Not Considered for Any Reason

4-23	Number of Claim Decision Appeals Pending at End of Period
4-24	Average Number of Days from Receipt of Appeal to Decision
4-25	Number of claims paid

**Schedule 5 – Consumer Complaints and Lawsuits**

5-1	Number of complaints received by Company (other than through the DOI)
5-2	Number of complaints received through DOI
5-3	Number of complaints resulting in claims reprocessing
5-4	Number of Lawsuits Open at Beginning of the Period
5-5	Number of Lawsuits Opened During the Period
5-6	Number of Lawsuits Closed During the Period
5-7	Number of Lawsuits Closed During the Period with Consideration for the Consumer
5-8	Number of Lawsuits Open at End of Period

**Schedule 6 – Marketing and Sales**

6-1	Number of Individual Applications Pending at the Beginning of the Period
6-2	Number of applications received
6-3	Number of Renewal/Reissue Individual Applications Received During the Period
6-4	Number of New Individual Applications Denied During the Period for Any Reason
6-5	Number of New Individual Applications Denied During the Period - Health Status or Condition
6-6	Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason
6-7	Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition
6-8	Number of New Individual Applications Approved During the Period
6-9	Number of Renewal/Reissue Individual Applications Approved During the Period
6-10	Number of Individual Applications Pending at the End of the Period
6-11	Number of applications initiated via phone
6-12	Number of applications completed via phone
6-13	Number of applications initiated face-to-face
6-14	Number of applications completed face-to-face
6-15	Number of applications initiated online (Electronically)
6-16	Number of applications completed online (Electronically)
6-17	Number of New Individual Applications initiated by Mail During the Period
6-18	Number of New Individual Applications completed by Mail During the Period
6-19	Number of New Individual Applications initiated by Any Other Method During the Period

6-20	Number of New Individual Applications completed by Any Other Method During the Period
6-21	Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)
6-22	Unearned Commissions returned to company on policies/certificates sold during the period?
6-23	Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)

**Participation Requirements:** All companies licensed and reporting at least \$50,000 of Short-Term Limited Duration Insurance (STLDI) premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

**Report by Residency:** This MCAS blank is designed to collect data from the perspective of individual insureds in each state that the form is marketed in. When reporting for forms issued to discretionary groups, associations, or trusts – data should be provided on each state of residence of the insureds, rather than only where the discretionary group, association or trust is situated.

## **General Definitions:**

**Short-Term Limited-Duration Insurance** - Health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract. (state and federal government guidelines may have renewal duration limitations)

**Association** – For purposes of this MCAS blank, a non-employer group that secures benefits for its members.

**Individual STLDI Product** – Policies marketed, sold, and issued to individual consumers, regardless of whether or not the policy forms have been filed with any State’s department of insurance. An individual STLDI policy is **not** issued to a trust, association, or administrator.

**Group STLDI Product/Coverage** - Policies issued to a trust, association, or administrator for the purpose of marketing, selling, and issuing certificates to individual consumers, regardless of whether or not the policy forms have been filed with any State’s department of insurance and regardless of where the association, trust, or administrator is situated.

**New Policies/Certificates Issued** - STLDI policy/certificate issued to an individual or family for whom no prior short-term coverage has been placed with the same insurer within the previous 63 days

**Policies / Certificates** - Refers to the coverage documents provided to individuals or families (i.e., state residents) who are enrolled in coverage (not the association)

**Policyholder / Certificateholder** – Refers to the individual who is afforded benefits of the coverage according to the laws of the state in which they reside (i.e., not the association). Policyholder is the individual when purchased in the individual market. Certificateholder is the individual when purchased through an Association, which is the policyholder.

**Renewal / Reissue** - STLDI policy/certificate issued to an individual or family for whom prior short-term coverage has been placed with the same insurer within 63 days of the prior coverage. If a policy is re-underwritten based on health factors or provides different benefits, it should be reported as a new policy/certificate issued.

## **Schedule 2 Definitions (Policy/Certificate Administration):**

**Rescission** – A rescission is a cancellation or discontinuance of coverage that is retroactive to the issue date. (Does not include cancellations for non-payment.)

**Written Premium** - Provide the total annual written premium for all policies and/or certificates issued to insureds residing in the state for which reporting is being completed

**Earned Premium** – Total premium earned from all policies/certificates written by the insurer during the specified period.

**Free Look** – A set number of days provided in an insurance policy/certificate that allows time for the purchaser to review the contract provisions with the right to return the policy/certificate for a full refund of all premium paid. Report the number of policies/certificates that were returned by the insured under the free look provision during the period, regardless of the original issuance date.

**Member months**– The *sum* of total number of lives insured on policies/certificates issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

### **Schedule 3 and 4 Definitions (Prior Authorization and Claims Administration):**

**Prior Authorization** – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification, this includes any provision requiring the insured to notify the company prior to treatment.

**Claim** – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

**Claims Received** - provide the total number of claims received during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed

**Claims Denied** - provide the total number of claims denied during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed; includes rejected and returned claims, whether in whole or in part

Clarification:

- The nine claim denial reporting categories are not exhaustive. Claim denials reported in the categories should be a subset of the reported total denials.

**Claims Paid** - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificateholders residing in the state for which reporting is being completed.

**Waiting Period:** Period of time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

**Schedules 5 Definitions (Consumer Requested Reviews/Grievance/Complaints):**

**Lawsuit**—An action brought in a court of law in which one party, the plaintiff, claims to have incurred a loss as a result of the action of another party, the defendant.

For purposes of reporting lawsuits for Short-Term Limited Duration Insurance products:

- Include only lawsuits brought by an applicant for insurance, a policyholder or a claimant/beneficiary as a plaintiff against the reporting insurer or its agent as a defendant;
- Include all lawsuits, whether or not a hearing or proceeding before the court occurred;
- Do not include arbitrations of any sort;
- If one lawsuit seeks damages under two or more policies or contracts, count the number of policies or contracts involved as the number of lawsuits. For example, if one lawsuit seeks damages under three policies or contracts, count the action as three lawsuits;
- If one lawsuit has two or more complainants, report the number of complainants as the number of lawsuits. For example, if one lawsuit has two complainants, report two lawsuits. If the lawsuit is a class action, see instructions for treatment of class action lawsuits;
- Report a lawsuit in the jurisdiction in which the policy was issued with the exception of class action lawsuits;
- Treatment of class action lawsuits: Report the opening and closing of a class action lawsuit once in each state in which a potential class member resides. Include an explanatory note with your submission stating the number of class action lawsuits included in the data and the general cause of action.

**Lawsuits Closed During the Period with Consideration for the Consumer**—A lawsuit closed during the reporting period in which a court order, jury verdict, or settlement resulted in payment, benefits, or other thing of value, i.e., consideration, to the applicant, policyholder, or beneficiary in an amount greater than offered by the reporting insurer before the lawsuit was brought.

**Schedule 6 Definitions (Marketing and Sales)**

**Commissions** - The total amount of compensation paid to any individual or entity for their consideration in marketing, selling, and attracting potential insureds, by whatever means this compensation is provided. Do not include monetary valuables paid to any individual or entity that is generally not able to be converted into actual money. NOTE: For products *not* related to the actual sale of a contract, do not include any amounts paid for the specific purpose of marketing, encouraging or promoting.

**Other Remuneration** - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.

*Adopted by MIS R&D (D) Working Group, 3/10/2021*

*Adopted by the MIS (D) Task Force, 7/27/2021*

*Adopted by the Market Regulation and Consumer Affairs (D) Committee, 8/16/2021*

*Adopted by Executive (EX) Committee and Plenary, 12/16/2021*

## Regulatory Information Retrieval System (RIRS) Proposed Coding Structure Changes

### Overview

Outlined below are the Market Information Systems Research and Development (D) Working Group proposed revisions to the Regulatory Information Retrieval System (RIRS) coding structure. These revisions address the serious deficiencies of the current coding structure. They are designed to render greater coherency to the data structure and make the system more compatible with other market information systems.

In brief, this proposal consists of:

- 1) New Record Type field to distinguish routine administrative actions from actions that are a result of an infraction or financial impairment. This distinction is important for market analysis purposes.
- 2) New Modification Indicator field to link related RIRS records. Some RIRS records represent a termination, modification, or extension of a previous RIRS record. This new field can be used to eliminate duplicate records when counting unique actions.
- 3) New Line of Business field to reflect infractions that arise out of activity specific to a line of business.
- 4) Significant Revisions to the Origin of Action, Reason for Action, and Disposition for Action codes to provide a more logical overall data structure.

### Record Type (New)

Code	Code Name	Definition	Code Status	Notes
XXX	Financial Impairment	Action was taken by the state regulatory authority with respect to the financial condition of an insurer or other regulated entity.	New	
XXX	Violation	Action was taken regarding a violation of statute or regulation. Excludes routine or administrative actions that do not involve such a violation.	New	
XXX	Administrative Action Only (no violation)	A formal action taken by the state regulatory authority in which no violation of statute or regulation has occurred related to the action. Could include such actions as rate filing review or transfer from a state's wind pool.	New	
XXX	Other	Any formal action that is not adequately described by any of the above three record types.	New	

### Modification Indicator (New)

Code	Code Name	Definition	Code Status	Notes
Y	Yes	Action is a Modification to Existing RIRS Record	New	If Yes, provide previous RIRS identifier in new field
N	No	Action is Not a Modification to Existing RIRS Record	New	

### Line of Business (New)

Code	Code Name	Definition	Code Status	Notes
XXX	Accident and Health - Group	Corresponds to financial annual statement	New	
XXX	Accident and Health - Individual	Corresponds to financial annual statement	New	
XXX	Annuity – Group	Corresponds to financial annual statement	New	
XXX	Annuity – Individual	Corresponds to financial annual statement	New	
XXX	Auto – Commercial	Corresponds to financial annual statement	New	
XXX	Auto – Private Passenger	Corresponds to financial annual statement	New	
XXX	Bail Bonds	Corresponds to financial annual statement	New	
XXX	Commercial Liability	Corresponds to financial annual statement	New	
XXX	Commercial Property	Corresponds to financial annual statement	New	
XXX	Credit	Corresponds to financial annual statement	New	
XXX	Fidelity and Surety	Corresponds to financial annual statement	New	
XXX	Homeowner	Corresponds to financial annual statement	New	
XXX	Life - Group	Corresponds to financial annual statement	New	
XXX	Life - Individual	Corresponds to financial annual statement	New	
XXX	Long Term Care	Corresponds to financial annual statement	New	
XXX	Medical Malpractice	Corresponds to financial annual statement	New	
XXX	Medicare Supplement	Corresponds to financial annual statement	New	
XXX	Title	Corresponds to financial annual statement	New	
XXX	Workers Compensation	Corresponds to financial annual statement	New	
XXX	None	Corresponds to financial annual statement	New	
XXX	Other	Corresponds to financial annual statement	New	

### Origin of Action (Revised)

The Origin of Action field is meant to provide information about the origin (source) of the regulatory action. The code(s) used should be reflective of the source of information or activity that resulted in the regulatory action. Information about the reason (allegations) and/or disposition (outcome) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
1002	FINRA	Reporting by a state insurance department of an action taken by FINRA associated with a domicile or resident entity or individual subject to the jurisdiction of said state insurance department.	Keep	
1003	Market Analysis	Action resulting from market analysis, including but not limited to actions resulting from Baseline, Level 1, or Level 2 market analysis reviews.	Keep	
1005	Complaint Investigation	Action resulting from an investigation of one or more complaints against the entity or individual.	Keep	
1007	Field Investigation	Action resulting from a regulatory investigation and verification of circumstances through direct communication with an entity or individual. These investigations often involve on-site work and would include investigations completed by those in fraud and/or investigation units of the department.	Keep	
1008	Public Inquiry	Concern resulting from close examination of a matter to determine information or truth provided by an outside party (other than the Insurance Department, insurer, or producer).	Delete	Used by 12 states, 17 times. Proposed alternative: (1055) "Third Party Information"
1010	Routine Dept. Action	Action resulting from recurring insurance	Keep	May also consider Code 1020

Code	Code Name	Definition	Code Status	Notes
		departmental activity not triggered by a regulatory issue contemplated in other origin codes. Examples of actions included in this code include, but are not limited to, instances where the entity fails to file a report timely.		
1013	Financial	Action resulting from activity associated with or related to financial aspects of the entity, including, but not be limited to, actions taken as result of financial filings (e.g., Risk Based Capital (RBC) filings), financially hazardous conditions, suspensions, rehabilitation, liquidations, mergers, domestications, etc.	Keep	
1015	Information/Action by Other State(s)	Action resulting from information or an action taken against the Entity or individual by another state's Department of Insurance or other state agency.	Code Name Change	Previous Code Name "Other States Action"
1016	Annual Statement Filing	Action resulting from the review of an insurers financial annual statement or market conduct annual statement.	Code Name Change	Previous Code Name "Annual Statement"
1018	Information/Referral from Another State Agency	Action resulting from information or referral from another state agency within the entering state.	Keep	
1020	Insurer Report	Action taken as the result of any type of report filed with the Department of Insurance not explicitly contemplated by another origin code. This would include, but not be limited to Statistical Filings and other state mandated filings.	Keep	May also consider Code 1010
1023	Statistical Filing	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Delete	Used by 10 states, 59 times. Proposed alternative: (1020) "Insurer Report"
1025	Legal	Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.	Keep	
1030	Market Conduct Exam	Action resulting from a market conduct examination, including but not limited actions resulting from targeted, comprehensive, or desk examinations.	Keep	
1035	Financial Exam	Action resulting from a financial examination of a regulated entity, including but not limited to actions taken because of routine examinations and premium tax audits.	Keep	
1040	Workers Comp Exam	Concern resulting from examination of a workers compensation insurer's business practices and operations in order to determine its compliance with state insurance laws and regulations.	Delete	Used by 3 states, 7 times. Proposed alternatives: (1030) "Market Conduct Exam", (1035) "Financial Exam", or both
1045	Combined Exam	Concern resulting from a combined Financial and Market Conduct Examination.	Delete	Used by 7 states, 43 times. Proposed alternative: (1030) "Market Conduct Exam" and (1035) "Financial Exam"
1050	Bankruptcy Notices	Concern resulting from a notice that an insurer or producer has filed for legal insolvency, indicating that the insurer is unable to meet financial obligations to customers and stockholders, or that a producer or agency has financial issues that may impact compliance with state insurance laws and regulations.	Delete	Used by 5 states, 6 times. Proposed alternative: (1025) "Legal"

Code	Code Name	Definition	Code Status	Notes
1055	Third Party Information	Action resulting from information obtained from an outside source that is not explicitly contemplated by another origin code. This would include, but not be limited to actions resulting from information contained in media coverage and other sources of public information.	Keep	
1060	Licensing / Company Administration	Action resulting from a regulated entity's licensing status. This would include but not be limited to actions resulting from the submission of applications by the regulatory entity, failure of the entity to provide information in response to an application.	Code Name Change	Previous Code Name "Licensing Administration"
1063	Background Check	Action resulting from the review of a background check of a producer or employee of a regulated entity. This would include but not be limited to actions stemming from a review of criminal, financial, or disciplinary events regardless of the source that are not explicitly contemplated by another origin code.	Keep	
1065	Other*	Action taken that was prompted by information, an activity or event not contemplated by another origin code.	Code Name Change	Previous Code Name "Other if checked you must enter description, up to 100 characters"
XXXX	Form/Rate/Rule Filing	Action taken as a result of a review/analysis of a regulated entity's policy form, rate, and/or rule filing. This would include a review/analysis of underwriting guidelines where such filings are required to be made.	New	
XXXX	Information/Referral from Federal Agency	Action resulting from information or referral from a Federal agency.	New	
XXXX	Market Conduct Initiative	Action resulting from a market conduct initiative along the continuum of regulatory responses, including but not limited actions resulting from interrogatories, targeted information gathering (i.e. surveys, data calls, etc.), and policy & procedure reviews.	New	
XXXX	Multi-state Regulatory Action/Settlement	Action resulting from a multi-state regulatory action and/or settlement of a regulated entity. This would include, but not be limited to, actions resulting from a multi-state examination, settlement or other coordinated activity along the continuum or regulatory responses.	New	
XXXX	Prior Dept. Action	An action taken as the direct result of a prior action taken against the entity or individual. This would include but not be limited to failure to comply with a previous order, lifting of prior orders, suspensions, or restrictions.	New	
XXXX	Self-reported Information	Action taken as the result of information voluntarily reported by the entity or individual.	New	

\*If checked, you must enter a description of up to 100 characters.

## Reason for Action (Revised)

The Reason for Action field is meant to provide information about the reason (allegations) for the regulatory action. The code(s) used

should be reflective of allegations associated with the action (i.e. the nature of the violation found). Information about the origin (source) and/or disposition (outcome) of the action should be reported in those respective fields. (max 20)

### Claims

Code	Code Name	Definition	Code Status	Notes
2015	Claim Handling	Finding of cause resulting from the process of dealing with demands for payment of contract/policy benefits by the insured or the insured's beneficiary or representative.	Delete	Proposed alternative: use new, more specific code(s) related to claim handling issues
XXXX	Claim Denials Due to Improper Rescission	Improper rescission of a policy subsequent to the presentation of a claim.	New	
XXXX	Failure to Pay Mandated Coverages	Improper denial or reduction of coverages that are mandated by statute or regulation.	New	
XXXX	Failure to Provide Appropriate Claims Materials or Other Reasonable Assistance	Failure to provide required claim forms, notifications of coverage, coinsurance, deductibles, or other items necessary to properly process a claim.	New	
XXXX	Failure to Resolve Timely / Prompt Pay	Failure to resolve and if appropriate pay claims within statutory timeframes. This would include failure to comply with 'prompt pay' statutes and/or regulations.	New	
XXXX	Files Not Adequately Documented	Inadequate documentation of claims and/or retention of claims records.	New	
XXXX	Improperly Compelling Claimant to Litigate	Delay or inadequate settlement offer made after claim liability has become reasonably clear, thus compelling a claimant to litigate.	New	
XXXX	Inadequate Explanations of Claims Denied / Closed Without Payment	Deficient correspondence with a claimant or policyholder regarding the reasons for a claim denial, including failure to explain the policy basis for a denial and appeal rights or other related issue in violation of statute or regulation.	New	
XXXX	Inadequate Loss Valuation Practices / Procedures	Improper damage estimates, total loss valuations or other claim valuation procedures and practices.	New	
XXXX	Inadequate / Untimely Investigation	Inadequate or untimely investigation to determine available coverage or liability.	New	
XXXX	Inappropriate Subrogation Practices / Procedures	Inappropriate recoupment of a loss from a liable third party, improper distribution of such a recoupment, and/or other inadequate subrogation practice and/or procedure.	New	
XXXX	Initial Contact Not Timely / Not Made	Failure to make initial contact or failure to make initial contact with an insured or claimant within timeframes established by statute and/or regulation.	New	
XXXX	Misrepresentation of Coverage	Available coverage was not adequately communicated to a policyholder or claimant.	New	
XXXX	Other Claims Handling Issue*	Any other claims handling issue not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Claims Settlement Practice*	All other improper claim handling procedures or practices not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Improper Denial of Claim*	All claim denial violations not included in an above category not described by any other reason code and/or combination of reason codes.	New	

### Complaint Handling

Code	Code Name	Definition	Code Status	Notes
XXXX	Failure to Maintain Complaint Log	Improper documentation of consumer complaints, both those received directly from a consumer and via insurance departments.	New	
XXXX	Failure to Provide Adequate Response / Resolution to Complaints	Failure to address issues that rose in a complaint and take appropriate remedial actions, as necessary.	New	
XXXX	Failure to Timely Respond / Manage Complaints	Failure to respond to consumer complaints within required time frames. This would include but not be limited to the failure to respond to the insurance department and/or the complainant.	New	
XXXX	Other Complaint Handling Issue*	Other deficiency in complaint handling practices and/or procedures (including the failure to have complaint handling procedures.) not described by any other reason code and/or combination of reason codes.	New	

### Escrow/Settlement, Closing or Security Deposit Funds

Code	Code Name	Definition	Code Status	Notes
XXXX	Funds Submitted for Collection / Deposited in Non-qualified Institution	Failure to collect and deposit funds in an appropriate institution, such as an institution insured by the FDIC.	New	
XXXX	Inappropriate Disbursement Procedures / Practices	Failure to disburse funds in conformity with all applicable statutes and regulations. This would include, but not be limited to escrow funds that are applied in a way that is not in accordance with statutes and/or regulations regarding the handling of funds, escrow shortages, failure to provide good funds, or Improper or Inadequate Escrow Accounting Procedures or Controls.	New	
XXXX	Inappropriate Interest Paid	Failure to pay appropriate interest in accordance with statute or regulation.	New	
XXXX	Other Escrow / Settlement, Closing or Security Deposit Funds Issue*	Any other issue not described by any other reason code and/or combination of reason codes.	New	

### Marketing & Sales

Code	Code Name	Definition	Code Status	Notes
2010	Marketing & Sales	Finding of cause resulting from an entity's activities involving the marketing, advertising and sales of products that are regulated by the Department of Insurance.	Delete	Proposed alternative: use new, more specific code(s) related to marketing and sales
2012	Unsuitable / Inappropriate Replacement	Failure to comply with mandated replacement and/or suitability statutes and/or regulations.	Code Name Change	Previous Code Name "Life Insurance Replacement Violation" Typically related to life insurance or annuities
2014	Misrepresentation of Insurance Produce / Policy	Deceptive representations regarding the nature of an insurance product.	Keep	
2025	Misleading Advertising	Use of advertising that does not comply with applicable state statutes and/or regulations, including but not limited to false and/or misleading advertising.	Code Name Change	Previous Code Name "Advertising"
2045	Rebating	Improperly providing monetary inducements to purchase coverage.	Keep	
2111	Inappropriate Sales or	Inappropriate sales and/or solicitation of	Keep	

Code	Code Name	Definition	Code Status	Notes
	Solicitation to a Military Service Member	insurance products to military service member, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.		
2112	Inappropriate Sales or Solicitation on a Military Installation**	Inappropriate sales or solicitation of insurance products on a military installation, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.	Keep	
XXXX	Disclosure / Outline of Coverage Inadequate / Not Timely / Not Provided	Inadequate procedures to provide full disclosure or appropriate outline of coverage to consumers in connection with the sale of an insurance product.	New	
XXXX	Failure to Provide Adequate Producer Training, Education, Compliance Oversight	Training materials and communications with producers fail to comply with statute or regulation.	New	
XXXX	Illustrations Inadequate / Not Timely / Not Provided	Sales materials and exhibits fail to contain all required information, disclaimers, or are otherwise misleading.	New	
XXXX	Other Marketing & Sales Issue*	Any of marketing and sales violation not described by any other reason code and/or combination of reason codes.	New	
XXXX	Other Unfair Marketing & Sales Practice*	Any other unfair marketing and sales practice not described by any other reason code and/or combination of reason codes.	New	

### Operations & Management

Code	Code Name	Definition	Code Status	Notes
2028	TPA Violation	Finding of cause resulting from non-compliance with a state's Third Party Administrator (TPA) laws and regulations.	Delete	Proposed alternative: (XXXX) "Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor"
2039	Failure to Maintain Adequate Books & Records	Records are incomplete, inaccessible, inconsistent, or disordered, or fail to conform to state record retention laws.	Code Name Change	Previous Code Name "Failure to Maintain Books & Records"
2065	Notice of Financial Impairment from Another State	Notification from another state of financial impairment.	Keep	
2070	Financial Impairment	Finding of cause resulting from an insurer having insufficient assets, capital, policyholder surplus, or reserves to meet financial obligations to customers and stockholders and is therefore ineligible to transact insurance business in the state.	Keep	
2072	Cure of Financial Impairment	Used when <i>Financial Impairment</i> was reported, where an insurer was found to be ineligible to transact insurance business, has remedied the problem; is now considered solvent and eligible to transact insurance business.	Keep	
2080	Dissolution	Finding of cause resulting from notification that a producer firm or insurer has been dissolved, disbanded, or liquidated as a corporation.	Keep	
2100	No Certificate of Authority	Finding of cause resulting from an insurer engaging in the business of insurance in a state without authorization from the Department of Insurance.	Keep	
2101	Exceeded Certificate of Authority	Engaging in activities not contemplated within the scope of authority of an existing certificate of	Code Name	Previous Code Name "Certification Violation"

Code	Code Name	Definition	Code Status	Notes
		authority. This could include, but not be limited to, writing lines of business not covered by the existing certificate of authority and/or exceeding geographical boundaries associated with the existing certificate of authority.	Change	
2102	Unauthorized Insurance Business	Finding of cause resulting from an entity engaging in actions that are regulated as the business of insurance without authorization from the Department of Insurance in the state.	Delete	Proposed alternative: (2100) "No Certificate of Authority" and/or (2101) "Exceeded Certificate of Authority"
XXXX	Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor	Failure to exercise an appropriate level of oversight of third parties that assume a business function and act on behalf of an insurer. Example: An MGA that is not operating in accordance with statutes and/or regulations regarding the supervisory responsibility for the local and field operations of an insurer.	New	
XXXX	Inadequate Appeals Practices / Procedures	Improper or inadequate procedures to appeal unsatisfactory claim outcomes. Examples: First-level appeals are reviewed by a qualified medical practitioner. Second-level review processes conform to applicable statute and/or regulation.	New	
XXXX	Inadequate External / Independent Review Practices / Procedures	Failure to provide appropriate cost-free access to an independent external body to review medical determinations in relations to the terms of a policy or applicable statute and/or regulation.	New	
XXXX	Inadequate Grievance Practices / Procedures	Failure to adhere to policy provisions regarding the handling of complaints or appeals by consumers or health care providers.	New	
XXXX	Inadequate Internal / External Audit Practices / Procedures	Company failed to implement proper surveillance procedures to ensure the absence of significant structural or systemic problems with core functions.	New	
XXXX	Inadequate Network	Failure to provide timely and local access to healthcare providers in accordance with policy provisions or state and/or federal requirements. Example: A health plan network that is not in accordance with requirements mandated by statute and/or regulation related to a network adequacy.	New	
XXXX	Inadequate Provider Credentialing / Monitoring	Failure to ensure that contracted providers are properly licensed and practicing within the scope of their license and at the contracted location.	New	
XXXX	Inadequate Safeguards for Security of Data & Information	Failure to adequately preserve the privacy of confidential or sensitive information. This would include but not be limited to, improper disclosure within a regulated entity, failure of procedures to maintain the integrity of company information stored in electronic or other media, failure to provide appropriate privacy disclosures to consumers, or to notify consumers of security breaches. Example: Failure to maintain adequate information controls, data backup and recovery systems, or to restrict access to sensitive information.	New	
XXXX	Inadequate Utilization Review	Improper procedures or practices associated	New	

Code	Code Name	Definition	Code Status	Notes
	Practices / Procedures	with monitoring the use, delivery, or efficiency of medical services by insureds.		
XXXX	Quality Assurance Violation	Inappropriate or inadequate procedures or practices associated with conducting quality assessments and improving health outcomes, including adequately communicating such procedures to health care providers.	New	
XXXX	Other Operations & Management Issue*	Any other management and operations issue not described by any other reason code and/or combination of reason codes.	New	

### Policyholder Service

Code	Code Name	Definition	Code Status	Notes
2020	Policyholder Service	Finding of cause resulting from a company's service to owners of insurance policies, including complaints, customer service, claims or any other service.	Delete	Proposed alternative: use new, more specific code(s) related to policyholder service
XXXX	COBRA Non-compliance	Improper documentation of eligibility for group health insurance coverage.	New	
XXXX	HIPPA Non-compliance	Improper handling of private electronic claims records or other patient information.	New	
XXXX	Improper Processing of Free Looks	Failure to remit a full refund if a policy is returned with required timeframes; or to adhere to any other free-look provisions prescribed by the policy or by statute or regulation.	New	
XXXX	Improper Processing of Nonforfeitures	Failure to secure a policyholder's interest in a policy in the event the policy lapses, in accordance with policy provisions or statute and/or regulation.	New	
XXXX	Improper Processing of Reinstatements	Differential treatment of similarly situated individuals with respect to reinstatement rights provided under the policy or as required by state law or regulation.	New	
XXXX	Premium / Billing Notices Inadequate / Not Timely / Not Provided	Failure to provide billing notices and/or notify consumers of premiums due within timeframes established by statute and/or regulation. This would include instances where billing notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Required Notification / Correspondence Inadequate / Not Timely / Not Provided	Failure to make any other required notification and/or made the notification in a timely manner. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Reasonable Attempts to Locate Policyholder Not Made	No reasonable attempt was made to locate policyholders or beneficiaries.	New	
XXXX	Other Policy Holder Service Issue*	Any other policyholder service issue not described by any other reason code and/or combination of reason codes, including but not limited to a failure to provide notification of changes in customer service telephone numbers or locations, failure to promptly answer telephone calls or electronic inquiries, or failure to clearly identify the name of the underwriter on correspondence.	New	

### Producer Licensing

Code	Code Name	Definition	Code Status	Notes
2026	Premium Finance Act Violation	Finding of cause resulting from non-compliance with the premium finance act, including but not limited to licensing, record-keeping, policy notices and contractual charges.	Delete	Used by 4 states, 5 times. Proposed alternative: use appropriate "other" code
2027	Surplus Lines Violation	A producer committed a violation of statutes and/or regulations related to surplus lines business.	Keep	
2030	Failure to Meet Continuing Education Requirements	A producer failed to meet the mandatory continuing education requirements. This would also include instances where the producer failed to maintain one or more qualifications to hold a license.	Keep	
2032	Continuing Education Requirements Met	A producer deficient in respects to meeting mandated continuing education requirements is now compliant. This would also include instances where the failure to maintain a qualification required to hold a license has been rectified.	Keep	
2037	Failure to Notify Department of Address Change	A producer failed to notify the department of a change in address in accordance with statutes and/or regulations. This would include instances where the producer failed to notify the department in a timely manner.	Keep	
2042	Failure to Pay Child Support / Student Loans	A producer license was denied, suspended, or revoked due to the producer failing to pay child support and/or student loans.	Code Name Change	Previous Code Name "Failure to Pay Child Support"
2055	Producer / Adjuster / Other Not Properly Licensed	A producer is not properly licensed to transact business for a given line of insurance; or adjuster not properly licensed according to statute or regulation.	Code Name Change	Previous Code Name "No License"
2056	Demonstrated Lack of Fitness or Trustworthiness	Action taken on a producer license due to a demonstrated lack of fitness and/or trustworthiness. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2058	Misstatement on Application	Action taken on a producer license due to a misstatement on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2059	Failure to Make Required Disclosure on Application	Action taken on a producer license due to the failure to make a required disclosure on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Code Name Change	Previous Code Name "Failure to Make Required Disclosure on application"
2060	Producer / Adjuster / Other Not Properly Appointed	A producer or adjuster is not properly appointed to an insurer as required by statute or regulation.	Code Name Change	Previous Code Name "Not Appointed"
2061	Selling for Unlicensed Insurer	A producer solicited on behalf of an unlicensed insurer.	Keep	
2062	Allowed Business from Agent Not Appointed / Licensed	Finding of cause resulting from an insurer accepting policy applications from producers at a time when they were not licensed or under appointment with that insurer as required by the state's laws and the company's requirements.	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed" and/or (2060) "Producer / Adjuster / Other Not Properly Appointed"
2063	Employed Unlicensed Individuals	Finding of cause resulting from employees of a producer or insurer conducting the business of insurance without required authorization or license from the Department of Insurance.	Delete	Proposed alternative: (2055) "Producer / Adjuster / Other Not Properly Licensed"
2064	Paid Commission to Unappointed Agents	Finding of cause resulting from an insurer or producer providing payment or sharing of commissions to producers who are not	Delete	Proposed alternative: (2060) "Producer / Adjuster / Other Not Properly Appointed"

Code	Code Name	Definition	Code Status	Notes
		appointed with the issuing insurer.		
2097	Bail Bond Forfeiture Judgment	Action taken on a producer license was due to a bail bond forfeiture judgment. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2075	Failure to Report Other State Action	Action was taken on a producer license due to the failure to report an action taken by another state. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2104	Failure to Remit Premiums to Insurer	A producer failed to remit premiums to an insurer.	Keep	
2105	Misappropriation of Premium	A producer misappropriated premium.	Keep	
2106	Forgery / Fraud	A producer committed forgery and/or fraud. This would include, but not be limited to, forgery of an insurance application, providing false evidence insurance, misrepresentation to insurer to obtain policy benefits and/or commission, and other acts of dishonest or fraud.  Example: Misrepresentation to insurer to obtain a life insurance policy with the intent to sell interests in the proceeds.	Code Name Change	Previous Code Name "Forgery"
2107	Criminal Record / History	Action taken on a producer license due a criminal record and/or history. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
2108	Criminal Proceedings	Action taken on a producer license due to criminal proceedings. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.	Keep	
XXXX	Producer / Adjuster Not Properly Terminated	Failure to adhere to all statutes and regulations regarding the termination of a producer, such as notification requirements to both the producer and the relevant regulation bodies.	New	
XXXX	Other Producer / Adjuster Licensing Issue*	Any other violation with respect to licensure and appointment of producers or adjusters not described by any other reason code and/or combination of reason codes.	New	
XXXX	Failure to Account for Premium Funds	Failure to maintain records showing the deposit, handling, and proper remittance premium funds.	New	
XXXX	Failure to Maintain Separate Fiduciary Account	Failure to create a fiduciary account for the deposit and remittance of premiums separate from agency operating funds.	New	
XXXX	Commingling of Premiums with Personal Funds	Failure to keep premium funds separate from personal funds.	New	
XXXX	Other Fiduciary/Accounting Violation*	A fiduciary violation not included in an above category, not described by any other reason code, or combination of reason codes	New.	

### Underwriting & Rating

Code	Code Name	Definition	Code Status	Notes
2005	Underwriting	Finding of cause resulting from the process of selecting, classifying, and rejecting risks in order to assign appropriate rates to insureds.	Delete	Proposed alternative: use new, more specific code(s) related to underwriting
2050	Rate Violation	Finding of cause resulting from use of premium rates not filed with the Department of Insurance,	Delete	Proposed alternative: use new,

Code	Code Name	Definition	Code Status	Notes
		or not aligned with rates that have been filed, or use of inadequate procedures to determine premium rates.		more specific code(s) related to rating violations
XXXX	Inadequate or Excessive Rate	Rates are either excessive or inadequate in relation to expected exposure presented by the risk and/or expected losses, as defined by statute and/or regulation.	New	
XXXX	Incorrect Application of Rate	Actual rates charged deviate from the insurer's established rates or rating plan. This would include, but not be limited to, instances where rates charged are not in accordance with state mandates, filed, do not adhere to filings, and/or improper documentation of modifications exists.  Example: Inconsistent application of scheduled rating plan across eligible risks.	New	
XXXX	Rates Not Filed / Approved	The use of rates that have not been filed or approved by the state insurance department as required by statute or regulation.	New	
XXXX	Rates Unfairly Discriminatory	Like risks are charged different rates in a way not justified by expected loss costs.	New	
XXXX	Use of Prohibited Rating Factors	Use of factors for rating prohibited by statute or regulation.	New	
XXXX	Other Rating Issue*	Any improper rating practice not described by any other reason code and/or combination of reason codes.	New	
2053	Forms Not Filed &/or Approved	The use of insurance forms that have not been properly filed or approved by the appropriate regulatory authority.	Code Name Change	Previous Code Name "Use of Unapproved Forms"
XXXX	Improper Question on Application	Insurance application contains improper questions or otherwise not in accordance with applicable statutes and/or regulations.	New	
XXXX	Mandated Coverages / Offerings Not Provided	Failure to provide coverage for benefits required by statute or regulation. This would include, but not be limited to, using forms that do not comply with statutes and/or regulations regarding mandated and/or required coverages.	New	
XXXX	Other Forms Issue*	Any other form violation not described by any other reason code and/or combination of reason codes.	New	
2003	Cancellation / Non- Renewal Notice Inadequate / Not Timely / Not Provided	Notice of the termination of coverage was not issued, was not issued within timeframes prescribed by statute or policy provisions. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.	Code Name Change	Previous Code Name "Failure to Send Required Cancellation / Non-Renewal Notice"
XXXX	Mandatory Disclosures / Notifications Inadequate / Not Timely / Not Provided	Improper issuance of disclosures or notifications, in violation of policy provisions, statute, or regulation. This would include notices of mandated coverage, disclosure of preexisting condition exclusions, or disclosure that credit insurance is optional and not a condition for loan approval. It does not include cancellation or nonrenewal notices, which have a separate code.	New	
XXXX	Unfairly Discriminatory Underwriting Practices / Procedures	Underwriting practices that treat like risks differently and violate statutes and/or regulations regarding the fair treatment of risks.	New	

Code	Code Name	Definition	Code Status	Notes
XXXX	Other Cancellation / Nonrenewal / Recession Issue*	Any other improper termination of coverage not described by any other reason code and/or combination of reason codes.  Example: Rescissions made for non-material misrepresentations.	New	
XXXX	Declination Notice – Inadequate / Not Timely / Not Provided	Failure to issue notify an applicant or failure to timely notify an applicant that coverage is rejected as required by statute and/or regulation. This would include instance where notices where inadequate and/or did not contain information required by statutes and/or regulations.	New	
XXXX	Other Declination Issue*	Other inappropriate declination not described by any other reason code and/or combination of reason codes.  Example: Failure to adhere to internal underwriting guidelines.	New	
XXXX	Other Underwriting Issue*	Any other violation related to the determination of eligibility for coverage, not described by any other reason code and/or combination of reason codes.	New	

### Miscellaneous

Code	Code	Definition	Code Status	Notes
2007	Market Conduct Examination	Finding of cause resulting from examination of the business practices and operations of an entity in order to determine its compliance with state insurance laws and regulations.	Delete	Describes origin of action Proposed alternative: (1030) “Market Conduct Exam” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2074	Other States Action	Finding of cause resulting from another state’s Department of Insurance activity about an issue which also affects the entering state.	Delete	Describes origin of action Proposed alternative: (1015) “Other States Action” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.
2029	Unfair Insurance Practices Act Violation	Finding of cause resulting from unfair methods of competition or deceptive acts being used, from this Act or the Unfair Trade Practices Act as applied to the business of insurance.	Delete	Proposed alternative: use new, more specific code(s) related to unfair insurance practices
2035	Failure to Cooperate with Examination / Investigation / Inquiry	Other failure to cooperate with an examination or investigation. This would include, but not be limited to, failure to respond to appropriate requests for information and/or providing inaccurate or misleading information.	Code Name Change	Previous Code Name “Failure to Respond”  If the issue is late or incomplete response, then use 2036.
2036	Late or Incomplete Response	Failure to respond timely and/or failure to provide a complete response in response to a request for information. This would include, but not be limited to failure to submit timely and complete mandated filings such as statistical reports and annual reports.	Keep	

Code	Code	Definition	Code Status	Notes
2038	Failure to Comply with Previous Order	Failure to comply with an order pertaining to corrective action, as determined by a follow-up examination, investigation, or other means.	Keep	
2040	Failure to Timely File	Failure to make a filing in a timely manner.	Keep	
2085	Failure to Pay Tax	Failure to pay tax.	Keep	
2087	Failure to Pay Fees	Failure to pay fees.	Keep	
2090	Failure to Pay Fine	Failure to pay fine.	Keep	
2095	Failure to Pay Assessment	Failure to pay an assessment.	Keep	
2103	Fiduciary Violation	Finding of cause resulting from producers violating positions of trust in relation to insurers and policyholders.	Delete	Proposed alternative: use new, more specific code(s) related to fiduciary violations
2110	Reconsideration	The Department of Insurance has re-evaluated a Regulatory Action because of new information received or because the entity has corrected the cause of action.	Keep	
2115	Other Miscellaneous*	Any other reason not described by any other reason code and/or combination of reason codes.	Code Name Change	Previous Code Name "Other*" (enter up to 100 char)

\*If checked, you must enter a description of up to 100 characters.

\*\*If code (2112) is checked, please enter the name of the Military Base in the '(xxxx) Other Marketing & Sales Issue\*' box.

## Disposition for Action (Revised)

The Disposition field is meant to provide information about the disposition (outcome) of the regulatory action. The code(s) used should be reflective of the outcome of the action. In other words what happened as a result of the action. Information about the reason (allegations) and/or origin (source) of the action should be reported in those respective fields. (max 4)

Code	Code Name	Definition	Code Status	Notes
3001	License, Denied	The entity or individual applied for a new license or attempted to renew a license and it was denied	Keep	
3003	License, Suspended	The entity or individual's license was suspended. The entity or individual is temporarily prohibited from engaging in the business of insurance.	Keep	
3004	License, Cancelled	The entity or individual's license was cancelled.	Keep	
3006	License, Revoked	The entity or individual's license was revoked; The entity or individual is prohibited from engaging in the business of insurance.	Keep	
3009	License, Probation	The entity or individual's license is subject to a probationary period during which the entity or individual is obligated to comply with certain standards and/or conditions specified by the issuing authority or the license can be cancelled, revoked or suspended.	Keep	
3010	License, Conditional	The entity or individual's license is issued on a conditional basis under which the entity or individual must meet certain standards and/or conditions specified by the issuing authority before an unrestricted license can be issued. Failure to meet the conditions may result in license being cancelled, revoked, or suspended by the issuing authority.	Keep	
3011	License, Supervision	The entity or individual's license is under supervision of the issuing authority and the	Keep	

Code	Code Name	Definition	Code Status	Notes
		entity or individual is subject to a formal supervisory plan regarding a hazardous financial condition or non-compliant business practice. Failure to comply with the supervisory plan may result in the license being cancelled, revoked, or suspended by the issuing authority.		
3012	License, Reinstatement	The license of an entity or individual was reinstated.	Keep	
3013	License, Granted	A license was granted to an entity or individual as a result of an administrative process regarding a prior action to deny, cancel or revoke a license.	Keep	
3014	License, Surrendered	The entity or individual's license was ordered to surrender the license.	Keep	
3015	License, Voluntarily Surrendered	The entity or individual's license was voluntarily surrendered by the entity or individual. This disposition is typically associated with situations where the entity or individual agreed to voluntarily surrender the license in lieu of the issuing authority pursuing additional administrative action.	Keep	
3016	License, Other*	Any other disposition related to an entity or individual license not described by any other disposition code or combination of codes.	Keep	
3021	Certificate of Authority, Denied	The entity's application for a certificate of authority or an expansion of an existing certificate of authority was denied by the issuing authority.	Keep	
3023	Certificate of Authority, Suspended	The regulated entity's certificate of authority was suspended for a specific time period. During this time period, the entity is prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3025	Certificate of Authority, Suspension Extended	The suspension of regulated entity's certificate of authority was extended beyond the initial suspension period. The temporary prohibition from engaging in the business of insurance in the affected jurisdiction is continued.	Keep	
3026	Certificate of Authority, Revoked	The regulated entity's certificate of authority was revoked. The entity prohibited from engaging in the business of insurance in the affected jurisdiction.	Keep	
3028	Certificate of Authority, Expired	The entity failed to take the appropriate action to renew or continue its certificate of authority.	Keep	
3029	Certificate of Authority, Probation	The regulated entity's certification of authority is subject to a probationary period during which the entity is obligated to comply with certain standards and/or conditions specified by the issuing authority or the certificate of authority can be cancelled, revoked or suspended.	Keep	
3031	Certificate of Authority, Reinstated	The regulated entity's certificate of authority was reinstated.	Keep	
3034	Certificate of Authority, Surrendered	The entity surrendered its certificate of authority.	Keep	
3036	Certificate of Authority, Other*	Any other disposition related to a certificate of authority not described by any other disposition code or combination of codes.	Keep	
3042	Cease and Desist from Violations	The entity was ordered to cease and desist	Keep	

Code	Code Name	Definition	Code Status	Notes
		from engaging in specific activities that are not compliant with insurance statutes, rules, and/or regulations of the issuing jurisdiction.		
3043	Cease and Desist from all Insurance Activity	The entity or individual was ordered to cease and desist from engaging in the business of insurance.	Keep	
3044	Remedial Measures Ordered	The entity or individual was ordered to take specific action in order to remediate a situation which caused harm to one or more persons as a result of one or more acts taken by the entity or individual.	Keep	
3045	Consent Order	The entity or individual entered into a voluntary agreement in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3046	Stipulated Agreement/Order from a commissioner	The entity or individual entered into a stipulated agreement which was approved via a formal process (i.e. approved by an administrative law judge or hearing examiner) in order to resolve the issue regulatory issue that is the subject of the action.	Keep	
3047	Previous Order Vacated / Stayed / Set Aside	A previous order under which the entity or individual was subject has been set aside, nullified, cancelled, or rescinded. Or an order that postpones or suspends a previous order.	Code Name Change	Previous Code Name "Previous Order Vacated"
3048	Ordered to Provide Requested Information	The entity or individual has been ordered to produce information requested by the jurisdiction under its statutory authority.	Keep	
3049	Stayed Order	The Department of Insurance stops a previously issued order from being put into effect.	Delete	Used by 3 states, 10 times. Proposed alternative: (3047) "Previous Order Vacated / Stayed / Set Aside"
3051	Final Agency Order	The final agency order was issued against the entity or individual.	Keep	
3052	Ordered to Comply with Specific Statute or Regulation	The entity or individual was ordered comply with a specific insurance statute, rule, and/or regulation.	Keep	
3055	Reprimanded / Censured	The entity or individual was formally reprimanded or censured.	Code Name Change	Previous Code Name "Reprimanded"
3060	Hearing Waiver	The entity or individual waived their right to a hearing.	Keep	
3065	Show Cause	An order directing the entity or individual to appear before the reporting jurisdiction to explain why they took or failed to act or why the reporting jurisdiction should or should not grant some relief.	Keep	
3070	Re-exam	The Department of Insurance orders a follow-up examination of an entity to ensure compliance with state laws and regulations.	Delete	Used by 4 states, 11 times. Proposed alternative: (3105) "Other"
3075	Rescission of	The Department of Insurance retracts a previous action or order. An additional Disposition code must be selected to identify what was rescinded. If Other is selected, text explanation must be entered into the Other action disposition field.	Keep	
3076	Involuntary Forfeiture	The Department of Insurance requires the surrender of the authority of an individual or firm to engage in the business of insurance in the state because of a crime, offense, or	Delete	Used by 0 states, 0 times. Proposed alternatives: (3102) "Monetary Penalty" or (3103)

Code	Code Name	Definition	Code Status	Notes
		breach of contract.		"Aggregated Monetary Penalty"
3078	Restitution	The entity or individual was ordered to pay restitution in order to compensate one or more persons or entities harmed by actions of the regulated or unauthorized entity or individual.	Keep	
3079	Suspended from Writing New Business; Renewals Ok	The entity is prohibited from writing new business. However, it is still permitted to service current policyholders.	Keep	
3080	Supervision	The financial condition of the entity was placed under supervision and being closely monitored by the jurisdiction.	Keep	
3085	Rehabilitation	The entity was found to be financially impaired or insolvent. Action is being taken to restore the impaired or insolvent entity to sound financial standing.	Keep	
3090	Liquidation	The entity was found to be insolvent and unable to become viable. Action is being taken to liquidate the entity.	Keep	
3095	Conservatorship	The entity and its financial condition are being evaluated to determine whether the policyholders and creditors will be best served by liquidation, rehabilitation, or returning the entity to private management.	Keep	
3097	Hearing	A hearing was brought about as are result of the action against the entity or individual.	Keep	
3100	Receivership	The entity was placed into receivership by jurisdiction in which the entity is legally domiciled.	Keep	
3101	Ancillary Receivership	The entity was placed into receivership by a jurisdiction other than the jurisdiction in which the entity is legally domiciled.	Keep	
3102	Monetary Penalty	Monetary fine or penalty imposed on a single entity or individual in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3103	Aggregate Monetary Penalty	Monetary fine or penalty imposed on one or more entities or individuals in a single action for one or more violations of insurance statutes, rules, and/or regulations.	Keep	
3104	Settlement	The Department of Insurance negotiates an agreement with an entity without legal action or litigation being undertaken.	Keep	
3105	Other*	Any other disposition not described by any other disposition code or combination of codes.	Keep	

\* If checked, you must enter a description of up to 100 characters.

*Adopted by the Financial Condition (E) Committee, 12/13/2021*  
*Adopted by the Executive (EX) Committee and Plenary, 12/16/2021*



# **Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation**

**Mutual Recognition of Jurisdictions (E) Working Group**

***Process for Evaluating Jurisdictions that Recognize and Accept  
the Group Capital Calculation***

- 1. Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions)<sup>1</sup> if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.
- 2. NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:
  - (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”;<sup>2</sup> or
  - (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

Jurisdictions meeting either of these criteria will be referred to informally as “‘Recognize and Accept’ Jurisdictions.” Sections 21D and 21E of Model #450 provide a general framework for how the process to identify “Recognize and Accept” Jurisdictions will work and specifically contemplates the development of a list of such jurisdictions through the NAIC Committee Process. The purpose of this document is to provide a documented evaluation process for creating and maintaining this list of jurisdictions that recognize and accept the GCC.

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<sup>1</sup> Under Section 4L(2)(e) of Model #440, if the worldwide insurance operations of a non-U.S. group are exempt from the GCC, the group’s U.S. Lead State Commissioner may nevertheless require a GCC that is limited to the group’s U.S. operations if: “after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace.” A group’s exemption is also contingent on the group providing sufficient information to the lead state, directly or through the group-wide supervisor, sufficient to enable the lead state to comply with the group supervision approach set forth in the *NAIC Financial Analysis Handbook*.

<sup>2</sup> Model #440. § 4L(2)(c).

- 3. Covered Agreements.** The “*Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance*” was signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements include, inter alia, the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. In relevant part, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.
- 4. Reciprocal Jurisdictions.** In response to the Covered Agreements, the NAIC also amended the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.
- 5. Other Jurisdictions that Recognize and Accept.** In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria:

- (a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;
- (b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);
- (c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;
- (d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) or 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.

- 6. Mutual Recognition of Jurisdictions (E) Working Group.** On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC (“*Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation*,” or “Recognize and Accept” Process). A separate process exists for evaluating Qualified and Reciprocal Jurisdictions (“*Process for Evaluating Qualified and Reciprocal Jurisdictions*”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.
- 7. List of Jurisdictions that Recognize and Accept the GCC.** The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.
- (a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9.]
  - (b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [see discussion in paragraphs 10 and 11.]
  - (c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 13.]

(d) Upon final inclusion of a jurisdiction on the List, any confidential documents reviewed by the Mutual Recognition of Jurisdictions (E) Working Group in its evaluation of the jurisdiction will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential. The NAIC will maintain the List on its public website and in other appropriate NAIC publications.

(e) If a non-US group's lead state exempts the group from the GCC, and the group-wide supervisor is based in a jurisdiction that is not on the "Recognize and Accept" List, the state must thoroughly document the justification for the exemption.

**8. Procedure for Evaluation of Non-U.S. Jurisdictions.** In undertaking the evaluation of a non-U.S. Jurisdiction for inclusion on the "Recognize and Accept" List, the Mutual Recognition of Jurisdictions (E) Working Group shall utilize similar processes and procedures to those outlined in the *Process for Evaluating Qualified and Reciprocal Jurisdictions*. Specifically, the Working Group will undertake the following procedure in making its evaluation:

(a) **Initiation of Evaluation.** Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group's intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. 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. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

- i. Will direct NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise to review the materials received from the jurisdiction. 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 the Federal Insurance Office (FIO) and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.
- ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a "Recognize and Accept" Jurisdiction.

- iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.
- iv. May review other public materials deemed relevant to making a determination.
- v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.
- vi. Relevant U.S. state and federal authorities will be notified of the Mutual Recognition of Jurisdictions (E) Working Group's decision to evaluate a jurisdiction.

- (b) **Preliminary Evaluation Report.** NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a "Recognize and Accept" Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.
- (c) **Final Evaluation Report.** Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.
- (d) **Summary of Findings and Determination.** 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 of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for informational purposes. Upon approval as a "Recognize and Accept" Jurisdiction by the Executive

(EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

**9. Evaluation of Reciprocal Jurisdictions.** Under Section 4L(2)(c) of Model #440, Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital are exempt from the GCC. Because a “recognize and accept” evaluation by the Mutual Recognition of Jurisdictions (E) Working Group is already part of the Reciprocal Jurisdiction review process, all Reciprocal Jurisdictions designated by the NAIC through that review process are also automatically designated as “Recognize and Accept” Jurisdictions. Likewise, in view of the terms of the EU and UK Covered Agreements, all EU Member States and the UK are automatically designated “Recognize and Accept” Jurisdictions. If there is a material change to the terms of the U.S.-EU or U.S.-UK Covered Agreement, or if the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will consider, and will consult with FIO and USTR regarding, whether and how the applicability of the procedures in this document may apply

**10. Evaluation of Non-Reciprocal Jurisdictions with U.S. Insurance Group Operations.** Under Section 21D(1)(a) of Model #450, a non-Reciprocal Jurisdiction, in which a U.S. insurance group has operations, that recognizes the U.S. state regulatory approach to group supervision and group capital may be included on the NAIC “Recognize and Accept” List. The Mutual Recognition of Jurisdictions (E) Working Group may rely on written confirmation by a competent regulatory authority in that jurisdiction that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction.

- (a) 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 written confirmation are true and accurate.
- (b) The jurisdiction must also have an acceptable Memorandum of Understanding to be included on the “Recognize and Accept” List, as described in paragraph 12 of this Process.

- (c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose. The NAIC will publish a form letter in the *Appendix: Letter Templates* that a competent regulatory authority of a non-U.S. jurisdiction may use to provide confirmation pursuant to Section 21D(1)(a), Section 21D(1)(b) and 21D(2) of Model #450 as well as a template letter that any “Recognize and Accept” Jurisdiction, including a Reciprocal Jurisdiction, may use to provide confirmation, pursuant to Section 21(E)(1) of Model #450, as to whether or not it requires a group capital filing for any U.S. based insurance group’s operations. NAIC Staff will work with the jurisdiction to modify these forms if necessary for a particular jurisdiction.

#### **11. Evaluation of Non-Reciprocal Jurisdictions with No U.S. Insurance Group Operations.**

Because the GCC embraces and encourages the concepts of mutual recognition and one group/one group-wide supervisor, a non-U.S. jurisdiction may be included on the “Recognize and Accept” List, enabling its insurance groups to do business in the U.S. without being subject to U.S group-wide supervision, even if no U.S. groups operate in that jurisdiction. Under Section 21D(1)(b) of Model #450, such a jurisdiction must document its recognition and acceptance by indicating formally in writing to the lead state of each of its insurance groups doing business in the U.S., with a copy to the International Association of Insurance Supervisors (IAIS), that the GCC is an acceptable international capital standard. The Mutual Recognition of Jurisdictions (E) Working Group may rely on written confirmation by a competent regulatory authority in that jurisdiction.

- (a) 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 written confirmation are true and accurate.
- (b) The jurisdiction must also have an acceptable Memorandum of Understanding to be included on the “Recognize and Accept” List, as described in paragraph 12 of this Process.
- (c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

**12. Memorandum of Understanding.** Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner of any U.S.-

based insurance group doing business in that jurisdiction, in accordance with a memorandum of understanding or similar document between the commissioner and the jurisdiction. Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

- (a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of sharing information concerning all insurers within the group.
- (b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must either (1) enter into an MOU with the lead state, or (2) enter into an MOU with a state that has agreed to serve as a single point of contact for multiple lead states, similar to the procedure for sharing information under the *Process for Evaluating Qualified and Reciprocal Jurisdictions*. The MOU must also provide for appropriate confidentiality safeguards with respect to the information shared among the jurisdictions.
- (c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

**13. Prudential Oversight and Solvency Monitoring.** Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. As part of Paragraph 8, *Procedure for Evaluation of Non-U.S. Jurisdiction*, the Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential

documents to confirm whether or not any “Recognize and Accept” Jurisdiction requires a subgroup group capital filing for a U.S.-based insurance group’s operations, and a discussion and findings on this review will be included in the Preliminary Evaluation Report, Final Evaluation Report and Summary of Findings and Determination. If the Working Group has evidence indicating that a jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations in that jurisdiction, it will attempt to obtain written confirmation of the existence and scope of any such requirement from a competent regulatory authority in that jurisdiction, but it is recognized that such a confirmation is not an essential element of the Working Group’s determination. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

**14. Process for Periodic Evaluation.** The process for determining whether a non-U.S. jurisdiction is a “Recognize and Accept” Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation to determine whether there have been any significant changes over the prior year that might affect inclusion on the List. This yearly review shall follow such abbreviated process as may be determined by the Working Group to be appropriate.

- (a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.
- (b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.
- (c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been

required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.

- (d) If a jurisdiction referred for re-evaluation under this Paragraph is a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall conduct a concurrent review of the jurisdiction’s continuing status as a Reciprocal Jurisdiction, or, in the case of a jurisdiction entitled to that status by virtue of a covered agreement, shall refer the matter to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities, in accordance with the *Process for Evaluating Qualified and Reciprocal Jurisdictions*.

### **Appendix: Letter Templates**

Paragraph 10(c) of the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* provides that the NAIC will publish a form letter that a competent regulatory authority of a non-U.S. jurisdiction that is not a Reciprocal Jurisdiction may use to provide confirmation pursuant to Section 21(D)(1)(a), Section 21(D)(1)(b) and 21(D)(2) of the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*, as well as a template letter that any “Recognize and Accept” Jurisdiction, including a Reciprocal Jurisdiction, may use to provide confirmation, pursuant to Section 21(E)(1) of Model #450, as to whether or not it requires a group capital filing for any U.S. based insurance group’s operations. The following template letters are designed to satisfy these requirements:

- A. Jurisdictions with U.S. Insurance Group Operations.** In order to satisfy the requirements of Sections 21D(1)(a) and 21D(2) of Model #450, the competent regulatory authority of a non-U.S. Jurisdiction in which U.S. insurance groups operate shall provide the NAIC with a written letter, confirming, as follows:

As the competent regulatory authority for [non-U.S. 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:

- [Non-U.S. Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including

worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and [non-U.S. Jurisdiction], including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.
- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

**B. Jurisdictions with No U.S. Insurance Group Operations.** In order to satisfy the requirements of Sections 21D(1)(b) and 21D(2) of Model #450, the competent regulatory authority of a non-U.S. Jurisdiction in which no U.S. insurance groups operate shall provide the NAIC with a written letter, confirming, as follows:

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. 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, with a copy to the International Association of Insurance Supervisors (IAIS), the following:

- [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC *Insurance Holding Company System Regulatory Act* (#440) as an acceptable international capital standard.
- Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and [non-U.S. Jurisdiction], including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.
- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

**C. Jurisdictions with Subgroup Capital Requirements.** Paragraph 13 of the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* provides that the Mutual Recognition of Jurisdictions (E) Working Group will attempt to obtain written confirmation from a competent regulatory authority in any jurisdiction where the Working Group has evidence indicating that the jurisdiction requires a subgroup group capital filing for any U.S. based insurance group's operations in that jurisdiction. The NAIC will identify such jurisdictions on the "Recognize and Accept" List, and will provide an explanation and discussion on such determination in its Summary of Findings and Determination. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

*Adopted by the Financial Condition (E) Committee, 12/13/2021*  
*Adopted by the Executive (EX) Committee and Plenary, 12/16/2021*



# **ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers**

**Reinsurance Financial Analysis (E) Working Group**

***ReFAWG Review Process for Passporting  
Certified and Reciprocal Jurisdiction Reinsurers  
("ReFAWG Review Process")***

**1. ReFAWG Review Process**

The Reinsurance Financial Analysis (E) Working Group (ReFAWG) normally operates in Executive Session, in accordance with the *NAIC Policy Statement on Open Meetings* and in open session when addressing policy issues. The authority of the Working Group is limited to that of an advisory body. This authority is derived from the 2011 *Preface to Credit for Reinsurance Models*, which provided that the purpose of the Working Group is “to provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.”

- a. In November 2011, the NAIC adopted revisions to its *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.
- b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). The revisions eliminate reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to \$250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to (1) jurisdictions subject to an in-force Covered Agreement within the U.S.; (2) accredited U.S. jurisdictions; and (3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).
- c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:
  - i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for

- reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
- ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to specific companies, entities or individuals.
  - iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related to certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.
  - iv. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
  - v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.
  - vi. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
  - vii. Ensure the public passporting website remains current.
  - viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

## **2. Lead States and Passporting Process**

- a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must submit certain information to each state in which it seeks such recognition. A reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to facilitate multi-state recognition or a reinsurer may decide to submit the information to each state as a separate application. Under the ReFAWG Review Process, ReFAWG will assist the states with the initial review of this information and provide guidance to the states in making their review of the reinsurer to determine whether it has met the regulatory requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.
- b. **Passporting for Certified Reinsurers** - In addition to this assistance to individual states, ReFAWG will also assist with a passporting process for the states. “Passporting” refers to the process under which a state has the discretion to defer to the certification of a reinsurer (and the rating assigned to that certified reinsurer) by another state. Under this process, a reinsurer will apply to an initial state for certification, referred to as the “Lead State,” which will begin its analysis of the reinsurer and notify ReFAWG of the application. The Lead State will complete its initial analysis and will submit filing information and other documentation to ReFAWG for a peer review. Upon completion of the confidential peer review process, ReFAWG will make its recommendation concerning both the certified status of the reinsurer and its rating. The Lead State then makes the final determination regarding certification, upon which the Lead State notifies ReFAWG and the certified reinsurer is eligible to apply for passporting into other states. States are encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

- c. **Passporting for Reciprocal Jurisdiction Reinsurers** - A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers as outlined in Sections 5 and 6 below. 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 compliance with this section. 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.
- d. **Discretion to Defer to Lead State** - If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states of the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and disseminate it to the states.
- e. **Communication with ReFAWG** - The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.
- f. **Change of Lead State** - The Lead State for a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer may change based upon mutual agreement between the current lead state and any other state where the reinsurer is recognized, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

### **3. ReFAWG Review Process for Certified Reinsurers**

ReFAWG makes available to the states a *Uniform Application Checklist for Certified Reinsurers* (Exhibit 1) for certification of reinsurers based upon the requirements of the Credit for Reinsurance Model Law and Regulation. It is intended that the checklist be used by lead states for the initial/renewal application review and by ReFAWG in its review of Passporting requests.

The following timeline applies to these filings:

<b>Timeline Event</b>	<b>Required Date</b>
Required Documents Filed with Lead State	June 30
Required Passporting Documents Uploaded to NAIC ReFAWG Database	August 31
NAIC Staff Re-Certification Review Process and Conference Calls	September 1 – November 30
All Passporting Re-Certifications Completed	December 1
Effective Date of Passporting Re-Certification	1/1/xx to 12/31/xx ( <b>Next Calendar Year</b> )
Applications for Passporting	1/1/xx to 12/31/xx

In order to be eligible for certification, the assuming insurer shall meet the following requirements:

- a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.
  
- b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than \$250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least \$250,000,000 and a central fund containing a balance of at least \$250,000,000.
  
- c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. *Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.*

d. The following table outlines the necessary ratings needed to meet a secure level:

<u>Ratings</u>	<u>Collateral Required</u>	<u>A.M. Best</u>	<u>Standard &amp; Poor's</u>	<u>Moody's</u>	<u>Fitch</u>	<u>Kroll</u>
Secure – 1	0%	A++	AAA	Aaa	AAA	AAA
Secure – 2	10%	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-	AA+, AA, AA-
Secure – 3	20%	A	A+, A	A1, A2	A+, A	A+, A
Secure – 4	50%	A-	A-	A3	A-	A-
Secure – 5	75%	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-	BBB+, BBB, BBB-
Vulnerable – 6	100%	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB, B+, B, B-, CCC+, CC, CCC-, DD	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D

e. **Protocol for Considering a Group Rating** - Section 8B(4) of the *Credit for Reinsurance Model Regulation* (#786) provides, in relevant part: “Each certified reinsurer shall be rated on a legal entity basis, **with due consideration being given to the group rating where appropriate....**” Understanding the rating agency basis for utilizing a group rating is a key factor in determining whether an applicant’s group rating may be considered appropriate. The recommended protocol for understanding the rationale involves one or more of the following protocol steps:

- i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;
- ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;
- iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;

- iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;
- v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or
- vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rationale for the use of a group rating.

**f. Changes in Ratings**

Section 8(B)(7)(a) of Model #786 provides that a certified reinsurer is required to notify the Commissioner of a certifying state within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons. The certified reinsurer may also fulfill this requirement by notifying its Lead State commissioner, with this information being distributed to other certifying states by the NAIC through the ReFAWG process. Upon receipt of any such notification, a certifying state should immediately notify ReFAWG in order to facilitate communication of the information to other states. ReFAWG will subsequently send notification to all applicable regulators and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).

Changes requiring action by a certifying state in accordance with statute and/or regulation may include but are not limited to: deterioration in financial condition; downgrade in a financial strength rating; change in the status of its domiciliary license; change in the qualification status of its domestic jurisdiction; and the triggering of certain thresholds with respect to reinsurance obligations to U.S. ceding insurers that are past due (in accordance with Section 8(B) of Model #786). While such changes may require action under statute or regulation, the ReFAWG process is intended to facilitate communication and coordination with respect to the date upon which changes in a certified reinsurer's rating/status are effective, as well as discussion of any other relevant issues.

As part of the ongoing review process, other information may come to the attention of a certifying state and/or ReFAWG that warrants consideration with respect to a certified reinsurer's rating/status. While ReFAWG cannot require a state to delay any action with respect to a certified reinsurer's rating/status, certifying states are strongly encouraged to notify ReFAWG prior to taking any related action, as the ReFAWG process will serve to provide a proactive regulatory mechanism for communication of such information, discussion among regulators with respect to changes being considered on the basis of subjective rating criteria, and possible coordination of applicable effective dates if such changes are enacted. Upon receipt of any such information, ReFAWG will send notification to the NAIC Chief Financial Regulators listing and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).

- g. **Schedule F/S (Ceded Reinsurance)** – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.
- h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.
- i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).
- j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.
- k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).
- l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.
- m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.
- n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

- o. **Public Notice** - The commissioner is required to post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting such notice. The commissioner will consider any comments received during the public notice period with respect to this application.

#### 4. Certified Reinsurers – Certified by Another NAIC Accredited Jurisdiction

If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the state has the discretion to defer to that jurisdiction's certification and assigned rating (i.e., passporting) as provided in the *Uniform Application Checklist for Certified Reinsurers* (Exhibit 1).

To assist in the determination to defer to another jurisdiction's certification the following documents are required:

- a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.
- b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant's statement on compliance. ReFAWG may also verify a certification issued by an NAIC accredited jurisdiction through its internal processes.
- c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant's certified reinsurer status (if applicable).
- d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.
- e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.
- f. **Public Notice** - The commissioner is required to post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the

application until at least 30 days after posting such notice. The commissioner will consider any comments received during the public notice period with respect to this application.

**5. Reciprocal Jurisdiction Process - Initial Application to Lead State**

**Annual Verification of Minimum Standards:**

<b>Timeline Event</b>	<b>Required Date</b>
Required Documents Filed with Lead State	June 30
Required Passporting Documents Uploaded to NAIC ReFAWG Database	August 31
NAIC Staff Re-Verification Process and Conference Calls	September 1 – November 30
All Passporting Re-Verifications Completed	December 1
Effective Date of Passporting Re-Verification	1/1/xx to 12/31/xx <b>(Next Calendar Year)</b>
Applications for Passporting	1/1/xx to 12/31/xx

Pursuant to the *Uniform Checklist for Reciprocal Jurisdiction Reinsurers* (Exhibit 2), the “Lead State” will uniformly require assuming insurers to provide the following documentation so that other states may rely upon the Lead State’s determination:

- a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction that is listed on the *NAIC List of Reciprocal Jurisdictions*. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction. The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.
  
- b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than \$250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250,000,000 (USD); and a central fund containing a balance of the equivalent of at least \$250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer satisfies this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the

confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

- c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio: The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer's supervisory authority must confirm to the Lead State commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.
- d. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.
- e. **Audited Financial Report** - The assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.
- f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor as provided under Section 9C(5)(b) of Model #786.
- g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786. The commissioner shall request the reinsurer to provide the information required to demonstrate the reinsurer's practice of prompt payment of claims under its reinsurance agreements prior to entry into a reinsurance agreement, and annually thereafter, in order to demonstrate compliance with Section 9C(6) of Model #786.
- h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement.

- i. **Prompt Payment of Claims** - The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (1) more than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner; (2) more than fifteen percent (15%) of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer \$100,000, or as otherwise specified in a Covered Agreement; or (3) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds \$50,000,000, or as otherwise specified in a Covered Agreement.

## 6. **Reciprocal Jurisdiction Process – Passporting States**

Per the *Uniform Checklist for Reciprocal Jurisdiction Reinsurers* (Exhibit 2), if an NAIC accredited jurisdiction has determined that the conditions set forth under the *Filing Requirements for Lead States* have been met, the commissioner has the discretion to defer to that jurisdiction's determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC. The following document is required to be filed with the state:

- a. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.
- b. **Verification of Determination Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.

## 7. **NAIC Staff Review of Certified and Reciprocal Jurisdiction Reinsurers**

The reinsurer will file this information with the initial reviewing state and such Lead State will submit the information to ReFAWG in accordance with the applicable information sharing process. This submission by the Lead State will also facilitate other states' access to the information. NAIC staff shall prepare a report for review by ReFAWG intended to provide information regarding whether the Lead State's submission meets the requirements of the ReFAWG Review Process, and to determine whether there are any deficiencies in the application. This report will be considered confidential but may be made available to states through the NAIC's information sharing process.

NAIC Staff under the direction of ReFAWG will assist in the review of the filings and in monitoring the ongoing condition of the reinsurers. If during the review process or during an interim period ReFAWG determines that a reinsurer's assigned rating or status may warrant reconsideration, notice will be sent to the Lead State. The specific issues identified will be presented for discussion during the next ReFAWG meeting.

## **8. Process for Ongoing Monitoring of Reinsurers**

Certified and Reciprocal Jurisdiction Reinsurers are required to file specific information to a certifying state on an ongoing basis. NAIC Staff and ReFAWG will review this information in an effort to assist states with the ongoing monitoring of the reinsurers. Subject to applicable state law, all non-public information submitted by reinsurers shall be kept confidential and regulator only.

## **9. Withdrawal/Termination of a Certified or Reciprocal Jurisdiction Reinsurer**

When a reinsurer requests to withdraw its status or the lead state terminates the reinsurer's status as a certified or reciprocal reinsurer, notice of this action should be promptly conveyed to the appropriate NAIC Staff. Once NAIC Staff receives notification of withdrawal or termination, the applicable Passported Reinsurers List(s) will be updated to reflect this status change. The Passported reinsurer will follow the lead state's laws regarding its withdrawal or termination regarding any active reinsurance contracts.

## **10. Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurer Status**

- a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the *Credit for Reinsurance Model Law* (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.
- b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business or business with existing liabilities and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC Blanks have been amended to reflect the status of these reinsurers with respect to each type of insurance assumed.
- c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. For example, a Reciprocal Jurisdiction Reinsurer may cross reference information/documentation that has been filed with

respect to its status as a Certified Reinsurer, so that it is not necessary to file duplicative documents. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

- d. During the initial phases of the implementation of the review of Reciprocal Jurisdiction Reinsurers, not all states may have fully implemented their internal processes for performing these reviews. During this interim period, if a Reciprocal Reinsurer has been approved by a lead state and ReFAWG, the Reciprocal Jurisdiction Reinsurer may seek passporting approval from other states that have adopted the model law and regulation even where a formal internal process for doing so has not yet been finalized. States and Reciprocal Jurisdiction Reinsurers are encouraged to communicate on these issues and, as appropriate, to coordinate through the NAIC to facilitate the passporting process.

#### **11. Commissioner Shall Create and Publish Lists**

Section 2E(3) of Model #785 and Section 8C(1) of Model #786 require the commissioner to publish a list of Qualified Jurisdictions, while Section 2E(4) of Model #785 and Section 8B(2) of Model #786 require the commissioner to publish a list of all Certified Reinsurers and their ratings. Section 2F(2) & (3) of Model #785 and Section 9D and E of Model #786 require the commissioner to (a) timely create and publish a list of Reciprocal Jurisdictions; and (b) timely create and publish a list of Reciprocal Jurisdiction Reinsurers. It is expected that the commissioner will publish these respective lists on the insurance department's website, along with special instructions or other guidance as to how Certified Reinsurers and Reciprocal Jurisdiction Reinsurers may meet the applicable filing requirements under the models. There currently are no specific requirements as to the format in which these lists must be published, but ReFAWG and NAIC staff will assist the states with questions on the publication of these lists. In addition, ReFAWG will maintain links on its NAIC webpage to the lists published on the insurance departments' webpages.

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MEMORANDUM

To: Financial Regulation Standards and Accreditation (F) Committee

From: Financial Condition (E) Committee

Date: March 8, 2021

Re: 2020 Revisions to *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)

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On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance.

Please find attached, memorandums and proposed changes to the Accreditation (E) Committee as adopted by the Financial Condition (E) Committee related to these most recent changes to #440 and #450. Each of the memorandum's summarize the basis for recommending that certain provisions of these model changes become part of the Accreditation program as well as suggested timing. With respect to timing, consistent with action taken by the Financial Regulation Standards and Accreditation (F) Committee to use an expedited process in 2019 with respect to the *Credit for Reinsurance Model Law* (#785) and the *Credit for Reinsurance Model Regulation* (#786) due to the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (Covered Agreement), we recommend a similar expedited process with respect to states who are a Group Wide Supervisor of a group with operations in the EU or UK. The attached provide further details on the specifics of such recommendations.

On August 14, F Committee voted to expose the referral for a 1-year comment period beginning January 1, 2022 (pending approval by Plenary at the Fall National Meeting).

The exposure by F Committee differs from the original exposure in two ways:

- The proposed effective date for all states is January 1, 2026.
- The proposed significant elements for the group capital calculation were modified to allow commissioners to grant exemptions to groups meeting the qualifications set forth in Model #450 Section 21A and Section 21B without the requirement to file at least once.

Note: In conjunction with the motion, the F Committee strongly encourages all states with a group impacted by the Covered Agreement to adopt the group capital calculation revisions to Model #440 and Model #450 for those groups effective Nov. 7, 2022. The Committee also strongly encourages states with a group impacted by the liquidity stress test to adopt the relevant revisions to Model #440 as soon as possible.



## MEMORANDUM

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

Re: 2020 Revisions to *Insurance Holding Company System Regulatory Model Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)

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### Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Working Group believes is appropriate with respect to only the GCC and expect the Financial Stability (EX) Task Force to make separate recommendations to the Committee with respect to the LST.

The GCC was developed as a result of discussions which began in 2015. The GCC is a natural extension of work state insurance regulators had begun, in part by lessons learned from the most recent financial crisis, to better understand an insurance group's financial risk profile for the purpose of enhancing policyholder protections. While state insurance regulators currently have the authority to obtain information regarding the capital positions of non-insurance affiliates, they do not have a consistent analytical framework for evaluating such information. The GCC is designed to address this shortcoming and will serve as an additional financial metric that will assist state insurance regulators in identifying risks that may emanate from a holding company system. The GCC, and related financial reporting, will provide comprehensive transparency to state insurance regulators, making risks more easily identifiable and quantifiable. For these reasons, the Working Group recommends adoption of #440 and #450 as accreditation standards for all states with the normal accreditation timeline, which would result in an effective date of January 1, 2026.

In addition, the GCC is intended to comply with the requirements under the "Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance" (Covered Agreement), which was signed on Sept. 22, 2017. On Dec. 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK). The GCC is intended to meet the requirement that the states have a "worldwide group capital calculation" in place by Nov. 7, 2022 in order to avoid the EU from imposing a group capital assessment or requirement at the level of the worldwide parent undertaking. Failure of any state to do so for any U.S. group operating in such jurisdiction raises the potential for any supervisor in the EU or UK to impose its own group capital calculation (e.g., Solvency II capital requirements) on that group and therefore all of the U.S. insurers within that group. Due to this agreement, the Working Group recommends that the accreditation standard become effective Nov. 7, 2022 for those states who are the Group Wide Supervisor of a group with operations in the EU or UK.

**A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:**

The current *Insurance Holding Company Systems* accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the GCC was designed to enhance these same standards that were previously included as accreditation standards.

**A statement as to why ultimate adoption by every jurisdiction may be desirable:**

The Group Capital Calculation (E) Working Group believes that all states that are the lead state for a group subject to the GCC should be required to adopt the model revisions. The GCC is a tool intended to help protect the policyholders in all states from the risk that can emanate from outside the domestic insurer and will be an input into the Group Profile Summary (GPS). After an initial filing by all insurance groups, the GCC is required for all U.S. insurance groups with greater than \$1 billion in premium. The groups subject to the GCC are expected to have domestic insurers in most U.S. states. Therefore, it is recommended that that the new significant elements apply to all states.

**A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:**

We are not currently aware of any states that have adopted the 2020 revisions to Model #440 and Model #450, although we have been advised that many states have begun their legislative processes for adoption of these revisions.

**A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:**

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Group Capital Calculation (E) Working Group supports the attached proposed significant elements (Attachment A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Group Capital Calculation (E) Working Group recommends that the accreditation standard become effective Nov. 7, 2022, the end of the 60-month period contemplated under the Covered Agreement, with enforcement of the standard to commence Jan. 1, 2023. However, the Working Group is also supportive of the effective date being bifurcated to allow those states that are not the Group Wide Supervisor of a group with operations in the EU or UK to be subject to a later effective date in line with the normal accreditation timeline, which would result in an effective date of January 1, 2026.

12/16/21

There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Group Capital Calculation (E) Working Group strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the GCC as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the GCC public in any way as they are designed as regulatory-only tools. Unlike RBC that has regulatory trigger points, the GCC does not, and the regulators of these groups believed it would be detrimental if these tools were used by insurers as a means to advertise their relative solvency strength.

**An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:**

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440 and Model #450, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the possible exemptions allowed under Model #450 are specifically designed to consider the cost to complete the GCC by the insurance company and the benefits of the GCC to the lead-state commissioner. More specifically, all insurers are required to submit the GCC at least once, after which time the expectation is that the lead state commissioner will evaluate the added insight brought to the state from GCC; then, provided the group has premium less than \$1 billion, no international business, no risky non-regulated entities and no banks or similar capital regulated entities in the group, the lead state commissioner can exempt the group from filing in the future.

In addition, the construction of the GCC also considers cost of completion and specifically provides a principle-based approach where the insurance company can exclude non-risky affiliates from the calculation and also provides the insurance company to group the information of multiple non-insurance/non-regulated affiliates as a means to further reduce the burden of completion. In short, the GCC is only as complex as the insurance group has structured itself, and therefore the GCC already inherently considers the cost to comply.

## 6. Insurance Holding Company Systems

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State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar, and the department should have adopted the NAIC *Insurance Holding Company System Model Regulation* (#450).

### *Insurance Holding Company Systems – continued*

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#### Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

#### New

- l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?
- i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?
  - ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?
  - iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?
  - iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?
  - v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?
  - vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

#### Changes to Existing

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

#### New

- m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
- n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?
- i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?

*The significant elements exposed by F Committee on Aug. 14, 2021 include a modification to element n.i and n.ii. Please see separate document containing the modified significant elements.*

- ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450? *See above comment regarding modifications.*
- iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?
- iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?



## MEMORANDUM

To: Financial Condition (E) Committee  
From: Financial Stability (E) Task Force  
Date: February 22, 2021  
Re: 2020 Revisions to *Insurance Holding Company System Regulatory Act* (#440)

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### Executive Summary

On Dec. 9, 2020, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implemented a Group Capital Calculation (GCC) for the purpose of group solvency supervision and Liquidity Stress Test (LST) for macroprudential surveillance. This memorandum makes recommendations with respect to the accreditation standards that this Task Force believes is appropriate with respect to only the LST and expect the Group Capital Calculation (E) Working Group to make separate recommendations to the Committee with respect to the GCC.

Post-financial crisis, regulators from all financial sectors across the globe recognized the need for macroprudential surveillance and tools to address macroprudential risks. While the solvency framework established and managed by the Financial Condition (E) Committee thoroughly addresses legal entity insurers and insurance groups, there was no group with a macroprudential scope. This Task Force was created to fill this gap, and in 2017 was charged to “analyze existing post-financial crisis regulatory reforms for their application in identifying macroprudential trends, including identifying possible areas of improvement or gaps, and propose . . . enhancements and/or additions to further improve the ability of state insurance regulators and industry to address macroprudential impacts.” The Task Force created the NAIC Macroprudential Initiative (MPI) to focus its efforts in four key areas: liquidity risk, recovery and resolution, capital stress testing, and exposure concentrations. Liquidity risk was consistently recognized as a key macroprudential risk by federal and international regulatory agencies, and there were several attempts to assess potential market impacts emanating from a liquidity stress in the insurance sector. Many of these analyses relied heavily on anecdotal assumptions and observations from behaviors of other financial sectors.

In order to provide more evidence-based analyses, the Task Force decided to develop a LST for large life insurers that would aim to capture the impact on the broader financial markets of aggregate asset sales under a liquidity stress event. Unlike capital adequacy, which has risk-based capital as a standardized legal entity capital assessment tool and the newly created Group Capital Calculation to provide a capital analysis tool at the group level, there is no regulatory liquidity assessment or stress tool. The Task Force focused on large life insurers due to the long-term cash buildup involved in many life insurance contracts and the potential for large scale liquidation of assets, not because liquidity risk does not exist in other insurance segments. Thus, the primary goal of the LST is to provide quantitative as well as qualitative insights for macroprudential surveillance, such as identifying the amount of asset sales that could occur during a specific stress scenario; but it will also aid micro prudential regulation as well. Because this stress testing is complex and resource-intensive, a set of scope criteria were developed to identify life insurers with large balances of activities assumed to be highly correlated with liquidity risk; thus, many life insurers will not be subject to the LST.

**A statement and explanation of how the potential standard is directly related to solvency surveillance and why the proposal should be included in the standards:**

The current *Insurance Holding Company Systems* accreditation standard requires that state law shall contain the significant elements from Model #440 and Model #450. These models have provided state insurance departments the framework for insurance group supervision since the early 1970s. Following the 2008 financial crisis, state regulators identified group supervision as an area where improvements could be made to the U.S. system. In December 2010, the NAIC adopted changes to the models enhancing the domestic legal structure under which holding companies are supervised. In December 2014, the NAIC adopted revisions to clarify legal authority and powers to act as a group-wide supervisor for internationally active insurance groups. These changes are newly required elements of the NAIC Accreditation Program and have been satisfactorily adopted by nearly all accredited U.S. jurisdictions. As discussed in the preceding paragraphs, the LST was designed to enhance these same standards that were previously included as accreditation standards.

Macroprudential risks can directly impact regulated legal entity insurers and groups, and/or can emanate from or be amplified by these insurers and transmitted externally. The NAIC solvency surveillance framework must address macroprudential risks to ensure that the companies states regulate remain financially strong for the protection of policyholders, while serving as a stabilizing force to contribute to financial stability, including in stressed financial markets. The LST is the first new tool developed for the macroprudential program within the financial solvency framework.

**A statement as to why ultimate adoption by every jurisdiction may be desirable:**

The Financial Stability Task Force believes that all states that are the lead state for a group subject to the LST should be required to adopt the model revisions. The LST is a tool intended to help assess the impacts the life insurance industry can have on the broader financial markets in a time of stress. Ideally, the tool would have been required of all life insurance groups, but this was not possible due to the complexity and resources required to accomplish such liquidity stress testing. Thus, the LST uses a set of scope criteria to identify those life insurers with significant amounts in activities assumed to have high liquidity risk, thus representing the larger portion of the life insurance industry in terms of liquidity risk rather than representing the entire life insurance industry. If a scoped-in life insurance group was not subject to the LST because a state did not adopt the model revisions, this would significantly reduce the ability of the NAIC to represent the results as truly macroprudential and reflective of the majority of risks of the life insurance sector. Additionally, the LST results will be helpful to the lead states in their group supervision efforts as well.

Though not every state will be the lead state of a scoped-in group, the Task Force still believes the model revisions for the LST should be adopted in every state. It is fairly common for legal entity insurers to move from one group to another, impacting the group dynamics including the lead state determination, and each state should have the LST in their statutes to ensure they will be prepared for any future appointment as lead state. Also, even without legal entities changing groups, business acquisition and operational changes within existing groups might subject a previously excluded group to the LST. Therefore, it is recommended that the new significant elements apply to all states.

**A statement as to the number of jurisdictions that have adopted and implemented the proposal or a similar proposal and their experience to date:**

We are not currently aware of any states that have adopted the 2020 revisions to Model #440, although we have been advised that many states have begun their legislative processes for adoption of these revisions.

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**A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:**

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Financial Stability (E) Task Force supports the attached proposed significant elements (Attached) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Financial Stability (E) Task Force recommends that the accreditation standard become effective Nov. 7, 2022, concurrent with the Group Capital Calculation revisions to the model, with enforcement of the standard to commence Jan. 1, 2023.

There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Financial Stability (E) Task Force strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the LST as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the LST public in any way as they are designed as regulatory-only tools using complex assumptions for potential future stress events and the results could easily be misinterpreted and misrepresented by other users, causing true financial harm to the insurers.

**An estimate of the cost for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it, if reasonably quantifiable:**

The NAIC has not performed a cost/benefit analysis with respect to the 2020 revisions to Model #440, nor do we believe that the specific costs for insurance companies to comply with the proposal and the impact on state insurance departments to enforce it are reasonably quantifiable. However, the LST scope criteria selects the larger, more complex life insurers, and all of these already perform some form of internal liquidity stress tests. While there are regulatory requirements for inputs and outputs, truly significant costs are avoided by using their existing internal stress testing systems instead of specifying a regulatory model.

## 6. Insurance Holding Company Systems

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State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar.

### *Insurance Holding Company Systems – continued*

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#### Changes to Existing

- k. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

#### New

- c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?
- d. Define “Scope Criteria” similar to that in Section 1M?
- l. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:
- i. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the *Financial Analysis Handbook* similar to Section 4L(3)?
  - ii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?
  - iii. Provision requiring compliance with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

#### Changes to Existing

- cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.
- m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

**The following significant elements were modified from the initial March 8, 2021 E Committee referral and exposed by the F Committee on Aug. 14, 2021 for a 1-year exposure beginning January 1, 2022 (pending approval by Plenary at the Fall National Meeting). The modifications to n(i) and n(ii) allow Commissioners to grant exemptions to the group capital calculation to groups meeting the standards set forth in Model Regulation #450 Section 21A and Section 21B without the requirement to file at least once.**

**The significant elements are separated into those that incorporate the group capital calculation and those that incorporate the liquidity stress test.**

## **6. Insurance Holding Company Systems (Group Capital Calculation)**

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State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar, and the department should have adopted the NAIC *Insurance Holding Company System Model Regulation* (#450).

### *Insurance Holding Company Systems – continued*

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#### Changes to Existing

k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?

#### New

- l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?
  - i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?
  - ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?
  - iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?
  - iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?
  - v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the world-wide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?
  - vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

#### Changes to Existing

cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

New

- m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
- n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?
  - i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?
    - o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?
  - ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?
    - o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?
  - iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?
  - iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?

**6. Insurance Holding Company Systems (Liquidity Stress Test)**

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State law should contain the NAIC *Insurance Holding Company System Regulatory Act* (#440), or an act substantially similar.

*Insurance Holding Company Systems – continued*

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Changes to Existing

- o. Additions to the filing requirements for the enterprise risk filing specified in Section 4L(1) of the Model #440 (see next item).

New

- c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?
- d. Define “Scope Criteria” similar to that in Section 1M?
- p. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:
  - vii. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the *Financial Analysis Handbook* similar to Section 4L(3)?
  - viii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

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- ix. Provision requiring compliance with the NAIC Liquidity Stress Test Framework's instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

Changes to Existing

- cc. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.
- q. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

Date: 12/1/21

## State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

### Executive (EX) Committee

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

### Life Insurance and Annuities (A) Committee

- Amendments to the *Annuity Disclosure Model Regulation (#245)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Amendments to the *Suitability in Annuity Transactions Model Regulation (#275)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. Seven states have enacted the revisions to the model.
- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities (#805)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 14 states have adopted the revisions to this model.

### Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act (#170)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.
  - Amendments to the *Health Maintenance Organization Model Act (#430)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.
  - Amendments to the *Insurance Holding Company System Regulatory Act (#440)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Six states have adopted the revisions to this model.
  - Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Two states have adopted the revisions to this model.
  - 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.
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**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. 46 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. 22 states have enacted this model.