

EXECUTIVE (EX) COMMITTEE AND PLENARY

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

Adopted the Amendments to 2021 Proposed Charges (Attachment One)

Adopted the Amendments to the *Valuation Manual* (Attachment Two)

Adopted the Amendments to the *Annuity Disclosure Model Regulation* (#245) (Attachment Three)

Failed to Adopt the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs) (Attachment Four)

Adopted the *Guideline for Definition of Reciprocal State in Receivership Laws* (Attachment Five)

Adopted the Revised *Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions* (Attachment Six)

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

Adopted the Amendments to the *Process for Evaluating Qualified and Reciprocal Jurisdictions* (Attachment Eight)

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

Draft Pending Adoption

Draft: 8/31/21

Executive (EX) Committee and Plenary
Columbus, Ohio
August 17, 2021

The Executive (EX) Committee and Plenary met in Columbus, OH, Aug. 17, 2021. The following members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Reyn Norman (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Evan G. Daniels represented by Jon Savary (AZ); Ricardo Lara represented by Bryant Henley (CA); Michael Conway represented by Peg Brown (CO); Karima M. Woods (DC); Trinidad Navarro (DE); John F. King represented by Martin Sullivan (GA); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Mike Chaney (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Russell Toal (NM); Linda A. Lacewell represented by My Chi To (NY); Judith L. French represented by Carrie Haughawout (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); James A. Dodrill (WV); and Jeff Rude (WY).

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

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

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

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

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

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

The Executive (EX) Committee received a status report on model law development efforts for amendments to: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) the *Annuity Disclosure Model Regulation* (#245); 3) the *Insurance Holding Company System Regulatory Act* (#440); 4) the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450); 5) the *Life Insurance Disclosure Model Regulation* (#580); 6) the *Nonadmitted Insurance Model Act* (#870); and 7) new models, including the Pet Insurance Model Law and the [State] Pharmacy Benefit Manager Licensure and Regulation Model Act (PBM Model).

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

Director Cameron made a motion, seconded by Director Farmer, to adopt the Aug. 15 report of the Executive (EX) Committee. The motion passed unanimously.

Draft Pending Adoption

2. Adopted by Consent the Committee, Subcommittee, and Task Force Minutes of the Spring National Meeting

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

3. Adopted Amendments to 2021 Proposed Charges

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

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

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

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

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

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

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

5. Adopted Amendments to the *Valuation Manual*

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

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

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

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

Draft Pending Adoption

6. Adopted Amendments to the Annuity Disclosure Model Regulation (#245)

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

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

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

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

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

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

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

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

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

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

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

The Committee received an update on the work of the Special (EX) Committee on Race and Insurance Workstream Five. The Workstream met July 8 and June 10. During these meetings, the Workstream discussed data collection issues, provider network,

Draft Pending Adoption

provider directories, and cultural competency. Based on its discussions on data collection, the Workstream released a draft “best practices” document for a public comment period ending Aug. 19. The Workstream plans to discuss any comments received on the draft document during its Aug. 26 meeting. The Workstream anticipates developing a similar “best practices” document on provider network, provider directories, and cultural competency.

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

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

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

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

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

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

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

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

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

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

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

Commissioner Schmidt noted that Kansas will be voting “no” on adoption of this PBM model because “as seen in the minutes and materials that came out of the drafting group, including the notes and summary of the issues that the drafting group addressed but did not come to consensus on and the action of the Committee to remove the contentious drafting note, the model law we are voting on does not address the issues that many states are interested in regulating. The drafting group worked hard

Draft Pending Adoption

on its charge, and its work should be commended. However, the final product before us today is, simply, an ineffective piece of legislation that I doubt will be adopted by a majority of my sister states. I believe the wiser course of action would have been to continue the hard work of drafting model legislation that addresses the substantive issues affecting health care in our states. States will remain free to adopt the model, no PBM legislation, a completely different legislation, or a modified version of the PBM model that includes more substantive topics. As the opposition to including the drafting note was concern about uniformity, we see here another example of bureaucracy interfering with flexible, good government. We will not have uniform adoption, so there is no need to adopt this model.”

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

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

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

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

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

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

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

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

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

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

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

Commissioner Pike made a motion, seconded by Chief Deputy Commissioner Slape, to adopt the Model Law Addressing Licensure or Registration of Pharmacy Benefit Managers (PBMs) (Attachment Four). A roll call vote was taken. The motion failed. Arizona, Georgia, Idaho, Indiana, Kansas, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, and West Virginia voted against the motion. Alaska, American Samoa, Arkansas, California, Connecticut, Delaware, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, and Virginia abstained. Alabama, Colorado, District of Columbia, Florida, Hawaii, Kentucky, Minnesota, Montana, Nebraska, Ohio, Oklahoma, Oregon, Tennessee, Texas, U.S. Virgin Islands, Utah, Washington, Wisconsin, and Wyoming voted in favor of the motion.

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

Commissioner Schmidt reported that the Property and Casualty Insurance (C) Committee met Aug. 16 and adopted its Spring National Meeting minutes.

Draft Pending Adoption

The Committee adopted the reports of its task forces and working groups: the Casualty Actuarial and Statistical (C) Task Force; the Surplus Lines (C) Task Force; the Title Insurance (C) Task Force; the Workers' Compensation (C) Task Force; the Cannabis Insurance (C) Working Group; the Catastrophe Insurance (C) Working Group; the Pet Insurance (C) Working Group; the Terrorism Insurance Implementation (C) Working Group; and the Transparency and Readability of Consumer Information (C) Working Group.

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

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

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

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

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

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

The Committee adopted the reports of its task forces and working groups: the Antifraud (D) Task Force; the Market Information Systems (D) Task Force; the Producer Licensing (D) Task Force; the Market Conduct Annual Statement Blanks (D) Working Group; the Market Conduct Examination Guidelines (D) Working Group; the Market Analysis Procedures (D) Working Group; and the Privacy Protections (D) Working Group.

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

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

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force; the Capital Adequacy (E) Task Force; the Examination Oversight (E) Task Force; the Financial Stability (E) Task Force; the 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 Mortgage Guaranty Insurance (E) Working Group; the Mutual Recognition of Jurisdictions (E) Working Group; the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; and the National Treatment and Coordination (E) Working Group. The report of the Financial Stability (E) Task Force included revised charges.

The Committee adopted a referral to the Statutory Accounting Principles (E) Working Group that requests consideration of changes to the Working Group's maintenance policy.

Draft Pending Adoption

The Committee took the following action: 1) adopted revisions to the *Process for Evaluating Qualified and Reciprocal Jurisdictions*; and 2) adopted revised charges for the renamed Macroprudential (E) Working Group.

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

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

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

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

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

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

13. Adopted the Revised SSAP No. 71

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

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

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

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

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

Commissioner White made a motion, seconded by Superintendent Cioppa, to adopt the changes to SSAP No. 71 (Attachment Six).

Draft Pending Adoption

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

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

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

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

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

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

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

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

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

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

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

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

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

Director Dunning reported that the Financial Regulation Standards and Accreditation (F) Committee met Aug. 13 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Arkansas; Indiana; Michigan; New Jersey; and Washington, DC.

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

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

Draft Pending Adoption

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

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

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

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

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

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

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

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

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

W:\National Meetings\2021\Summer\Plenary\8-Plenary.docx

Draft: 7/21/2021

Adopted by the Executive (EX) Committee and Plenary, Aug. 17, 2021

Adopted by the Executive (EX) Committee, Aug. 15, 2021

Adopted by the Special (EX) Committee on Race and Insurance, July 21, 2021

2021/2022 Proposed Charges

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

Draft: 6/15/21

Adopted by the Health Insurance and Managed Care (B) Committee – June 22, 2021

Adopted by the Regulatory Framework (B) Task Force – June 15, 2021

2021 REVISED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The **Regulatory Framework (B) Task Force** will:
 - A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
 - B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
 - C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
 - D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2021.
 - E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze and report developments related to association health plans (AHPs).
 - F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.
2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
 - A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
3. The **ERISA (B) Working Group** will:
 - A. Monitor, 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) 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 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
 - B. Monitor, facilitate and coordinate best practices with the states, the DOL and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
 - C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
 - D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC *Market Regulation Handbook*.
 - E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** will:
 - A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.
 - B. Develop a white paper to: 1) analyze and assess the role PBMs, Pharmacy Services Administrative Organizations (PSAOs) and other supply chain entities, play in the provision of prescription drug benefits; 2) identify, examine and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating and spread pricing, including the implications of the *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.

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

Draft: 5/25/21

Adopted by the Market Regulation and Consumer Affairs (D) Committee, July 27, 2021
Adopted by the Antifraud (D) Task Force, May 25, 2021

2021 Revised Charges

ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Antifraud (D) Task Force** will:
 - A. Work with NAIC committees, task forces and working groups (e.g., Title Insurance (C) Task Force, etc.) to review issues and concerns related to fraud activities and schemes related to insurance fraud.
 - B. Coordinate efforts to address national concerns related to agent fraud and activities of unauthorized agents related to insurance sales.
 - C. Coordinate the enforcement and investigation efforts of state and federal securities regulators with state insurance fraud bureaus.
 - D. Coordinate with state, federal and international law enforcement agencies in addressing antifraud issues relating to the insurance industry.
 - E. Review and provide comments to the International Association of Insurance Supervisors (IAIS) on its Insurance Core Principles (ICPs) related to insurance fraud.
 - F. Coordinate activities and information from national antifraud organizations and provide information to state insurance fraud bureaus.
 - G. Coordinate activities and information with state and federal fraud divisions to determine guidelines that will assist with reciprocal involvement concerning antifraud issues resulting from natural disasters and catastrophes.
 - H. Coordinate efforts with the insurance industry to address antifraud issues and concerns.
 - I. Evaluate and recommend methods to track national fraud trends.
2. The **Antifraud Education Enhancement (D) Working Group** will:
 - A. Develop seminars, trainings and webinars regarding insurance fraud. Provide three webinars by the 2021 Fall National Meeting.
3. The **Antifraud Technology (D) Working Group** will:
 - A. Review and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.
 - B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2021 Fall National Meeting.
4. **The Improper Marketing of Health Insurance (D) Working Group will:**
 - A. Coordinate with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinate appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.
 - B. Review existing NAIC Models and Guidelines that address the use of lead generators for sales of health insurance products, and identify models and guidelines that need to be updated or developed to address current marketplace activities.

Draft: 7/27/21

Adopted by the Financial Condition (E) Committee, TBD

Adopted by the Financial Stability (E) Task Force, July 27, 2021

2021 Revised Charges

FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The **Financial Stability (E) Task Force** will:
 - A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.
 1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.
 - B. Consider state insurance regulators' input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.
 1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
 2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the *State Ahead* initiative.
 - C. Serve as a forum to coordinate state insurance regulators' perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as "systemically important" and "internationally active" both pre- and post-designation, including:
 1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
 2. Analyze proposed rules by the federal agencies that relate to financial stability.
 3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers (G-SIIs) and internationally active insurance groups (IAIGs).
 4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.
2. **The Macroprudential (E) Working Group** will:
 - ~~A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations;~~
 - ~~B. Assist with the remaining MPI projects related to counterparty disclosures and capital stress testing as needed;~~
 - ~~C. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions;~~
 - ~~D. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators' ability to monitor industry trends from a macroprudential perspective;~~
 - ~~E. Oversee the documentation of the NAIC's macroprudential policies, procedures, and tools; and~~
 - ~~F. Provide the Task Force with proposed responses to IAIS and other international initiatives as needed~~

~~The Liquidity Assessment (EX) Subgroup will:~~

 - ~~A. Continue to consider regulatory needs for data related to liquidity risk, and develop recommendations as needed.~~
 - ~~B. Refine and implement a liquidity stress testing framework proposal for consideration by the Financial Condition (E) Committee.~~
 - ~~C. Continue to develop and administer data collection tools, leveraging existing data where feasible, to provide the Financial Stability (EX) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating market conditions affected by the COVID-19 pandemic.~~

W:\National Meetings\2021\Summer\Plenary\Att 1 Amendments\2021Charges.pdf

Attachment Number	Page Number	LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date
1	3	2019-33	Sect II, VM-20, VM-51	Clarify the definition of individually underwritten life insurance and the applicability of PBR requirements for group contracts with individual risk selection issued under insurance certificates.	7/1/2021
2	11	2020-02	VM-20 Section 2.H and new Section 2.I	Provide clearer guidance on the boundaries of a company's latitude in following VM-20 steps	10/29/2020
3	15	2020-03	VM-20 Section 3.B.3	Clarify NPR calculation requirements	8/27/2020
4	19	2020-08	VM-20 Section 9.C.2.d.vi.	Clarify and introduce a third permissible technique for the calculation of company experience rates.	12/3/2020
5	22	2020-09	VM Section II, Subsection 1.D	Modify Life PBR Exemption	11/5/2020
6	25	2020-10	VM-20, VM-31	Mortality improvement	6/10/2021
7	35	2020-11	VM Section II, Subsection 1.D.4	Modify Life PBR Exemption-Part 2	2/11/2021
8	37	2020-13	VM-20, Sec 7.D.3	Asset Collar	4/8/2021
9	38	2021-03	VM-21, Section 6.C.5:	Update the reference to required minimum distribution age	5/6/2021
10	41	2021-04	VM-02 Section 3.A	Clarify the language in the previously adopted edits to VM-02 to avoid any potential circularity.	4/29/2021
11	43	2021-05	VM-01, VM-20 7.E, VM-21 4.D, VM-31 3.D.6, 3.F.6	Clarify modeled company investment strategy and comparison to the alternative investment strategy	5/20/2021
12	48	2021-06	VM-50, VM-51	Revise VM-50 and VM-51 to allow experience reporting a reinsurer or third-party administrator and a correction to VM-51 Appendix 4	5/27/2021
13	91	2021-07	VM-20 Section 2.A.3, 3.A, 3.B 3.C and 6.B	Clarify ULSG NPR Calculation Requirements	6/24/2021
14	99	2021-09	VM-21 Section 1.E (new), 3.H (new), VM-31 Section 3.E.1, 3.F.2.e	Update VM-31 materiality language to be consistent new section of VM-21 addressing materiality.	7/1/2021
15	102	2021-10	VM 51 App 4	Remove "at issue" from Smoker Status data element name to allow for use of the smoker status at the time of data submission	6/24/2021

W:\National Meetings\2021\Summer\Plenary\Att 2 ValuationManualAmendmentsChart.pdf

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

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

2. NAIC staff support contact information:

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

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

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

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

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

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

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

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

Yes or No (Check one)

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

1 x 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

Adopted by Life Insurance and Annuities (A) Committee on July 19, 2018

ANNUITY DISCLOSURE MODEL REGULATION

Table of Contents

Section 1.	Purpose
Section 2.	Authority
Section 3.	Applicability and Scope
Section 4.	Definitions
Section 5.	Standards for the Disclosure Document and Buyer's Guide
Section 6.	Standards for Annuity Illustrations
Section 7.	Report to Contract Owners
Section 8.	Penalties
Section 9.	Separability
Section 10.	[Optional] Recordkeeping
Section 11.	Effective Date
Appendix A.	Annuity Illustration Example

* * * *

Section 6. Standards for Annuity Illustrations

* * * *

F. An illustration shall conform to the following requirements:

- (1) The illustration shall be labeled with the date on which it was prepared;
- (2) Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");
- (3) The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;
- (4) If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue age plus the numbers of years the contract is assumed to have been in force;
- (5) The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;
- (6) Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;
- (7) Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;
- (8) **Except as provided in Paragraph (22),** ~~the~~ non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;

- (9) In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent ten (10) calendar years; one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the least index value growth (the “low scenario”); one to reflect the historical performance of the index for the continuous period of ten (10) calendar years out of the last twenty (20) calendar years that would result in the most index value growth (the “high scenario”). The following requirements apply:
- (a) The most recent ten (10) calendar years and the last twenty (20) calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three (3) months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;
 - (b) If any index utilized in determination of an account value has not been in existence for at least ten (10) calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of those indexes has not been in existence for at least ten (10) calendar years, the allocation to such indexed account(s) shall be assumed to be zero;
 - (c) If any index utilized in determination of an account value has been in existence for at least ten (10) calendar years but less than twenty (20) calendar years, the ten (10) calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;
 - (d) The non-guaranteed element(s), such as caps, spreads, participation rates or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element(s);
 - (e) If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:
 - (i) The allocation used in the illustration shall be the same for all three scenarios; and
 - (ii) The ten (10) calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.
 - (f) The geometric mean annual effective rate of the account value growth over the ten (10) calendar year period shall be shown for each scenario;
 - (g) If the most recent ten (10) calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection H, the most recent ten (10) calendar year historical period experience of the index shall be used for each subsequent ten (10) calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;
 - (h) The low and high scenarios: (i) need not show surrender values (if different than account values); (ii) shall not extend beyond ten (10) calendar years (and therefore are not subject to the requirements of subsection H beyond subsection H(1)(a)); and (iii) may be shown on a separate page. A graphical presentation shall also be included comparing the movement of the account value over the ten (10) calendar year period for the low scenario, the high scenario and the most recent ten (10) calendar year scenario; and

- (i) The low and high scenarios should reflect the irregular nature of the index performance and should trigger every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;
- (10) The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., “see page 1 for guaranteed elements”);
- (11) The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;
- (12) The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest and application of any market value adjustment, as applicable;
- (13) Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;
- (14) Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:
 - (a) The benefits and values are not guaranteed;
 - (b) The assumptions on which they are based are subject to change by the insurer; and
 - (c) Actual results may be higher or lower;
- (15) Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps or spreads for fixed indexed annuities;
- (16) The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;
- (17) Illustrations shall be concise and easy to read;
- (18) Key terms shall be defined and then used consistently throughout the illustration;
- (19) Illustrations shall not depict values beyond the maximum annuitization age or date;
- (20) Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and
- (21) Illustrations shall show both annuity income rates per \$1000.00 and the dollar amounts of the periodic income payable.
- (22) **For participating immediate and deferred income annuities:**
 - (a) Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);
 - (b) Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds or falls short of expectations;

- (c) If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;
- (d) If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:
 - (i) Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and
 - (ii) The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subparagraph iii, below, based on the time to maturity or reinvestment (the “Tenor”) of the investments supporting the cohort of policies.
 - (iii) Maximum long-term interest rates should be calculated for tenors of 3 months (or less), 5 years, 10 years and 20 years (or more), using U.S. Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).
 - (iv) The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.
 - (v) Grading to the maximum long-term interest rates should take place over:
 - (I) No less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates; or
 - (II) No more than 20 years from the issue if the U.S. Treasury rates as of the illustration date are above the long-term rates.
 - (vi) When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall satisfy the following conditions:
 - (I) Assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates, and
 - (II) Illustrate dividends no less than half of the dividends illustrated under the current dividend scales.
 - (III) If (a) and (b) above are in conflict—i.e., if half of the current dividends are greater than would be permitted by Condition (a)—then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.

- (vii) The illustration should include a disclosure that is substantially similar to the following:

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

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

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

Tenor	Current Interest Rate	Long Term
	Treasury Rate as of 12/31/2016	Mean Reversed Treasury Rate
3 Month (or less)	0.51%	3.00%
5 Year	1.93%	4.50%
10 Year	2.45%	5.00%
20 Years (or more)	3.06%	5.50%

PROJECT HISTORY-2021
ANNUITY DISCLOSURE MODEL REGULATION (#245)

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

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

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

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

States Participating:

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

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

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

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

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

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

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

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

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

making any additional revision to the model. During the 2021 Spring National Meeting, the Committee agreed to disband the Working Group once these revisions to Model #245 were considered by the Membership.

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

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

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

None.

W:\National Meetings\2021\Summer\Plenary\Att 3 Model245_combined_final.pdf

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

Pharmacy Benefit Manger Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:

Jolie Matthews jmatthews@naic.org

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

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

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

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

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

If yes, please explain why

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

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: The current subgroup would target completion of a model within one year.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

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

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

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

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

No

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

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

Adopted by the Health Insurance and Managed Care (B) Committee – 6/22/21
Adopted by the Regulatory Framework (B) Task Force – 3/18/21
Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup – 10/29/20

Draft: 6/22/21
A new model

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

Table of Contents

Section 1.	Short Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Applicability
Section 5.	Licensing Requirement
Section 6.	Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices
Section 7.	Enforcement
Section 8.	Regulations
Section 9.	Severability
Section 10.	Effective Date

Section 1. Short Title

This Act shall be known and may be cited as the Pharmacy Benefit Manager Licensure and Regulation Act.

Section 2. Purpose

- A. This Act establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans.
- B. The purpose of this Act is to:
 - (1) Promote, preserve, and protect the public health, safety and welfare through effective regulation and licensure of pharmacy benefit managers;
 - (2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as provide for consumer savings, and fairness in prescription drug benefits;
 - (3) Provide for powers and duties of the commissioner; and
 - (4) Prescribe penalties and fines for violations of this Act.

Section 3. Definitions

For purposes of this Act:

- A. “Claims processing services” means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:
 - (1) Receiving payments for pharmacist services;
 - (2) Making payments to pharmacists or pharmacies for pharmacist services; or
 - (3) Both paragraphs (1) and (2).
- B. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- C. “Covered person” means a member, policyholder, subscriber, enrollee, beneficiary, dependent or other individual participating in a health benefit plan.
- D. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of [physical, mental or behavioral] health care services.
- E. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- F. “Other prescription drug or device services” means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including, but not limited to:
 - (1) Negotiating rebates, discounts or other financial incentives and arrangements with drug companies;
 - (2) Disbursing or distributing rebates;
 - (3) Managing or participating in incentive programs or arrangements for pharmacist services;
 - (4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;
 - (5) Developing and maintaining formularies;
 - (6) Designing prescription benefit programs; or
 - (7) Advertising or promoting services.
- G. “Pharmacist” means an individual licensed as a pharmacist by the [state] Board of Pharmacy.
- H. “Pharmacist services” means products, goods, and services or any combination of products, goods and services, provided as a part of the practice of pharmacy.
- I. “Pharmacy” means the place licensed by the [state] Board of Pharmacy in which drugs, chemicals, medicines, prescriptions and poisons are compounded, dispensed or sold at retail.
- J.
 - (1) “Pharmacy benefit manager” means a person, business or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to covered persons who are residents of this state, for health benefit plans.
 - (2) “Pharmacy benefit manager” does not include:
 - (a) A health care facility licensed in this state;
 - (b) A health care professional licensed in this state;
 - (c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or

- (d) A health carrier to the extent that it performs any claims processing and other prescription drug or device services exclusively for its enrollees.

Section 4. Applicability

- A. This Act shall apply to a contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after the effective date of this Act, including any health carrier that performs claims processing or other prescription drug or device services through a third party.

Drafting Note: States may want to consider adding language to Subsection A above or Section 10 of this Act providing additional time for pharmacy benefit managers to come into compliance with the requirements of this Act.

- B. As a condition of licensure, any contract in existence on the date the pharmacy benefit manager receives its license to do business in this state shall comply with the requirements of this Act.
- C. Nothing in this Act is intended or shall be construed to conflict with existing relevant federal law.

Section 5. Licensing Requirement

- A. A person may not establish or operate as a pharmacy benefit manager in this state for health benefit plans without first obtaining a license from the commissioner under this Act.
- B. The commissioner may adopt regulations establishing the licensing application, financial and reporting requirements for pharmacy benefit managers under this Act.

Drafting Note: States that are restricted in their rulemaking to only what is prescribed in statute may want to consider including in this section specific financial standards required for a person or organization to obtain a license to operate as a pharmacy benefit manager in this state.

- C. A person applying for a pharmacy benefit manager license shall submit an application for licensure in the form and manner prescribed by the commissioner.

Drafting Note: States may want to consider reviewing their third-party administrator statute if a state wishes to specify what documents must be provided to the commissioner to obtain a pharmacy benefit manager license in the state.

- D. A person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee of \$[X].
- E. The commissioner may refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.
- F.
 - (1) Unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations, including the payment of an annual license renewal fee of \$[X] and completion of a renewal application on a form prescribed by the commissioner.
 - (2) Such renewal fee and application shall be received by the commissioner on or before [x] days prior to the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

Section 6. Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

- A. In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:
- (1) The nature of treatment, risks or alternative thereto;
 - (2) The availability of alternate therapies, consultations, or tests;
 - (3) The decision of utilization reviewers or similar persons to authorize or deny services;
 - (4) The process that is used to authorize or deny healthcare services or benefits; or
 - (5) Information on financial incentives and structures used by the insurer.
- B. A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.
- C. A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:
- (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and
 - (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:
 - (a) Marks as confidential any document in which the information appears; or
 - (b) Requests confidential treatment for any oral communication of the information.
- D. A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to pharmacist or pharmacy:
- (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or
 - (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this Act.
- E. (1) A pharmacy benefit manager may not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price.
- (2) Any amount paid by a covered person under paragraph (1) of this subsection shall be attributable toward any deductible or, to the extent consistent with section 2707 of the Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan.

Section 7. Enforcement

- A. The commissioner shall enforce compliance with the requirements of this Act.
- B. (1) The commissioner may examine or audit the books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine compliance with this Act.

Drafting Note: States may want to consider including a reference to the cost of examinations in the *Model Law on Examinations* (#390).

Drafting Note: States may want to consider incorporating their existing market conduct examination statutes into this Act rather than relying on the examination authority provided under this section.

- (2) The information or data acquired during an examination under paragraph (1) is:
 - (a) Considered proprietary and confidential;
 - (b) Not subject to the [Freedom of Information Act] of this state;
 - (c) Not subject to subpoena; and
 - (d) Not subject to discovery or admissible in evidence in any private civil action.
- C. The commissioner may use any document or information provided pursuant to Section 6C of this Act or Section 6D of this Act in the performance of the commissioner's duties to determine compliance with this Act.
- D. The commissioner may impose a penalty on a pharmacy benefit manager or the health carrier with which it is contracted, or both, for a violation of this Act. The penalty may not exceed [insert appropriate state penalty] per entity for each violation of this Act.

Drafting Note: If an appeals process is not otherwise provided, a state should consider adding such a provision to this section.

Section 8. Regulations

The commissioner may promulgate regulations relating to pharmacy benefit managers that are not inconsistent with this Act.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of this Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 10. Effective Date

This Act shall be effective [insert date]. A person doing business in this state as a pharmacy benefit manager on or before the effective date of this Act shall have six (6) months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

PROJECT HISTORY-2021

[STATE] PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

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

In 2018, after the full NAIC membership adopted the revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22), there was consensus for the NAIC to explore whether to develop a new model regulating pharmacy benefit managers (PBMs). The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to discuss the issue. In 2019, the Subgroup decided to move forward with a 2019 charge to “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers.” The charge also states, “[t]he Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

In March 2019, the Subgroup adopted a Request for NAIC Model Law Development to work on the proposed new PBM model. The Task Force and the Health Insurance and Managed Care (B) Committee both adopted the Request for NAIC Model Law Development at the 2019 Spring National Meeting. The Executive (EX) Committee adopted the request at the 2019 Summer National Meeting. Based on its work plan, the Subgroup met 12 times throughout the summer and early fall of 2019 to hear from various stakeholders on the issues the Subgroup wanted to hear more about, such as rebating, discounts, prescription drug pricing, and how PBMs are currently regulated. The Subgroup’s goal was to have its members all equally educated on these issues before it started drafting a model.

Following these informational meetings, the Subgroup determined that it had received sufficient information to move forward with drafting the proposed model. In November 2019, the Subgroup established an ad hoc technical drafting group to develop an initial draft for the full Subgroup’s review. The ad hoc technical drafting group met in December 2019 and January 2020. Due to the COVID-19 pandemic, the Subgroup was unable to meet to discuss the ad hoc technical drafting group’s draft until July 2020. During that meeting, the Subgroup discussed the initial draft and formally exposed the draft for public comment until Sept. 1, 2020. Following the end of the public comment deadline, the Subgroup met Oct. 22, 2020; Oct. 8, 2020; Oct. 1, 2020; Sept. 24, 2020; and Sept. 14, 2020, to discuss the Sept. 1, 2020, comments received on the proposed new model. During its Oct. 29, 2020, meeting, the Subgroup adopted the new model and forwarded it to the Task Force for its consideration.

As adopted by the Subgroup, at its core, the PBM model is a PBM licensing model. Sections 1–4 of the proposed PBM model set out the model’s purpose, scope, and definitions. Section 5 provides the PBM licensing provisions, including provisions related to approving initial PBM licenses and renewals. Section 6—Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices includes language related to gag clauses and information-sharing for the purposes of enforcement. Section 7 of the proposed PBM model provides enforcement language and penalties for any violations of the model act. Section 8—Regulations provides that the commissioner may promulgate regulations relating to PBMs that are not inconsistent with the model act. Section 8 also includes a drafting note to Section 8 to providing state statutory citations for 15 topic areas that some states might want to consider when developing their state legislation regulating PBMs. Section 9 and Section 10 provide, respectively, for the severability of the model act’s provisions and an effective date.

The Task Force met during the 2020 Fall National Meeting to consider the new PBM model. Given some issues with the proposed PBM model, particularly issues concerning a proposed drafting note for Section 8, the Task Force deferred acting on the PBM model and exposed it for an additional 30-day public comment period. Following the end of the public comment period, the Task Force met March 1 to discuss the comments received. During this meeting, the Task Force extensively discussed the comments received on the Section 8 drafting note and the potential impact of the U.S. Supreme Court’s decision in *Rutledge vs. Pharmaceutical Care Management Association (PCMA)* on the draft PBM model. The Task Force adopted the PBM model March 18 and forwarded it to the Health Insurance and Managed Care (B) Committee for its consideration. The Committee deferred acting on the proposed PBM model during its meeting at the Spring National Meeting. The Committee extensively discussed the proposed Section 8 drafting note during a meeting June 22. Following that discussion, the Committee adopted the PBM model without the Section 8 drafting note to address concerns about the precedent of including optional sections the states could consider in adopting an NAIC model. In addition, in making this decision, the Committee considered that the Task Force had adopted a new charge for the Subgroup to develop a white paper that would explore the PBM business practices highlighted in the drafting note, including current and emerging state laws on these practices.

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

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed new model. The members of the Subgroup were: Alabama, Alaska, Arkansas, California, District of Columbia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Oregon chaired the Subgroup. Nebraska was vice chair of the Subgroup.

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

The Regulatory Framework (B) Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018. In 2019, the Task Force adopted a charge for the Subgroup to, “[c]onsider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.”

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

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

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

Beginning in March 2019 and ending in October 2020, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup reviewed and discussed all the comments received. Numerous interested parties participated in the drafting process. The interested parties represented all stakeholder groups, including consumers, insurers, providers, and PBM representatives. Each draft of proposed revisions was posted to the Subgroup’s web page on the NAIC website. All comment letters received were also posted. The Subgroup met in open meetings throughout the drafting process. In addition to the Subgroup’s drafting process, during its discussions of the PBM model, the Regulatory Framework (B) Task Force also held open meetings and posted all comment letters on its website.

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

There was one significant item of controversy raised and ultimately resolved during the drafting process. The item of controversy concerned the proposed drafting note to Section 8. The proposed drafting note provided state statutory citations for 15 topic areas reflecting current PBM business practices that some states might want to consider when developing their state legislation regulating PBMs. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup took this approach as a compromise between some states that wanted the PBM model to focus only on the licensing and registration by state departments of insurance (DOIs) and other states that wanted to go further to include substantive provisions related to these PBM business practices. The 15 topic areas are those areas where the Subgroup found, at this time, a lack of national consensus to include in the proposed PBM model. During the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee discussion of the PBM model, concerns were raised about the potential of a lack of uniformity in adoption by the states, which is a key component of the NAIC model law development procedures, if states selected different provisions to include in their state law in implementing the PBM model. Given this concern, some stakeholders suggested that the options approach in the Section 8 drafting note was not the appropriate approach to take and instead suggested that the Task Force consider a charge to the Subgroup to develop a white paper that would examine current and emerging state laws related to the PBM business practices outlined in the drafting note. Following its adoption of the PBM model, during its June 15 meeting, the Task Force adopted such a charge for the Subgroup. During its June 22 meeting, the Committee decided to delete the Section 8 drafting note, given the adoption of the Subgroup charge to develop a white paper and the issues related to the drafting note.

Another issue that arose was whether to defer adoption of the PBM model because of the *Rutledge* decision, which upheld an Arkansas law regulating certain PBM business practices. Those suggesting deferring the PBM model adoption asserted that the *Rutledge* decision supported state efforts to enact laws regulating PBM business practices, and the PBM model should be revised to include substantive provisions related to these PBM business practices. The Task Force decided to move forward with the PBM model, as drafted by the Subgroup, because of the different interpretations of the *Rutledge* decision as it relates to Employee Retirement Income Security Act of 1974 (ERISA) preemption of state laws regulating PBM business practices. To address this issue, the Task Force included in its charge to the Subgroup to develop a white paper language requiring the Subgroup to also examine the impact of the *Rutledge* decision on states seeking to enact laws regulating certain PBM business practices. In its discussions related to this issue, the Committee supported addressing this issue through the white paper.

The Subgroup also received comments concerning Section 6. Some commenters suggested that the gag clause provision in this section should mirror the federal gag clause language. The Subgroup did not accept that suggestion.

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

None.

W:\National Meetings\2021\Summer\Plenary\Att 4 PBMs_combined_final.pdf

New Guideline: Draft: 4/22/21

Adopted by the Financial Condition (E) Committee, April 13, 2021

Adopted by the Receivership and Insolvency (E) Task Force, March 12, 2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

Drafting Note: The receivership laws of most states address the coordination of receiverships involving multiple states. Typically, these laws provide that a domiciliary receiver appointed in another state has certain rights and protections, such as the following:

- The domiciliary receiver is vested with the title to the insurer's assets in the state.
- Attachments, garnishments or levies against the insurer or its assets are prohibited.
- Actions against the insurer and its insureds are stayed for a specified period of time.

In many states' laws, these provisions may apply only if the domiciliary state is a "reciprocal state." Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago. These definitions may be inconsistent with laws in other states, and they may be more prescriptive than the Part A standards of the NAIC Financial Regulation Standards and Accreditation Program for state receivership laws. As a result, the assets of a receivership estate might not be protected outside of the domiciliary state, and the receiver may be forced to defend litigation in multiple forums.

The provisions described above are intended to promote judicial economy, which benefits all participants in the receivership process. This guideline provides a statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of these provisions. Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws and should prevent unnecessary litigation regarding the recognition of a state as a reciprocal state.

Definition of Reciprocal State for Receivership

"Reciprocal state" means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official.

Draft: 7/12/21

PROJECT HISTORY-2021

GUIDELINE FOR DEFINITION OF RECIPROCAL STATE IN RECEIVERSHIP LAWS

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

The Receivership and Insolvency (E) Task Force has an active and ongoing charge, which was adopted in each year of this project by the Executive (EX) Committee and Plenary, that reads as follows:

Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

In 2020, the Task Force finalized its Macroprudential Initiative (MPI) study, which began in 2019, and addressed the referral from the Financial Stability (EX) Task Force to evaluate receivership and guaranty fund laws and practices in the context of the MPI. The Task Force surveyed state insurance regulators and interested parties on each of the key provisions of receivership and guaranty fund laws that states should consider adopting into their laws, particularly with respect to receivership of insurers operating in multiple states. While a receivership of a multi-jurisdictional insurer would not likely have a material impact on financial stability or the broader financial markets, this project highlighted areas of the receivership process that may need attention, including laws related to full faith and credit of stays and injunctions.

The Task Force discussed the effect of whether a stay or injunction entered into a receivership court is honored in another state. This has been the subject of a lot of litigation, and receivers have expressed concern about this issue. The receivership laws of most states address the coordination of receiverships involving multiple states. However, in many states' laws, these provisions may apply only if the domiciliary state is a "reciprocal state." Frequently, the definition of a reciprocal state is based on NAIC model laws adopted more than 20 years ago.

The Task Force drafted this Guideline as an alternative to address how states define "reciprocal state." This Guideline provides an optional statutory definition that may be used by states with a reciprocity requirement to effectuate the purposes of provisions regarding the coordination of receiverships involving multiple states.

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

The Receivership and Insolvency (E) Task Force was responsible for drafting the Guideline. The 2020 and 2021 members of the Task Force were:

2020: Texas (Chair); District of Columbia (Vice Chair); Alaska; American Samoa; Arkansas; California; Colorado; Connecticut; Florida; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; North Carolina; Oklahoma; Pennsylvania; Rhode Island; South Carolina; Tennessee; and Utah.

2021: Texas (Chair); Louisiana (Vice Chair); American Samoa; Arizona; Colorado; Connecticut; Florida; Hawaii; Illinois; Iowa; Kansas; Kentucky; Maine; Massachusetts; Michigan; Missouri; Montana; Nebraska; New Jersey; New Mexico; North Carolina; Northern Mariana Islands; Oklahoma; Pennsylvania; Rhode Island; South Carolina; and Utah.

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

As described in paragraph 1, on its Oct. 7, 2020, meeting, the Task Force agreed to draft a guideline to address this issue, which was identified through the results of the MPI study and the subsequent survey regarding key provisions of receivership and guaranty fund laws that states should consider adopting into their laws.

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

The Guideline was drafted by Task Force members: Florida; Maine; Texas; and Patrick Cantilo (Cantilo and Bennett LLP), an interested party. This drafting group met Oct. 19, 2020, and considered language contained in both the Florida and Maine laws. Rather than identifying a list of specific key provisions in law that would be required for a state to be defined as "reciprocal," the drafting group agreed to use the same criteria used by the NAIC Financial Regulation Standards and Accreditation Program.

Under this definition, any state meeting the applicable NAIC Part A Accreditation standards for receivership laws, which requires a state to have a “receivership scheme,” will be treated as a reciprocal state. The definition recognizes the diversity of existing state receivership laws, and it should avoid unnecessary litigation regarding the recognition of a state as a reciprocal state.

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

On Nov. 19, 2020, the Task Force met to release the draft Guideline for a 42-day public comment period ending Dec. 31, 2020. The exposure was distributed by email to members, interested state insurance regulators, and interested parties of the Task Force; and it was posted to the NAIC website.

The Task Force did not receive any comments.

The Task Force adopted the Guideline on March 12, 2021.

The Financial Condition (E) Committee adopted the Guideline on April 13, 2021.

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

There were no issues of significance raised during the exposure periods or during meetings.

7. List the key provisions of the model (sections considered most essential to state adoption).

The Guideline provides the following definition, as well as an explanatory drafting note:

“Reciprocal state” means a state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state’s insurance commissioner or comparable insurance regulatory official.

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

The Guideline will not be considered for any accreditation standard.

W:\National Meetings\2021\Summer\Plenary\Att 5 ReciprocalStateGuideline final_combined.pdf



MEMORANDUM

TO: NAIC Plenary

FROM: Scott White, Financial Condition (E) Committee

DATE: June 29

RE: Agenda item 2019-24: Levelized and Persistency Commission

This memorandum summarizes both 1) the adopted changes to SSAP No. 71—Policy Acquisition Costs and Commissions, 2) and an overview of the key points of the levelized commission agenda item 2019-24 which were adopted into the changes to SSAP No. 71.

The Statutory Accounting Principles (E) Working Group began discussion in August 2019 and on March 15, 2021, adopted revisions (see illustrated revisions page 5) which are effective Dec. 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the revisions as adopted by the Working Group with a vote of 41 members in favor and two opposed (LA and OK). On April 13, 2021, the Financial Condition (E) Committee adopted these same revisions to SSAP No. 71 with a vote of 11-3 (Mississippi, New Mexico and South Carolina dissenting).

Overview

- Acquisition Costs: Acquisition costs are expenses incurred in the acquisition of new and renewal insurance contracts. These are costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). It is a foundational concept for statutory accounting principles (SAP) that acquisition costs including commissions are expensed as incurred. This is because incurred costs are not available to pay policyholder claims. Both U.S. generally accepted accounting principles (GAAP) and SAP would calculate acquisition costs in a similar manner. GAAP treatment capitalizes acquisition costs and expenses them over time to match revenue and expenses. This is one of the major financial reporting differences between SAP and GAAP. These differences are intentional because SAP is measuring the ability to pay policyholder claims using the foundational principles of conservatism, consistency and recognition. GAAP, on the other hand, is focused on matching revenue to expenses.

Washington, DC 444 North Capitol Street NW, Suite 700, Washington, DC 20001-1509	p 202 471 3990	f 816 460 7493
Kansas City 1100 Walnut Street NW, Suite 1500, Kansas City, MO 64106-2197	p 816 842 3600	f 816 783 8175
New York One New York Plaza, Suite 4210, New York, NY 20004	p 212 398 9000	f 212 382 4207

www.naic.org



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

- Funding Agreement: A funding agreement is using a third-party to pay commission costs on the insurer's behalf, with the insurer repaying the third-party over time plus interest. To ensure consistent and conservative treatment, and appropriate recognition, SSAP No. 71 requires that the full amount of the funding agreement liability be recognized upfront by the insurer plus interest and fees owed to date. This is because the substance of the agreement is a LOAN. That is, the third-party is paying an insurer's acquisition commission obligation and accepting repayment over time (e.g., over 3-8 years).
- Persistency Commission Versus Loan with a Contingency Element: A normal persistency commission is one in which additional commission is earned over time, when a policy is renewed or remains in force. A distinct difference is that persistency commission occurs subsequent to an initial sales commission. The triggering event is the continuation (or renewal) of a policy. An additional amount is owed if the policy persists overtime. A persistency commission is typically a much smaller payment than initial sales commission. For example, a small percentage if the policy is in force in years 2-10.

Note: Although traditional persistency commission is not required to be recognized before the triggering event (e.g., renewal), earlier comments from industry noted that they could be inadvertently scoped in with the initially exposed revisions. The adopted edits addressed this concern and are clear that the recognition of commission is based on the triggering event, which is the policy action, such as initial issuance or renewal.

The practice under dispute represents initial sales commission that is not being recognized by a limited number of insurers. With these designs, the insurer has an agreement to reimburse a third-party in the future (who has paid the commission cost to the agent on the insurer's behalf) plus interest and fees. The third-party agreement notes that the insurer does not have to pay the future installments if the policy lapses. *(The impacted insurers have noted that this practice inserts a "persistency" element into the initial sales commission already incurred. This is actually a LOAN with a contingency element.)* Note: Insurers are required to recognize the full initial commission cost when a policy is issued. If a policy is cancelled, at that time, an insurer can derecognize the liability to repay the third party.

Disputed practice: Those few insurers that are not recognizing the full liability under the funding agreement (to repay the parties who are paying acquisition costs on their behalf) are not following the long-standing guidance in SSAP No. 71. These limited companies are only recognizing a fraction of the acquisition commission expense, which results in misleading financial statements, and presents a better financial position than actually exists (as the company has unrecorded liabilities for commissions already paid on their behalf). SSAP No. 71 requires recognition of the full liability amount of such an



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

agreement, even if repayment is not guaranteed. The small number of insurers have asserted that their reporting is a decades-long practice. However the SSAP No. 71 guidance that requires full accrual of the liability was adopted in 1998 and is based on even earlier statutory accounting guidance which notes that, “The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.” The Working Group discussions identified that not recognizing the full liability appears to have been practiced by only a small minority of companies, which supports that the majority of industry is reporting correctly.

- Lapse - Lapse risk is a risk identified in Model 791 Life and Health Reinsurance, as a significant insurance risk therefore it cannot be transferred to a non-insurance entity. However, some employing the disputed practice have tried to assert that it has been transferred to the funding agent.
- Overview of Edits: Revisions clarify that an insurance entity cannot use third-party structures to recharacterize and delay recognition of liabilities for initial sales commission owed, regardless of how a third-party arrangement is structured with regards to the timing of the payment from the insurers. This guidance clarifies that it is the writing of the insurance contract that obligates the insurer and recognition of expense shall occur consistently among insurers. SSAP No. 71 does not require advanced recognition for expected renewals or normal persistency metrics. When an insurance policy is issued, renewed or when metrics are met that require additional commission, then SSAP No. 71 consistently requires expense recognition for all insurers.
- Substantive / Nonsubstantive - The determination of a change as substantive or nonsubstantive is based on whether the edits reflect original intent (nonsubstantive) or incorporates new accounting concepts (substantive). Throughout the discussion process, it has been reiterated that the edits simply clarify the original intent of SSAP No. 71. As such, the change was classified as nonsubstantive. The impact to companies or the number of companies that have incorrectly applied accounting guidance is not a factor in determining whether a clarifying edit is substantive or nonsubstantive. However, the incorrect application only seems to involve a limited number of linked-companies, with other entities following the original intent of SSAP No. 71, which supports that the changes are nonsubstantive and consistent with original intent. The March 15 Working Group discussion affirmed the nonsubstantive classification of the revisions was consistent with the policy statement.
- Correction of Error / Change in Accounting Principle: An earlier comment from an impacted company identified that there is a process concern as the edits to SSAP No. 71 are classified as a change in accounting principle and not a correction of error. (*Under*



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

SSAP No. 3—Accounting Changes and Correction of Errors, a mistake in the application of accounting principles is a correction of an error.) The edits proposed in July 2020 were to classify changes required from misapplication of SSAP No. 71 as a correction of error. However, in response to comments, the Working Group agreed to designate the impact as a change in accounting principle. This provision was provided to assist companies in reflecting the change. Both processes require the impact to be recognized to unassigned funds (surplus). If reported as a correction of an error, then an entity may be subject to filing amended financial statements for periods in which the error was reflected. As a change in accounting principle, then the entity calculates the change as a cumulative effect to the Jan. 1 balance in the current year financials.

- Use of Funding Agreements: SSAP No. 71 does not prohibit the use of funding agreements or the use of third parties to pay commission expense to selling agents. SSAP No. 71 simply requires consistent recognition of commission expense based on policy issuance or renewal. The involvement of third parties and funding agreements to front commission owed to selling agents is not a free service. These third-parties require fees and interest from these financing arrangements; which presumably exceeds the costs of commission only. The long-standing guidance in SSAP No. 71 requires recognition of the full amount of unpaid principal and interest accrued to date in these arrangements. One comment raised during the discussion was that the clarified guidance would hurt policyholders. This comment was never fully substantiated, but it was noted that failing to report expenses in line with SSAP No. 71 would result with inappropriate financial positions – which could hurt policyholders. Additionally, it was noted that if the process to defer expense recognition was sanctioned, then all insurers would have to engage in these arrangements to prevent competitive disadvantages with reporting.
- Payments to the Direct Agent: Some of the comments received from the impacted companies (or their representatives) have tried to indicate that the timing (and how) the initial sales commission is paid to the direct selling agent by the third-party should not impact the recognition of commission expense by the insurer. These comments were made because it has been highlighted that in the known situations, the third-party agents have already paid the direct selling agent the owed commission. Although the third-party payment to the direct selling agent substantiates that a commission was owed from policy issuance, the payment to the direct agent is not the triggering event. (Meaning, even if a third-party was to revise their agreements with direct agents to delay payment, this will not change that the insurer owes commission expense from policy issuance. The initial sales commission is triggered by policy issuance.)
- Consistent Application Across Companies: SSAP No. 71 is a “common area” SSAP and applies to all entities regardless of their line of business or product offerings. Some comments made to regulators have implied that certain large companies are permitted processes that are not in line with SSAP No. 71. It is speculated that these comments are



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

trying to compare commission expenses from renewals (which are not required until policy renewal occurs) to the process engaged by these companies in which they have not recognized commission expense from the initial issuance of policies. This goes back to these impacted companies mischaracterizing these financing arrangements as “persistence” commission. These timing arrangements do not alter the requirement to recognize commission expense with the issuance of a policy. Because many of these funding agreements were mischaracterized, it was noted that the disputed practice is difficult to identify on financial examinations and audits. One Working Group member shared that they had dealt with an issue like this previously when \$16 million of off-balance sheet commission liabilities was identified after a third party funding agent applied to the liquidator for reimbursement.

- Impacted Companies: Throughout the discussion, key industry representatives continued to highlight that the impacted companies were less “than 10” and likely “5 or less.” The impacted companies were requested to reach out to domiciliary states to provide information. However the impact for these few companies is expected to be material. A consumer representative also voiced concerns about the illusory surplus and unlevel playing field such arrangements create. Because of the unfair competitive advantages that are perceived, the Working Group was not in favor of grandfathering the practices. However the Working Group did discuss that companies could have discussions with their domiciliary states regarding obtaining a permitted practice for phasing in the financial impact. A permitted practice approach was favored because the impact to the affected companies may vary.

Effective Date: Although nonsubstantive revisions are generally effective upon adoption, the Working Group ultimately determined to have a Dec. 31, 2021 effective date. Two of the industry commenters (Guggenheim and interested parties (Delaware Life)) stated support for an effective date no sooner than Dec. 31, 2021 at the March meeting. Annual 2020 effective dates were previously deferred. While some members of the Working Group supported an effective date earlier in 2021, it was discussed that a year end 2021 effective date would allow insurers, to assess the impact and review contracts, and additionally allow the issue to be fully through the NAIC committee process. During the March meeting, the National Council of Insurance Legislators (NCOIL) comments were supportive of a later effective date or an extended phase-in period. The Working Group determined that a year-end 2021 effective date was preferred because of the competitive issues and because the revisions were viewed as a clarification of long-standing guidance. The Working Group also reiterated its prior comments that the limited number of companies seeking phase in application could seek a permitted practice and that the permitted practices disclosures would provide regulatory transparency.



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Adopted Revisions to SSAP No. 71 (new text from the prior exposure is shown as shaded):

2. Acquisition costs are those costs that are incurred in the acquisition of new and renewal insurance contracts and include those costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). Acquisition costs and commissions shall be expensed as incurred. Determination of when acquisition costs and commissions have been incurred shall be made in accordance with SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

3. Contingent commission liabilities shall be determined in accordance with the terms of each individual commission agreement. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity such as retrospective premium adjustments and loss reserves, including incurred but not reported.

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. (Note: levelized repayments made by the reporting entity extend the repayment period but might not be a straight-line repayment.) These transactions are, in fact, funding agreements between a reporting entity and a third party, regardless of how the payment to the third party is characterized. The continuance of the stream of payments specified in the levelized commission contract is a mechanism which attempts to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.

5. The use of an arrangement such as a levelized commission arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency, but rather are linked to the repayment of an advance amount paid by a third party to the direct selling agents requires the establishment of a liability by the reporting entity for the full amount of the unpaid principal and accrued interest which is



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

payable to a third party related to levelized commissions. Arrangements that use a third party to pay agents who write policies for the reporting entity and the insured can be an attempt to de-link the relationship between the insurer and those agents and defer or levelize the acquisition commissions. The insurance reporting entity is required to recognize the full amount of earned commission costs to the direct policy writing agents even if those costs are paid indirectly to the agents by a third party through the use of levelized commission, or similar arrangement, which is in substance a funding arrangement. Having a third party pay commission costs to the selling agent is strong evidence of a potential funding arrangement which shall be recognized as a liability because the substance of the arrangement indicates that repayment is reasonable and probable, even if a contingency has been incorporated into the funding arrangement, until the underlying policy has been cancelled. A third-party structure cannot recharacterize (e.g. by referencing policy persistency) and delay recognition of liabilities for initial sales commission owed from the writing of policies regardless of how a third-party arrangement is structured with regards to the timing of payment from the insurer. The amount owed for full initial sales commission shall be recognized immediately as the writing of an insurance contract is the event that obligates the insurer, and such action shall occur consistently among insurers. As such, this recognition is required regardless of if the insurer owes a selling agent directly or if a third-party has been contracted to provide payment to the selling agent.

Effective Date and Transition

7. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*. The nonsubstantive revisions adopted March 15, 2021 regarding levelized commission are to clarify the original intent of this statement and apply to existing contracts in effect as of December 31, 2021 and new contracts thereafter .

W:\National Meetings\2021\Summer\Plenary\Att 6 SSAP71_MemofromECommitteeChair.pdf

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

Receivership Law (E) Working Group

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

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

- *Insurance Holding Company System Regulatory Act (#440)*
- *Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)*

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board's (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The *Insurance Holding Company System Model Act (#440)* requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The *Insurance Holding Company System Model Regulation (#450)*, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of "insurer" under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450 Consistency with any revisions to Model 440

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

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

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

If yes, please explain why:

While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: See previous discussion.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

The *Insurance Holding Company System Model Act* (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

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

No.

Adopted by the Financial Condition (E) Committee July 8, 2021
Adopted by the Receivership and Insolvency (E) Task Force May 20, 2021
Adopted by the Receivership Law (E) Working Group May 4, 2021

INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

Table of Contents

Section 1.	Definitions
Section 2.	Subsidiaries of Insurers
Section 3.	Acquisitions of Control of or Merger With Domestic Insurer
Section 3.1	Acquisitions Involving Insurers Not Otherwise Covered
Section 4.	Registration of Insurers
Section 5.	Standards and Management of an Insurer Within an Insurance Holding Company System
Section 6.	Examination
Section 7.	Supervisory Colleges
Section 7.1	Group-wide Supervision of Internationally Active Insurance Groups
Section 8.	Confidential Treatment
Section 9.	Rules and Regulations
Section 10.	Injunctions, Prohibitions against Voting Securities, Sequestration of Voting Securities
Section 11.	Sanctions
Section 12.	Receivership
Section 13.	Recovery
Section 14.	Revocation, Suspension, or Nonrenewal of Insurer's License
Section 15.	Judicial Review, Mandamus
Section 16.	Conflict with Other Laws
Section 17.	Separability of Provisions
Section 18.	Effective Date
Appendix.	Alternate Provisions

Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System

- A. Transactions Within an Insurance Holding Company System
- (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:
- (a) The terms shall be fair and reasonable;
 - (b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;
 - (c) Charges or fees for services performed shall be reasonable;
 - (d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;
 - (e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; ~~and~~
 - (f) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs; ~~-~~

- (g) If an insurer subject to this Act is deemed by the commissioner to be in a hazardous financial condition as defined by [insert citation for Model Regulation for Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition] or a condition that would be grounds for supervision, conservation or a delinquency proceeding, then the commissioner may require the insurer to secure and maintain either a deposit, held by the commissioner, or a bond, as determined by the insurer at the insurer’s discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the commissioner required the deposit or the bond.

In determining whether a deposit or a bond is required, the commissioner should consider whether concerns exist with respect to the affiliated person’s ability to fulfill the contract(s) or agreement(s) if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding, and a deposit or bond is necessary, the commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one year, and whether such deposit or bond should be required for a single contract, multiple contracts or a contract only with a specific person(s);

Drafting Note: This section is intended to apply to a broad range of affiliate managerial and support service contracts including, for example, general managerial services, financial accounting and actuarial services, data management, investment portfolio management and support and policy and policyholder services. (Performance collateralization for reinsurance and other risk transfer or financial contracts with affiliates is typically addressed in the underlying contractual agreements and is beyond the scope of these deposit/bond requirements). The intent of the deposit or bond is to ensure the affiliated services provided under the contract(s) are fulfilled. In determining appropriate circumstances when a commissioner may require a deposit or bond, (deposit vs. bond to be determined by the insurer) and in specifying an amount, the commissioner should evaluate and consider whether an insurer subject to this act is in a hazardous financial condition or a condition that would be grounds for substantial regulatory action, including supervision, conservation or a delinquency proceeding. If it is, the deposit or bond requirement would be available as an additional regulatory remedy at the discretion of the commissioner. Note, the commissioner should consider whether the affiliated person is already required to post a deposit or bond under applicable laws regulating third-party administrators.

- (h) All records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons’ records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer’s business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer’s business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate’s default under a lease or other agreement; and,

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

- (i) Premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to [the receivership act of the state].

- (2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs (a) through (g), may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any.
- (a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transactions are equal to or exceed:
 - (i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;
 - (ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;
 - (b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transactions are equal to or exceed:
 - (i) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders as of the 31st day of December next preceding;
 - (ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding;
 - (c) Reinsurance agreements or modifications thereto, including:
 - (i) All reinsurance pooling agreements;
 - (ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer and non-affiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;
 - (d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;
 - (e) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

- (f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 2 of this Act (or authorized under any other section of this Chapter), or in non-subsidiary insurance affiliates that are subject to the provisions of this Act, are exempt from this requirement; and

Drafting Note: When reviewing the notification required to be submitted pursuant to Section 5A(2)(f), the commissioner should examine prior and existing investments of this type to establish that these investments separately or together with other transactions, are not being made to contravene the dividend limitations set forth in Section 5B. However, an investment in a controlling person or in an affiliate shall not be considered a dividend or distribution to shareholders when applying Section 5B of this Act.

- (g) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

- (3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise his or her authority under Section 11.
- (4) The commissioner, in reviewing transactions pursuant to Subsection A(2), shall consider whether the transactions comply with the standards set forth in Subsection A(1) and whether they may adversely affect the interests of policyholders.
- (5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.
- (6) **Supervision, seizure, conservatorship or receivership proceedings.**
 - (a) Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to Subsection 5A(2)(d) shall be subject to the jurisdiction of any supervision, seizure, conservatorship or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator or liquidator for the insurer appointed pursuant to [supervision and receivership acts] for the purpose of interpreting, enforcing and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that:
 - (i) Are an integral part of the insurer's operations, including, but not limited to management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment or any other similar functions; or
 - (ii) Are essential to the insurer's ability to fulfill its obligations under insurance policies.
 - (b) The commissioner may require that an agreement or contract pursuant to Subsection 5A(2)(d) for the provision of services described in (i) and (ii) above specify that the affiliate consents to the jurisdiction as set forth in this Subsection 5A(6).

Drafting Note: Subsection 5A(6) is not intended to subject affiliates, in particular those that may be subject to regulation in other jurisdictions, to the general jurisdiction of pending supervision, seizure, conservation or receivership court proceedings in this state or the general authority of a supervisor, conservator or receiver for a domestic insurer. Rather, the jurisdiction and authority conferred by this provision is limited to ensuring that a domestic insurer continues to receive essential services from

an affiliate that it has contracted with to provide such services, in accordance with the terms of the contract and applicable law, during the aforementioned proceedings. Subsection 5A(6)(b) gives the commissioner discretion to require documentation of an affiliate's consent to this jurisdiction in the agreement or contract. In determining appropriate circumstances when a commissioner may require such provision, the commissioner should consider the scope and materiality to the domestic insurer of the contract, the nature of the holding company system, and whether examination or investigation of the domestic insurer warrants requirement of such a provision.

B. Dividends and other Distributions

No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

- (1) Ten percent (10%) of the insurer's surplus as regards policyholders as of the 31st day of December next preceding; or
- (2) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until (1) the commissioner has approved the payment of the dividend or distribution or (2) the commissioner has not disapproved payment within the thirty-day period referred to above.

Drafting Note: The following Subsection C entitled "Management of Domestic Insurers Subject to Registration" is optional and is to be adopted according to the needs of the individual jurisdiction.

C. Management of Domestic Insurers Subject To Registration.

- (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this Act.
- (2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of Section 5A(1).
- (3) Not less than one-third of the directors of a domestic insurer, and not less than one-third of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

- (4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.
 - (5) The provisions of Paragraphs (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of Paragraphs (3) and (4) with respect to such controlling entity.
 - (6) An insurer may make application to the commissioner for a waiver from the requirements of this subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than \$300,000,000. An insurer may also make application to the commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.
- D. Adequacy of Surplus. For purposes of this Act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:
- (1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;
 - (2) The extent to which the insurer's business is diversified among several lines of insurance;
 - (3) The number and size of risks insured in each line of business;
 - (4) The extent of the geographical dispersion of the insurer's insured risks;
 - (5) The nature and extent of the insurer's reinsurance program;
 - (6) The quality, diversification and liquidity of the insurer's investment portfolio;
 - (7) The recent past and projected future trend in the size of the insurer's investment portfolio;
 - (8) The surplus as regards policyholders maintained by other comparable insurers;
 - (9) The adequacy of the insurer's reserves; and
 - (10) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the commissioner the investment so warrants.
-

Draft: 7/8/21

PROJECT HISTORY-2021

REVISIONS TO *INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)* AND *INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)*

RECEIVERSHIP

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

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

“Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.”

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

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

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.

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

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

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

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

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

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI's proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

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

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5.A.(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties' revisions.

7. List the key provisions of the model (sections considered most essential to state adoption).

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- Section 5A(1) of Model #440
 - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
 - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation.
 - Premiums are the property of the insurer, with any right of offset subject to receivership law.
- Section 5A(6) of Model #440
 - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.
- Section 19 of Model #450
 - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
 - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
 - In the event of receivership (now including supervision and conservatorship):
 - The rights of the insurer extend to the receiver or guaranty fund.
 - The affiliate will make available essential personnel.
 - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
 - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

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

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

"W:\National Meetings\2021\Summer\Plenary\13_MO440-combined_final.pdf"

REQUEST FOR NAIC MODEL LAW DEVELOPMENT

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

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

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

Receivership Law (E) Working Group

2. NAIC staff support contact information:

Jane Koenigsman
jkoenigsman@naic.org
816-783-8145

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

- *Insurance Holding Company System Regulatory Act (#440)*
- *Insurance Holding Company System Regulation with Reporting Forms and Instructions (#450)*

In 2018 the Financial Stability (EX) Task Force made a referral to the Receivership and Insolvency (E) Task Force as part of the Macro Prudential Initiative (MPI). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Financial Stability Board's (FSB) Key Attributes (KAs) of Effective Resolution Regimes for Financial Institutions KA 3.2 states that a resolution authority should have the power to ensure the continuity of essential services and functions by requiring companies in the group to continue providing services. Under Common Framework for the supervision of Internationally Active Insurance Groups (ComFrame) (CF 12.7a), a resolution authority may take steps to provide continuity of essential services by requiring other entities within the IAIG (including non-regulated entities) to continue services. The Task Force identified the following authority and remedies available within the US regime related to these international standards:

- The *Insurance Holding Company System Model Act (#440)* requires approval of affiliated transactions, allowing a regulator to identify agreements that could create obstacles in a receivership. The *Insurance Holding Company System Model Regulation (#450)*, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The Receiver can take action against a provider that refuses to continue services under a contract, or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the Receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

One potential solution is to revise the definition of "insurer" under state insurance holding company laws to encompass affiliated entities whose sole purpose is to provide services to the insurer.

The NAIC adopted 2020 charges for the Receivership Law (E) Working Group to: “Review and provide recommendations for remedies to ensure continuity of essential services and functions to an insurer in receivership by affiliated entities, including non-regulated entities. Consult with the Group Solvency Issues (E) Working Group as the topic relates to affiliated intercompany agreements.”

Scope of the Proposed Revisions to Models 440 and 450

The scope of the request is limited to addressing the issue of continuation of essential services through affiliated intercompany agreements that arise during the receivership of an insurance company. The Receivership Law (E) Working Group under the Receivership and Insolvency (E) Task Force would complete the review and recommend proposed revisions. Revisions may be necessary to the following sections of Models 440 and 450 including, but not limited to:

- Model 440 Section 1. Definitions
- Model 440 Section 5. Standards and Management of an Insurer Within an Insurance Holding Company System
- Model 440 Section 12. Receivership
- Model 450 Consistency with any revisions to Model 440

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

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

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

If yes, please explain why:

While this change is being made in connection with the NAICs Macro Prudential Initiative, most important is that such changes are needed to address the challenges receivers continue to encounter in the area of continuation services which often result in significant additional legal and administrative expenses to the receivership estate and all members of the Task Force supported this request.

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

Yes or No (Check one)

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary: See previous discussion.

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

1 2 3 4 5 (Check one)

High Likelihood

Low Likelihood

Explanation, if necessary:

At this juncture, the changes in concepts being considered are simple and because they have the potential to reduce expenses incurred by receivership estates, we believe such changes will be widely supported by all parties.

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

The *Insurance Holding Company System Model Act* (#440) is an Accreditation Standard but the task force has not yet considered whether this should become part of the required elements of that specific standard. However, given the potential the changes have in reducing the cost of regulation under receiverships, a national standard is likely appropriate.

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

No.

Adopted by the Financial Condition (E) Committee July 8, 2021
Adopted by the Receivership and Insolvency (E) Task Force May 20, 2021
Adopted by the Receivership Law (E) Working Group May 4, 2021

**INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION
WITH REPORTING FORMS AND INSTRUCTIONS**

Table of Contents

Section 1.	Authority
Section 2.	Purpose
Section 3.	Severability Clause
Section 4.	Forms - General Requirements
Section 5.	Forms - Incorporation by Reference, Summaries and Omissions
Section 6.	Forms - Information Unknown or Unavailable and Extension of Time to Furnish
Section 7.	Forms - Additional Information and Exhibits
Section 8.	Definitions
Section 9.	Subsidiaries of Domestic Insurers
Section 10.	Acquisition of Control - Statement Filing (Form A)
Section 11.	Amendments to Form A
Section 12.	Acquisition of Section 3A(4) Insurers
Section 13.	Pre-Acquisition Notification (Form E)
Section 14.	Annual Registration of Insurers -Statement Filing (Form B)
Section 15.	Summary of Changes to Registration - Statement Filing (Form C)
Section 16.	Amendments to Form B
Section 17.	Alternative and Consolidated Registration
Section 18.	Disclaimers and Termination of Registration
Section 19.	Transactions Subject to Prior Notice - Notice Filing (Form D)
Section 20.	Enterprise Risk Report
Section 21.	Group Capital Calculation
Section 22.	Extraordinary Dividends and Other Distributions
Section 23.	Adequacy of Surplus
Form A	Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer
Form B	Insurance Holding Company System Annual Registration Statement
Form C	Summary of Changes to Registration Statement
Form D	Prior Notice of a Transaction
Form E	Pre-Acquisition Notification Form
Form F	Enterprise Risk Report

Section 19. Transactions Subject to Prior Notice - Notice Filing

- A. An insurer required to give notice of a proposed transaction pursuant to Section 5 of the Act shall furnish the required information on Form D, hereby made a part of these regulations.
- B. Agreements for cost sharing services and management services shall at a minimum and as applicable:
- (1) Identify the person providing services and the nature of such services;
 - (2) Set forth the methods to allocate costs;
 - (3) Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;

- (4) Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
- (5) State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
- (6) Define ~~books and~~ records and data of the insurer to include all ~~books and~~ records and data developed or maintained under or related to the agreement ~~that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;~~
- (7) Specify that all ~~books and~~ records and data of the insurer are and remain the property of the insurer, and:
 - (a) Are subject to control of the insurer;
 - (b) Are identifiable; and
 - (c) Are segregated from all other persons' records and data, or are readily capable of segregation at no additional cost to the insurer;

Drafting Note: The “at no additional cost to the insurer” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the insurer. Since records and data of the insurer are the property of the insurer, the insurer should not pay a cost to segregate commingled records and data from other data of the affiliate.

- (8) State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
- (9) Include standards for termination of the agreement with and without cause;
- (10) Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services ~~and for any actions by the affiliate that violate provisions of the agreement required in Subsections 19B(11), 19B(12), 19B(13), 19B(14) and 19B(15) of this regulation;~~
- (11) Specify that, if the insurer is placed in supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~receivership or seized by the commissioner under the State Receivership Act:~~
 - (a) ~~All of the rights of the insurer under the agreement extend to the receiver or commissioner to the extent permitted by [law of the state]; and,~~
 - (b) All records and data of the insurer shall be identifiable, and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the commissioner;

Drafting Note: The “at no additional cost to the receiver or the commissioner” language is not intended to prohibit recovery of the fair and reasonable cost associated with transferring records and data to the receiver or the commissioner. Since records and data of the insurer are the property of the insurer, the receiver or commissioner should not pay a cost to segregate commingled records and data from other data of the affiliate.

- (c) A complete set of ~~all books and~~ records and data of the insurer will immediately be made available to the receiver or the commissioner, ~~shall be made available in a usable format, and shall be turned over to the receiver or commissioner immediately upon the receiver or the commissioner's request, and the cost to transfer data to the receiver or the commissioner shall be fair and reasonable; and,~~

Drafting Note: The fair and reasonable cost to transfer data to the receiver or commissioner refers to the cost associated with physically or electronically transferring records and data files to the receiver or commissioner. This cost does not include costs to separate comingled data and records that should have been segregated or readily capable of segregation.

- (d) The affiliated person(s) will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or commissioner;
 - (12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~the State Receivership Act; and~~
 - (13) Specify that the affiliate will provide the essential services for a minimum period of time [specified in the agreement] after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], as ordered or directed by the receiver or commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court;
 - (134) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts]~~a seizure by the commissioner under the State Receivership Act, and will make them available to the receiver or commissioner as ordered or directed by the receiver or commissioner;~~ for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, commissioner or supervising court; and~~;~~
 - (15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship or receivership pursuant to [supervision and receivership acts], and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under Subsections 19B(11), 19B(12), 19B(13) and 19B(14) of this regulation will extend to such guaranty association(s).
-

Draft: 7/8/21

PROJECT HISTORY-2021

REVISIONS TO *INSURANCE HOLDING COMPANY SYSTEM MODEL ACT (#440)* AND *INSURANCE HOLDING COMPANY SYSTEM MODEL REGULATION WITH REPORTING FORMS AND INSTRUCTIONS (#450)*

RECEIVERSHIP

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

In 2020, the NAIC Plenary adopted a new charge for the Receivership Law (E) Working Group. The charge is still active and reads as follows:

“Review and provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities. Among other solutions, this will encompass a review of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) to provide proposed revisions to address the continuation of essential services through affiliated intercompany agreements in a receivership.”

Prior to, and prompting the need for, the adoption of this charge, the Receivership and Insolvency (E) Task Force performed a macroprudential analysis of the U.S. system of insurance regulation with respect to receivership laws compared to international standards under the Financial Stability Board (FSB) and under the Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame). At the 2019 Summer National Meeting, the Receivership and Insolvency (E) Task Force adopted a report including recommendations to address receivership powers that are implicit in state laws, rather than explicit. One such area is the power to ensure the continuity of essential services and functions within a holding company group once an insurer is placed into receivership.

The Task Force identified the following authority and remedies available within the U.S. regime related to these international standards:

- Model #440 requires approval of affiliated transactions, allowing a state insurance regulator to identify agreements that could create obstacles in a receivership. Model #450, Section 19, provides that cost sharing and management agreements specify if the insurer is placed in receivership that an affiliate has no automatic right to terminate the agreement.
- The receiver can take action against a provider that refuses to continue services under a contract or seek an order requiring it to turn over records. If an affiliate providing services is inextricably intertwined with the insurer, the receiver could also seek to place the affiliate into receivership.

However, it was noted that some of these authorities and remedies may not address the immediate need to continue services in some receiverships. Despite these available remedies, receivers continue to be challenged by this issue in receivership, often resulting in significant additional legal and administrative expenses to the receivership estate.

In 2020, the Receivership Law (E) Working Group was given the charge to provide recommendations for remedies to ensure the continuity of essential services and functions to an insurer in receivership by affiliated entities, including nonregulated entities and specifically for agreements with affiliated entities whose sole business purpose is to provide services to the insurance company.

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

The Receivership Law (E) Working Group of the Receivership and Insolvency (E) Task Force drafted the initial revisions to Model #440 and Model #450. The 2020 and 2021 members of the Subgroup were: Illinois (Co-Chair); Pennsylvania (Co-Chair); Arkansas; California; Colorado; Connecticut; Florida; Iowa; Louisiana (2021); Maine; Massachusetts; Michigan; Missouri; Nebraska; Texas; and Washington.

A drafting group was formed to draft the revisions. Members included: Florida; Illinois; Maine; Michigan; Oklahoma; Pennsylvania; and Texas.

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

As described in paragraph 1 above, the initial charge prompting a review of Model #440 and Model #450 was given to the Receivership Law (E) Working Group for 2020. The Request for NAIC Model Law Development to open Model #440 and Model #450 for revision was adopted by the Executive (EX) Committee at the 2020 Summer National Meeting.

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

In August 2020, the Receivership Law (E) Working Group began its work to address its charge by conducting a survey of state insurance regulators and interested parties to gather feedback on possible provisions to be addressed and goals of those revisions to Model #440 and Model #450. Survey responses were received from state insurance regulators and interested parties identifying specific sections of the models and topics to be considered.

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

On Dec. 17, 2020, the Receivership Law (E) Working Group met in open session to expose proposed amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 42-day public comment period ending Jan. 29, 2021. Comments were received from Florida; the American Council of Life Insurers (ACLI); America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); Arbor Strategies LLC; Morgan, Lewis & Bockius LLP and the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA); and the National Conference of Insurance Guaranty Funds (NCIGF).

On Feb. 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted by the drafting group as discussed during the meeting. The Working Group exposed proposed revised amendments to Section 5A and Section 11 of Model #440 and Section 19 of #450 for a 14-day public comment period ending Feb. 4, 2021. Comments were received from AHIP and the BCBSA; the American Property Casualty Insurance Association (APCIA); Arbor Strategies LLC; and NOLHGA and the NCIGF.

On March 4, 2021, the Receivership Law (E) Working Group met in open session to discuss comments received. Subsequent edits were drafted as discussed during the meeting by the drafting group in coordination with the interested parties that had provided comments. The Working Group co-chairs released proposed revised amendments to Section 5A(1)(g) of Model #440 for a 30-day public comment period ending April 9, 2021. One comment letter was received from the ACLI. The ACLI's proposed edit was accepted.

All exposures were distributed by email to members, interested state insurance regulators and interested parties of both the Receivership Law (E) Working Group and the Receivership and Insolvency (E) Task Force and posted to the NAIC website.

All issues raised by members, interested state insurance regulators and interested parties were explained or addressed in the revisions to the original amendments.

The amendments were adopted by the Receivership Law (E) Working Group on May 4, 2021.

The amendments were adopted by the Receivership and Insolvency (E) Task Force on May 20, 2021.

The amendments were adopted by the Financial Condition (E) Committee on July 8, 2021.

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

There were no unresolved issues of real significance raised during the exposure periods. However, the following issue was considered and addressed by the Receivership Law (E) Working Group. Interested parties requested and provided draft revisions to the amendments in Section 5.A.(1)(g) regarding the requirement for a bond or deposit that limits the provision to insurers found to be in a condition of hazardous financial condition or a condition that would be grounds for supervision, conservation or a delinquency proceeding. Interested parties also provided revisions to the subsection and the accompanying drafting note that would further define and clarify the circumstances and the agreements to which the subsection could be applied. The Working Group was agreeable to these changes and accepted interested parties' revisions.

7. List the key provisions of the model (sections considered most essential to state adoption).

The amendments to Model #440 are within Section 5, Standards and Management of an Insurer Within an Insurance Holding Company System, and within Model #450 Section 19, Transactions Subject to Prior Notice.

- Section 5A(1) of Model #440
 - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them.
 - If the commissioner deems the insurer to be in a statutorily defined hazardous financial condition, the commissioner may require a bond or deposit, limited in amount, after consideration of whether there are concerns about the affiliated party's ability to fulfill the contract in the event of a liquidation.
 - Premiums are the property of the insurer, with any right of offset subject to receivership law.
- Section 5A(6) of Model #440
 - The affiliated entity is subject to jurisdiction of receivership court, and in certain circumstances the commissioner may require the affiliate to agree to this in writing.
- Section 19 of Model #450
 - Books and records of the insurer are updated to specifically include data of the insurer, being the property of the insurer. The data and records should be identifiable and capable of segregation. Essentially the data and records should be available to the receiver in the event of insolvency, including the systems necessary to access them. The data is specifically defined in Model #450.
 - Model #450 includes a provision relating to indemnification of the insurer in the event of gross negligence or willful misconduct by the affiliate.
 - In the event of receivership (now including supervision and conservatorship):
 - The rights of the insurer extend to the receiver or guaranty fund.
 - The affiliate will make available essential personnel.
 - The affiliate will continue the services for a minimum period of time as specified in the agreement with timely payment for post-receivership work.
 - The affiliate will maintain necessary systems, programs or infrastructure and make them available to the receiver or commissioner for as long as the affiliate receives timely post-receivership payment unless released by the receiver, commissioner or receivership court.

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

The Receivership and Insolvency (E) Task Force has not had formal discussions with respect to whether the current Insurance Holding Company Systems accreditation standard under the NAIC Financial Regulation Standards and Accreditation Program should be amended to include the current revisions to Model #440 and Model #450. The Task Force will consider this and make appropriate referrals prior to the 2022 Spring National Meeting.

"W:\National Meetings\2021\Summer\Plenary\Att 7 MO440_M0450 FINAL.pdf"

Adopted by the Executive (EX) Committee and Plenary, Aug. 17, 2021
Adopted by the Financial Condition (E) Committee, Aug. 14, 2021
Adopted by the Reinsurance (E) Task Force, July 27, 2021



Process for Evaluating Qualified and Reciprocal Jurisdictions

Table of Contents

I. Preamble

II. Principles for Evaluation of Non-U.S. Jurisdictions

III. Procedure for Evaluation of Non-U.S. Jurisdictions

1. Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction
2. Evaluation of Jurisdiction
3. NAIC Review of Evaluation Materials
4. Discretionary On-site Review
5. Standard of Review
6. Additional Information to be Considered as Part of Evaluation
7. Preliminary Evaluation Report
8. Review of Preliminary Evaluation Report
9. Opportunity to Respond to Preliminary Evaluation Report
10. NAIC Determination Regarding List of Qualified Jurisdictions
11. Memorandum of Understanding (MOU)
12. Process for Periodic Evaluation
13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions
14. Termination of Status as Qualified and/or Reciprocal Jurisdiction
15. Passporting Process for Reciprocal Jurisdictions

IV. Evaluation Methodology

Section A: Laws and Regulations

Section B: Regulatory Practices and Procedures

Section C: Jurisdiction's Requirements Applicable to U.S.-Domiciled Reinsurers

Section D: Regulatory Cooperation and Information Sharing

Section E: History of Performance of Domestic Reinsurers

Section F: Enforcement of Final U.S. Judgments

Section G: Solvent Schemes of Arrangement

V. Appendices: Specific Guidance with Respect to Section A and Section B

Appendix A: Laws and Regulations

Appendix B: Regulatory Practices and Procedures

I. Preamble

Purpose

The revised *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786) (collectively, the Credit for Reinsurance Models) require an assuming insurer to be licensed and domiciled in a “Qualified Jurisdiction” in order to be eligible for certification by a state as a certified reinsurer for reinsurance collateral reduction purposes. In 2012, the NAIC Reinsurance (E) Task Force was charged to develop an NAIC process to evaluate the reinsurance supervisory systems of non-U.S. jurisdictions, for the purposes of developing and maintaining a list of jurisdictions recommended for recognition by the states as Qualified Jurisdictions. This charge was extended in 2019 to encompass the recognition of Reciprocal Jurisdictions in accordance with the 2019 amendments to the Credit for Reinsurance Models, including the maintenance of a list of recommended Reciprocal Jurisdictions. The purpose of the *Process for Evaluating Qualified and Reciprocal Jurisdictions* is to provide a documented evaluation process for creating and maintaining these NAIC lists.

Background

On November 6, 2011, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions serve to reduce reinsurance collateral requirements for certified reinsurers that are licensed and domiciled in Qualified Jurisdictions. Under the previous version of the Credit for Reinsurance Models, in order for U.S. ceding insurers to receive reinsurance credit, the reinsurance was required to be ceded to U.S.-licensed reinsurers or secured by collateral representing 100% of U.S. liabilities for which the credit is recorded. When considering revisions to the Credit for Reinsurance Models, the Reinsurance (E) Task Force contemplated establishing an accreditation-like process, modeled on the current NAIC Financial Regulation Standards and Accreditation Program, to review the reinsurance supervisory systems of non-U.S. jurisdictions. Under the revised Credit for Reinsurance Models, the approval of Qualified Jurisdictions is left to the authority of the states; however, the models provide that a list of Qualified Jurisdictions will be created through the NAIC committee process, and that individual states must consider this list when approving jurisdictions.

The federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), enacted in 2010, authorizes the U.S. Treasury Secretary and the U.S. Trade Representative (USTR), jointly, to negotiate and enter into “covered agreements” on behalf of the United States. These are bilateral or multilateral agreements with foreign governments, authorities or regulators relating to insurance prudential measures, which can preempt contrary state insurance laws or regulatory measures. The Dodd-Frank Act also created the Federal Insurance Office (FIO), which has the following authority: (1) coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters; (2) assist the Secretary of the U.S. Department of the Treasury in negotiating covered agreements; (3) determine whether the states’ insurance measures are preempted by covered agreements; and (4) consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance. It is the NAIC’s intention to communicate and coordinate with the FIO and related federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.

On September 22, 2017, the United States and the European Union (EU) entered into the “*Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance*.” A similar agreement with the United Kingdom (UK) was signed on December 18, 2018. Both agreements (collectively referred to as the “Covered Agreements”) will require the states to eliminate reinsurance collateral requirements for reinsurers licensed and domiciled in these jurisdictions within 60 months (five years) after signing or face potential federal preemption by the Federal Insurance Office (FIO) under the Dodd-Frank Act.

Reciprocal Jurisdictions

On June 25, 2019, the NAIC Executive (EX) Committee and Plenary adopted revisions to the Credit for Reinsurance Models. These revisions were intended to conform the Models to the relevant provisions of the Covered Agreements. The Covered Agreements would eliminate reinsurance collateral requirements for EU and UK reinsurers that maintain a minimum amount of own funds equivalent to \$250 million and a solvency capital requirement (SCR) of 100% under Solvency II, among other conditions. Conversely, U.S. reinsurers that maintain capital and surplus equivalent to 226 million euros with a risk-based capital (RBC) of 300% of authorized control level would not be required to maintain a local presence in order to do business in the EU or UK or post reinsurance collateral. Under the revised Credit for Reinsurance Models, jurisdictions that are subject to in-force covered agreements are considered to be Reciprocal Jurisdictions,¹ and reinsurers that have their head office or are domiciled in a Reciprocal Jurisdiction are not required to post reinsurance collateral if they meet all of the requirements of the Credit for Reinsurance Models.

Under the revised Credit for Reinsurance Models, not only are jurisdictions that are subject to Covered Agreements treated as Reciprocal Jurisdictions for reinsurance collateral purposes, but any other Qualified Jurisdiction also has a pathway to qualify for collateral elimination as a Reciprocal Jurisdiction States that meet the requirements of the NAIC Financial Standards and Accreditation Program are also considered to be Reciprocal Jurisdictions.

The NAIC has updated and revised this *Process for Evaluating Qualified and Reciprocal Jurisdictions* to specify how Qualified Jurisdictions that recognize key NAIC solvency initiatives, including group supervision and group capital standards, and also meet the other requirements under the revised Credit for Reinsurance Models, will be recognized as Reciprocal Jurisdictions and receive similar treatment as that provided under the EU and UK Covered Agreements, including the elimination of reinsurance collateral and local presence requirements by the states.

¹ The hypothetical possibility that a future covered agreement might not relate to reinsurance is addressed in Section 2F(1)(a)(i) of Model #785, which limits automatic Reciprocal Jurisdiction status to a covered agreement that “addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.”

II. Principles for the Evaluation of Non-U.S. Jurisdictions

1. The NAIC model revisions applicable to certified reinsurers are intended to facilitate cross-border reinsurance transactions and enhance competition within the U.S. market, while ensuring that U.S. insurers and policyholders are adequately protected against the risk of insolvency. To be eligible for certification, a reinsurer must be domiciled and licensed in a Qualified Jurisdiction as determined by the domestic regulator of the ceding insurer. A Qualified Jurisdiction not subject to an in-force Covered Agreement under the Dodd-Frank Act may also be determined to be a Reciprocal Jurisdiction, and reinsurers that have their head office or are domiciled in any such Reciprocal Jurisdiction will not be required to post reinsurance collateral, provided they meet the minimum capital and financial strength requirements and comply with the other requirements of the Credit for Reinsurance Models.
2. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions and Reciprocal Jurisdictions will be conducted in accordance with the provisions of the Credit for Reinsurance Models and any other relevant guidance developed by the NAIC.
3. The evaluation of non-U.S. jurisdictions as Qualified Jurisdictions is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Financial Regulation Standards and Accreditation Program (Accreditation Program), adherence to international supervisory standards, and relevant international guidance for recognition of reinsurance supervision. It is not intended as a prescriptive comparison to the NAIC Accreditation Program. In order for a Qualified Jurisdiction that is not subject to an in-force Covered Agreement to be evaluated as a Reciprocal Jurisdiction, that Qualified Jurisdiction must agree to recognize the states' approach to group supervision, including group capital, and other such requirements as provided under the Credit for Reinsurance Models.
4. The states shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the Qualified Jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of Qualified Jurisdiction status is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.
5. Each state may evaluate a non-U.S. jurisdiction to determine if it is a Qualified Jurisdiction. A list of Qualified Jurisdictions will be published through the NAIC committee process. A state must consider this list in its determination of Qualified Jurisdictions, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Qualified Jurisdictions contained in the Credit for Reinsurance Models. The creation of this list does not constitute a delegation of regulatory authority to the NAIC. The regulatory authority to recognize a Qualified Jurisdiction resides solely in each state and the NAIC List of Qualified Jurisdictions is not binding on the states.
6. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force Covered Agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the List of Reciprocal Jurisdictions. A state must consider this list in its determination of Reciprocal Jurisdiction status, and if the state approves a jurisdiction not on this list, the state must thoroughly document the justification for approving this jurisdiction in accordance with the standards for approving Reciprocal Jurisdictions contained in the Credit for Reinsurance Models. Under the Credit for Reinsurance Model Law (as adopted by a state) the state must recognize the Reciprocal Jurisdiction status of jurisdictions subject to an in-force Covered Agreement.

7. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting,” as discussed more fully below in paragraph 15 of Section III.
8. Both Qualified Jurisdictions and Reciprocal Jurisdictions have agreed to share information and cooperate with the state with respect to all applicable reinsurers domiciled within that jurisdiction, in accordance with the Credit for Reinsurance Models, as adopted by the state. Critical factors in the evaluation process include but are not limited to the history of performance by assuming insurers in the applicant jurisdiction and any documented evidence of substantial problems with the enforcement of final U.S. judgments in the applicant jurisdiction. A jurisdiction will not be a Qualified Jurisdiction if the commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.
9. The determination of Qualified Jurisdiction status can only be made with respect to the reinsurance supervisory system in existence and applied by a non-U.S. jurisdiction at the time of the evaluation.
10. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to the evaluation of the reinsurance supervisory systems of non-U.S. jurisdictions.

III. Procedure for Evaluation of Non-U.S. Jurisdictions

1. Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction.

- a. Priority will be given to requests from the states and from those jurisdictions specifically requesting an evaluation by the NAIC.
- b. Formal notification of the NAIC's intent to initiate the evaluation process will be sent by the NAIC to the reinsurance supervisory authority in the jurisdiction selected, with copies to the FIO and other relevant federal authorities as appropriate. The NAIC will issue public notice on the NAIC website upon confirmation that the jurisdiction is willing to participate in the evaluation process. The NAIC will at this time request public comments with respect to consideration of the jurisdiction as a Qualified Jurisdiction. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document, subject to a preliminary confidentiality and information sharing agreement between the NAIC, relevant states and the applicant jurisdiction.
- c. Relevant U.S. state and federal authorities will be notified of the NAIC's decision to evaluate a jurisdiction.

2. Evaluation of Jurisdiction

- a. Evaluation Materials. The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction's regulatory system by using the information identified in Section A through Section G of the Evaluation Methodology (Evaluation Materials). The Mutual Recognition of Jurisdictions (E) Working Group will begin by undertaking a review of the most recent Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will also invite each jurisdiction or its designee to provide information relative to Section A through Section G of the Evaluation Methodology in order to update, complete or supplement publicly available information. The Mutual Recognition of Jurisdictions (E) Working Group may also request or accept relevant information from reinsurers domiciled in the jurisdiction under review.
- b. The Mutual Recognition of Jurisdictions (E) Working Group will notify the jurisdiction of any information upon which the Working Group is relying. In that communication, the NAIC will invite the supervisory authority to compare the materials identified by the NAIC to the materials described in Appendix A and Appendix B, and provide information required to update the identified public information or supplement the public information, as required, to address the topics identified in Section A through Section G of the Evaluation Methodology. The use of publicly available information (e.g., the FSAP Report and/or the Insurance Sector Technical Note) is intended to lessen the burden on applicant jurisdictions by requiring the production of information that is readily available, while still addressing substantive areas of inquiry detailed in the Evaluation Methodology. The Mutual Recognition of Jurisdictions (E) Working Group's review at this stage will be focused on how the jurisdiction's laws, regulations, administrative practices and procedures, and regulatory authorities regulate the financial solvency of its domestic reinsurers in comparison to key principles underlying the U.S. financial solvency framework² and other factors set forth in the Evaluation Methodology.

² The U.S. financial solvency framework is understood to refer to the key elements provided in the NAIC Financial Regulation Standards and Accreditation Program. Appendix A and Appendix B are derived from this framework.

- c. After reviewing the Evaluation Materials, the Mutual Recognition of Jurisdictions (E) Working Group may request that the applicant jurisdiction submit supplemental information as necessary to determine whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. The Working Group will address specific questions directly with the jurisdiction related to items detailed in the Evaluation Methodology that are not otherwise addressed in the Evaluation Materials.
- d. The NAIC will request that all responses from the jurisdiction being evaluated be provided in English. Any responses submitted with respect to a jurisdiction's laws and regulations should be provided by a person qualified in that jurisdiction to provide such analyses and, in the case of statutory analysis, qualified to provide such legal interpretations, to ensure that the jurisdiction is providing an accurate description.
- e. The NAIC does not intend to review confidential company-specific information in this process, and has focused the procedure on reviewing publicly available information. No confidential company-specific information shall be disclosed or disseminated during the course of the jurisdiction's evaluation unless specifically requested, subject to appropriate confidentiality safeguards addressed in a preliminary confidentiality and information-sharing agreement. If no such agreement is executed or the jurisdiction is unable to enter into such an agreement under its regulatory authority, the NAIC will not accept any confidential company-specific information.

3. NAIC Review of Evaluation Materials

- a. NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise will review the jurisdiction's Evaluation Materials.
- b. Expenses with respect to the evaluations will be absorbed within the NAIC budget. This will be periodically reviewed.
- c. Timeline for review. A project management approach will be developed with respect to the overall timeline applicable to each evaluation.
- d. Upon completing its review of the Evaluation Materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to FIO and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

4. Discretionary On-site Review

- a. The NAIC may ask the jurisdiction under consideration for the opportunity to perform an on-site review of the jurisdiction's reinsurance supervisory system. Factors that the Mutual Recognition of Jurisdictions (E) Working Group will consider in determining whether an on-site review is appropriate include the completeness of the information provided by the jurisdiction under review, the general familiarity of the jurisdiction by the NAIC staff or other state regulators participating in the review based on prior conduct or dealings with the jurisdiction, and the results of other evaluations performed by other regulatory or supervisory organizations. If the review is performed, it will be coordinated through the NAIC, utilizing personnel with the appropriate knowledge, experience and expertise. Individual states may also request that representatives from their state be added to the review team.
- b. The review team will communicate with the supervisory authority in advance of the on-site visit to clearly identify the objectives, expectations and procedures with respect to the review, as well as any significant

issues or concerns identified within the review of the Evaluation Materials. Information to be considered during the on-site review includes, but is not limited to, the following:

- i. Interviews with supervisory authority personnel.
 - ii. Review of organizational and personnel practices.
 - iii. Any additional information beneficial to gaining an understanding of document and communication flows.
- c. Upon completing the on-site review, the reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation.

5. Standard of Review

The evaluation is intended as an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. The standard for qualification of a jurisdiction is that the NAIC must reasonably conclude that the jurisdiction's reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction's demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction's laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.

6. Additional Information to be Considered as Part of Evaluation

The NAIC may also consider information from sources other than the jurisdiction under review. This information includes:

- a. Documents, reports and information from appropriate international, U.S. federal and U.S. state authorities.
- b. Public comments from interested parties.
- c. Rating agency information.
- d. Any other relevant information.

7. Preliminary Evaluation Report

- a. NAIC staff and/or outside consultants will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. This preliminary report will be private and confidential (i.e., may only be reviewed by Working Group members, designated NAIC staff, consultants, the states, the FIO and other relevant federal authorities that specifically request to be kept apprised of this information, provided that such entities have entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction. Any outside consultants retained by the NAIC will be required to enter into a confidentiality and nondisclosure agreement.).
- b. The report will be prepared in a consistent style and format to be developed by NAIC staff. It will contain detailed advisory information and recommendations with respect to the evaluation of the jurisdiction's reinsurance supervisory system and the documented practices and procedures thereunder. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a Qualified Jurisdiction.

- c. All workpapers and reports, including supporting documentation and data, produced as part of the evaluation process are the property of the NAIC and shall be maintained at the NAIC Central Office. In the event that the NAIC shall come into possession of any confidential information, the information shall be held subject to a confidentiality and information-sharing agreement, which will outline the appropriate actions necessary to protect the confidentiality of such information.

8. Review of Preliminary Evaluation Report

- a. The Mutual Recognition of Jurisdictions (E) Working Group's review of the Preliminary Evaluation Report will be held in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings.
- b. The Mutual Recognition of Jurisdictions (E) Working Group will make a preliminary determination as to whether the jurisdiction under consideration satisfies the Standard of Review and is deemed acceptable to be included on the NAIC List of Qualified Jurisdictions. If the preliminary determination is that the jurisdiction should not be included on the NAIC List of Qualified Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will set forth its specific findings and identify those areas of concern with respect to this determination.
- c. The results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review.

9. Opportunity to Respond to Preliminary Evaluation Report

- a. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. This is not intended to be a formal appeals process that would initiate U.S. state administrative due process requirements.
- b. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Mutual Recognition of Jurisdictions (E) Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session in accordance with the NAIC Policy Statement on Open Meetings. This report will be approved upon an affirmative vote of a majority of the members in attendance at this meeting.
- c. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the summary for public comment. The detailed report will be a confidential, regulator-only document. The report may be shared with any state indicating that it is considering relying on the NAIC List of Qualified Jurisdictions and has entered into a preliminary confidentiality and information-sharing agreement with the foreign jurisdiction.

10. NAIC Determination Regarding List of Qualified Jurisdictions

- a. Once the Mutual Recognition of Jurisdictions (E) Working Group has adopted its Final Evaluation Report, it will submit the summary of its findings and its recommendation to the Reinsurance (E) Task Force at an open meeting. Upon approval by the Reinsurance (E) Task Force, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the FIO, USTR and other relevant federal authorities for consultation purposes. Upon approval as a Qualified Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Qualified Jurisdictions. The NAIC will maintain the List of Qualified Jurisdictions on its public website and in other appropriate NAIC publications.

- b. In the event that a jurisdiction is not approved as a Qualified Jurisdiction, the supervisory authority will be eligible for reapplication at the discretion of the NAIC.
- c. Upon final adoption of the Mutual Recognition of Jurisdictions (E) Working Group's determination with respect to a jurisdiction, the Final Evaluation Report will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential.

11. Memorandum of Understanding (MOU)

- a. A Qualified Jurisdiction must agree to share information and cooperate on a confidential basis with the U.S. state insurance regulatory authority with respect to all certified reinsurers domiciled within that jurisdiction.
- b. The International Association of Insurance Supervisors (IAIS) Multilateral Memorandum of Understanding (MMoU) is the recommended method under which a Qualified Jurisdiction will agree to share information and cooperate with U.S. state insurance regulatory authorities. However, until such time as a state has been approved as a signatory to the MMoU by the IAIS, the state may rely on an MOU entered into by a "Lead State" designated by the NAIC. This Lead State will act as a conduit for information between the Qualified Jurisdiction and other states that have certified a reinsurer domiciled and licensed in that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the NAIC Master Information Sharing and Confidentiality Agreement, and, as applicable, in the IAIS MMoU, or in a bilateral MOU between the Lead State and the Qualified Jurisdiction. The jurisdiction must also confirm in writing that it is willing to permit this Lead State to act as the contact for purposes of obtaining information concerning its certified reinsurers, provided that the Lead State share that information with the other states requesting the information only in a manner consistent with the terms governing the further sharing of information included, as applicable, in the IAIS MMoU or bilateral MOU between the Lead State and the Qualified Jurisdiction.
- c. If a Qualified Jurisdiction has not been approved by the IAIS as a party to the MMoU, it must enter into an MOU with a Lead State. The MOU must provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions.
- d. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

12. Process for Evaluation after Initial Approval

- a. The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Mutual Recognition of Jurisdictions (E) Working Group to be appropriate. It shall include a review of the jurisdiction's status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13.
- b. Qualified Jurisdictions must provide the Mutual Recognition of Jurisdictions (E) Working Group with notice of any material change in the applicable reinsurance supervisory system that may affect the status of

the Qualified Jurisdiction. A U.S. jurisdiction should also notify the Mutual Recognition of Jurisdictions (E) Working Group if it receives notice of any material change in the applicable reinsurance supervisory system, or any adverse developments with respect to enforcement of final U.S. judgments, that may affect the status of the Qualified Jurisdiction. U.S. ceding insurers may also initiate notice to the Mutual Recognition of Jurisdictions (E) Working Group if they receive notice of any material change in the applicable reinsurance supervisory system or any adverse developments with respect to enforcement of final U.S. judgments. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will consider whether it is necessary to re-evaluate the status of the Qualified Jurisdiction. Any review will be conducted in accordance with the procedure set forth in paragraph 14.

- c. The Mutual Recognition of Jurisdictions (E) Working Group will monitor those jurisdictions that have been approved as Qualified or Reciprocal Jurisdictions by individual states, but are not included on the applicable NAIC List.

13. Review of Qualified Jurisdictions as Potential Reciprocal Jurisdictions

- a. In evaluating whether to designate a Qualified Jurisdiction as a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall utilize such processes and procedures as outlined in the immediately-preceding paragraphs 1 – 12 of Section III. *Procedure for Evaluation of Non-U.S. Jurisdictions* such as the Mutual Recognition of Jurisdictions (E) Working Group deems is appropriate. Specifically, the Mutual Recognition of Jurisdictions (E) Working Group will use processes and procedures outlined in paragraph 1 (*Initiation of Evaluation of the Reinsurance Supervisory System of an Individual Jurisdiction*), paragraph 3 (*NAIC Review of Evaluation Materials*), paragraph 7 (*Preliminary Evaluation Report*), paragraph 8 (*Review of Preliminary Evaluation Report*), paragraph 9 (*Opportunity to Respond to Preliminary Evaluation Report*), paragraph 10 (*NAIC Determination regarding List of Qualified Jurisdictions*), paragraph 11 (*Memorandum of Understanding*) and paragraph 12 (*Process for Evaluation after Initial Approval*), as modified for use with applicants for Reciprocal Jurisdiction status.
- b. A Qualified Jurisdiction may not be reviewed for inclusion on the NAIC List of Reciprocal Jurisdictions unless it has undergone the *Evaluation Methodology* outlined in Section IV, and remains in good standing with the NAIC as a Qualified Jurisdiction. The Mutual Recognition of Jurisdictions (E) Working Group may, if it determines an extended review period to be appropriate after its initial approval of a new Qualified Jurisdiction, defer consideration of that jurisdiction as a possible Reciprocal Jurisdiction until there has been sufficient United States experience with that jurisdiction and its Certified Reinsurers that the Working Group believes it is appropriate to progress from collateral reduction to collateral elimination. Nothing in this process requires a finding that a Qualified Jurisdiction meets the standards for recognition as a Reciprocal Jurisdiction, and the Mutual Recognition of Jurisdictions (E) Working Group may base its determination on all relevant information, which may include factors not specifically included in this *Process for Evaluating Qualified and Reciprocal Jurisdictions*.
- c. A list of Reciprocal Jurisdictions will be published through the NAIC committee process. Jurisdictions subject to an in-force covered agreement and states that meet the requirements of the NAIC Financial Standards and Accreditation Program are automatically included on the NAIC List of Reciprocal Jurisdictions. In making its recommendation with respect to whether a Qualified Jurisdiction that is not automatically designated as a Reciprocal Jurisdiction should be added to the NAIC List of Reciprocal

Jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group shall undertake the following analysis in making its evaluation:

- i. The Qualified Jurisdiction must confirm that an insurer which has its head office or is domiciled in that jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as the same insurer would receive credit for reinsurance assumed by an assuming insurer domiciled in that jurisdiction;
 - ii. The Qualified Jurisdiction must confirm that it does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by that jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;
 - iii. The Qualified Jurisdiction must recognize the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by its competent regulatory authority that insurance groups that are domiciled or maintain their worldwide headquarters in a jurisdiction accredited by the NAIC shall be subject only to their U.S. home jurisdiction's worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision by the Qualified Jurisdiction at the level of the worldwide parent undertaking of the insurance or reinsurance group;
 - iv. The Qualified Jurisdiction must provide written confirmation by its competent regulatory authority that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the Qualified Jurisdiction, including but not limited to the IAIS MMoU or other multilateral memoranda of understanding coordinated by the NAIC. This requirement may be satisfied by an MOU with a Lead State, which shall provide for appropriate confidentiality safeguards with respect to the information shared between the jurisdictions, similar to the MOU requirement outlined in paragraph 11 of this section III; and
 - v. The Qualified Jurisdiction must confirm that it will provide to the states on an annual basis confirmation that each eligible assuming insurer that is domiciled in the Qualified Jurisdiction continues to comply with the requirements set forth in in Section 9C(2) and (3) of Model #786; i.e., must maintain, on an ongoing basis, minimum capital and surplus of no less than \$250,000,000, and the required minimum solvency or capital ratio, as applicable.
- d. In order to satisfy the requirements of subsection (c) above, the chief insurance supervisor of the Qualified Jurisdiction being evaluated as a Reciprocal Jurisdiction may provide the NAIC with a written letter confirming, as follows:

[Jurisdiction] is a Qualified Jurisdiction under the NAIC *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786), and is currently in good standing on the *NAIC List of Qualified Jurisdictions*. As the lead insurance regulatory supervisor for [Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- An insurer which has its head office or is domiciled in [Jurisdiction] shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit would be granted for reinsurance assumed by insurers domiciled in [Jurisdiction]. [Jurisdiction] does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by [Jurisdiction] or as a condition to allow the ceding insurer to recognize credit for such reinsurance.
 - [Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurance groups that are domiciled or maintain their worldwide headquarters in jurisdictions accredited by the NAIC shall be subject only to their U.S. home jurisdiction's worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the [Jurisdiction].
 - [Jurisdiction] confirms that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the states in accordance with a memorandum of understanding or similar document between a state and the [Jurisdiction].
 - [Jurisdiction] will annually provide to the states confirmation that applicable assuming insurers domiciled in [Jurisdiction] maintain minimum capital and surplus of no less than \$250,000,000, and maintain on an ongoing basis the required minimum solvency or capital ratio, as applicable.
 - Finally, I confirm that [Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.
- e. The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination, the representations in the letter are true and accurate, and will prepare for the review by the Reinsurance Task Force a Summary of Findings and Determination recommending that the Qualified Jurisdiction be recognized as a Reciprocal Jurisdiction. Upon approval by the Task Force, the Summary of Findings and Determination will be submitted for a vote of the NAIC Executive (EX) Committee and Plenary for inclusion on the List of Reciprocal Jurisdictions.
- f. The Mutual Recognition of Jurisdictions (E) Working Group, working in coordination with the Qualified Jurisdiction and the Reinsurance Financial Analysis (E) Working Group, must make a determination on a minimum solvency or capital ratio under which reinsurers licensed and domiciled in the Qualified Jurisdiction may assume insurance from U.S. ceding companies without posting reinsurance collateral. The applicable minimum solvency or capital ratio must be an effective measure of solvency, comparable to either an NAIC risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, or one hundred percent (100%) of the solvency capital requirement (SCR) as calculated under the Solvency II Directive issued by the European Union, giving due consideration to any applicable

equivalency assessment conducted by the European Insurance and Occupational Pensions Authority (EIOPA) on the Qualified Jurisdiction with respect to Solvency II.

14. Termination of Status as Qualified and/or Reciprocal Jurisdiction

- a. If the Mutual Recognition of Jurisdictions (E) Working Group finds a Qualified Jurisdiction to be out of compliance at any time with the requirements to be a Qualified Jurisdiction, the specific reasons will be documented in a report to the jurisdiction under review. The Mutual Recognition of Jurisdictions (E) Working Group would then report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. The status as a Qualified Jurisdiction may be placed on probation, suspended or revoked by the NAIC. If a Qualified Jurisdiction is also a Reciprocal Jurisdiction subject to a Covered Agreement, the Mutual Recognition of Jurisdictions (E) Working Group and the NAIC will initiate communications and consult with FIO, USTR and any other relevant federal and/or international authorities before any action is taken with respect to that Qualified Jurisdiction's status.
- b. Except for Reciprocal Jurisdictions entitled to automatic recognition, a jurisdiction's status as a Reciprocal Jurisdiction may be placed on probation, suspended or revoked for good cause in the same manner as provided for Qualified Jurisdictions. If cause is found to question the fitness of a Reciprocal Jurisdiction that is subject to an in-force Covered Agreement, or its compliance with applicable requirements of the covered agreement, the Mutual Recognition of Jurisdictions (E) Working Group would report any concerns to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities. It is intended that compliance with the covered agreement will be addressed through the Joint Committee process established under the covered agreement, or through termination of the covered agreement by the parties to the covered agreement. The NAIC, individual state regulators and interested parties may raise these issues directly with FIO, USTR or other relevant federal authorities.
- c. Both Qualified Jurisdictions and Reciprocal Jurisdictions that are not subject to a covered agreement are obligated to provide notice to the Mutual Recognition of Jurisdictions (E) Working Group of any applicable changes to their reinsurance supervisory system or changes to the assurances provided in the letter set forth in paragraph 13. States and U.S. ceding insurers may also provide notice of such changes to the Working Group. Upon notice of any such material changes, the Working Group will meet in regulator-only session to determine if these changes are in fact material to continuing recognition by the NAIC as either a Qualified or Reciprocal Jurisdiction. The Working Group will work directly with the jurisdiction to address any issues that have been identified. If these issues cannot be resolved through this regulator-only dialogue, then the Working Group will report its recommendation to the Reinsurance Task Force, which will consider a suspension of the jurisdiction's status as a Qualified or Reciprocal Jurisdiction in open session. The Task Force will then make a recommendation to the NAIC Plenary on the action, if any, to be taken, which may include placing the Qualified or Reciprocal Jurisdiction's status on probation, or suspending or revoking its status.
- d. If a Qualified or Reciprocal Jurisdiction's status is placed on probation by the NAIC, the material change will be noted in an update to its Summary of Finding and Determination in order to provide notice to the states and U.S. ceding insurers of this material change. If the NAIC decides to suspend or revoke its status, the jurisdiction may be given a reasonable time period, no more than 18 months, to rectify its noncompliance with the standards and return it to good standing. Once the NAIC's suspension or revocation

takes effect, it is expected that the same action will be taken by the respective states that have recognized the jurisdiction as a Qualified or Reciprocal Jurisdiction.

- e. There is no administrative right to appeal the decision of the NAIC with respect to the revocation of status as a Qualified or Reciprocal Jurisdiction, but the jurisdiction can apply for reinstatement after a one-year period.
- f. During the period in which a Qualified or Reciprocal Jurisdiction's status has been suspended by a state, any new reinsurance assumed by a reinsurer domiciled in that jurisdiction from a ceding insurer domiciled in that state will not be eligible for credit unless the transaction qualifies for credit on the basis of security posted by the ceding insurer or some other basis that does not depend on recognition of the jurisdiction as a Qualified or Reciprocal Jurisdiction. However, suspension does not affect credit for reinsurance that was already in force.
- g. If a Qualified or Reciprocal Jurisdiction's status is revoked by a state, then those Certified Reinsurers and/or Reciprocal Jurisdiction Reinsurers domiciled in that jurisdiction no longer qualify for that status, which generally obligates them to post one hundred percent (100%) collateral on all their liabilities assumed from ceding insurers domiciled in that state. The state has the option to suspend a reinsurer's certification indefinitely, in lieu of revocation, in which case the obligation to post collateral applies prospectively to all new, renewed and amended reinsurance agreements. If the reinsurer's eligibility is revoked, it must be granted at least three months after the effective date of the revocation to cure any deficiency in collateral, unless exceptional circumstances make a shorter period necessary for policyholder and other consumer protection.
- h. The factors used in the evaluation of Reciprocal Jurisdictions are not the same as are utilized in the evaluation of Qualified Jurisdictions. A Qualified Jurisdiction that has been approved by the NAIC as a Reciprocal Jurisdiction may have its status as a Reciprocal Jurisdiction either suspended or revoked but still meet the requirements to be a Qualified Jurisdiction. However, if a Reciprocal Jurisdiction that is not subject to a covered agreement has its status as a Qualified Jurisdiction revoked, it cannot maintain its status as a Reciprocal Jurisdiction, because it must be a Qualified Jurisdiction to meet the requirements of a Reciprocal Jurisdiction.

15. Passporting Process for Certified and Reciprocal Jurisdiction Reinsurers

- a. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called "passporting" under which the commissioner has the discretion to defer to another state's determination with respect to the requirements for both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.
- b. The passporting process is facilitated through the Reinsurance Financial Analysis (E) Working Group (ReFAWG). It is intended that ReFAWG will help facilitate multi-state recognition of Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and address issues of uniformity among the states, both with respect to initial application and subsequent changes in rating or status. The ReFAWG Review Process is set forth in the *ReFAWG Procedures Manual*.

- c. Section 9C(7) of the *Credit for Reinsurance Model Regulation* (#786) provides that the “assuming insurer’s supervisory authority must confirm to the commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) [i.e., minimum capital and surplus of no less than \$250 million] and (3) [i.e., minimum solvency or capital ratio] of this subsection.” Section 9E(1) of Model #786 then provides that “The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection C.” A Reciprocal Jurisdiction may satisfy the requirements of Section 9C(7) of Model #786 either by providing the information required by Section 9C(7) itself, or by providing an assuming insurer domiciled in that Reciprocal Jurisdiction with a document confirming the required information, which the assuming insurer would file annually. With either filing method, in lieu of filing the required information directly with the domiciliary states of each of the reinsurer’s U.S. ceding companies, the information may be filed with either the Lead State or the NAIC, which will share this documentation with the other states through the ReFAWG Review Process in satisfaction of their respective filing requirements.

IV. Evaluation Methodology

The Evaluation Methodology was developed to be consistent with the provisions of the NAIC Credit for Reinsurance Models. It is intended to provide an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program, adherence to international supervisory standards and relevant international guidance for recognition of reinsurance supervision. Although the methodology includes a comparison of the jurisdiction's supervisory system to a number of key elements from the NAIC Accreditation Program, it is not intended as a prescriptive assessment under the NAIC Accreditation Program. Rather, the NAIC Accreditation Program simply provide the framework for the outcomes-based analysis. The NAIC will evaluate the appropriateness and effectiveness of the reinsurance supervisory system within the jurisdiction and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the U.S. The determination of a Qualified Jurisdiction is based on the effectiveness of the entire reinsurance supervisory system within the jurisdiction.

The Evaluation Methodology consists of the following:

- Section A: Laws and Regulations
- Section B: Regulatory Practices and Procedures
- Section C: Jurisdiction's Requirements Applicable to U.S.-Domiciled Reinsurers
- Section D: Regulatory Cooperation and Information Sharing
- Section E: History of Performance of Domestic Reinsurers
- Section F: Enforcement of Final U.S. Judgments
- Section G: Solvent Schemes of Arrangement

This information will be the basis for the Final Evaluation Report and the determination of whether the jurisdiction will be included on the NAIC List of Qualified Jurisdictions.

Section A: Laws and Regulations

The NAIC will review publicly available information, as well as information provided by an applicant jurisdiction with respect to its laws and regulations, in an effort to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. This will include a review of elements believed to be basic building blocks for sound insurance/reinsurance regulation.³ A jurisdiction's effectiveness under Section A may be demonstrated through law, regulation or established practice that implements the general authority granted to the jurisdiction, or any combination of laws, regulations or practices that meet the objective.

The Mutual Recognition of Jurisdictions (E) Working Group will initiate evaluation of a jurisdiction's regulatory system by gathering and undertaking a review of the most recent FSAP Report, ROSC and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. The Mutual Recognition of Jurisdictions (E) Working Group will simultaneously invite each jurisdiction (or its designee) to provide information relative to Section A (and other sections, as relevant) to assist the NAIC in evaluating its laws and regulations. The NAIC will review this information in conjunction with Appendix A, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix A is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction is requested to address the following information, which the NAIC will consider, at a minimum, in determining whether the outcomes achieved by the jurisdiction's laws and regulations meet an acceptable level of effectiveness for the jurisdiction to be included on the NAIC List of Qualified Jurisdictions:

1. Confirmation of the jurisdiction's most recent FSAP Report, including relevant updates with respect to descriptions or elements of the FSAP Report in which changes have occurred since the assessment or where information might otherwise be outdated.
2. Confirmation of the jurisdiction's ROSC, including relevant updates with respect to descriptions or elements of the ROSC in which changes have occurred since the report was completed or where information might otherwise be outdated.
3. If materials responsive to the topics under review have been provided in response to information exchanges between the jurisdiction under review and the NAIC, such prior responses may be cross-referenced provided updates are submitted, if required to address changes in laws or procedures.
4. Any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC's evaluation process in order to address, on an outcomes basis, the key elements described within Appendix A.

The NAIC will review the information provided by the applicant jurisdiction and determine whether it is adequate to reasonably conclude whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner. After reviewing the initial submission, the NAIC may request that the applicant jurisdiction submit supplemental information as necessary in order to make this determination. An applicant jurisdiction is strongly encouraged to provide thorough, detailed and current information in its initial submission in order to

³ The basic considerations under this section are derived from Model #786, Section 8C(2), which include: (a) the framework under which the assuming reinsurer is regulated; (b) the structure and authority of the jurisdiction's reinsurance supervisory authority with regard to solvency regulation requirements and financial surveillance; (c) the substance of financial and operating standards for reinsurers domiciled in the jurisdiction; and (d) the form and substance of financial reports required to be filed or made publicly available by reinsurers domiciled in the jurisdiction and the accounting principles used.

minimize the number and extent of supplemental information requests from the NAIC with respect to Section A of this Evaluation Methodology. The NAIC will provide a complete description in the Final Evaluation Report of the information provided in the Evaluation Materials, and any updates or other information that have been provided by the applicant jurisdiction.

Section B: Regulatory Practices and Procedures

Section B is intended to facilitate an evaluation of whether the jurisdiction effectively employs baseline regulatory practices and procedures to supplement and support enforcement of the jurisdiction's financial solvency laws and regulations described in Section A. This evaluation methodology recognizes that variation may exist in practices and procedures across jurisdictions due to the unique situations each jurisdiction faces. Jurisdictions differ with respect to staff and technology resources that are available, as well as the characteristics of the domestic industry regulated. A determination of effectiveness may be achieved using various financial solvency oversight practices and procedures. This evaluation is not intended to be prescriptive in nature.

The NAIC will utilize the information provided by the jurisdiction as outlined under Section A in completing this section of the evaluation. The NAIC will review this information in conjunction with Appendix B, which provides more detailed guidance with respect to elements the NAIC intends to consider on an outcomes basis in the evaluation under this section. Appendix B is not intended as a prescriptive checklist of requirements a jurisdiction must meet in order to be a Qualified Jurisdiction. Rather, it is provided in an effort to facilitate an outcomes-based comparison to financial solvency regulation under the NAIC Accreditation Program. An applicant jurisdiction should also provide any other information, descriptions or responses the jurisdiction believes would be beneficial to the NAIC's evaluation process in order to address, on an outcomes basis, the key elements described within Appendix B.

Section C: Jurisdiction's Requirements Applicable to U.S. Domiciled Reinsurers

The jurisdiction is requested to describe and explain the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. supervisory authority to reinsurers licensed and domiciled in the U.S.

Section D: Regulatory Cooperation and Information-Sharing

The Credit for Reinsurance Models require the supervisory authority to share information and cooperate with the U.S. state insurance regulators with respect to all certified reinsurers domiciled within their jurisdiction. The jurisdiction is requested to provide an explanation of the supervisory authority's ability to cooperate, share information and enter into an MOU with U.S. state insurance regulators and confirm that they are willing to enter into an MOU. This should include information with respect to any existing MOU with U.S. state and/or federal authorities that pertain to reinsurance. Both the jurisdiction and the states may rely on the IAIS MMoU to satisfy this requirement, and any states that have not yet been approved by the IAIS as a signatory to the MMoU may rely on an MOU entered into by a Lead State with the jurisdiction until such time that the state has been approved as a signatory to the IAIS MMoU. The NAIC and the states will communicate and coordinate with the FIO, USTR and other relevant federal authorities as appropriate with respect to this process.

Section E: History of Performance of Domestic Reinsurers

The jurisdiction is requested to provide a general description with respect to the historical performance of reinsurers domiciled in the jurisdiction. The NAIC does not intend to review confidential company-specific information under this section. Rather, it is intended that any information provided would be publicly available, unless specifically addressed with the jurisdiction under review. This discussion should address, at a minimum, the following information:

- a. Number of reinsurers domiciled in the jurisdiction, and a list of any reinsurers domiciled in the jurisdiction that have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, of no less than \$250,000,000.
- b. Up to a 10-year history of any regulatory actions taken against specific reinsurers.
- c. Up to a 10-year history listing any reinsurers that have gone through insolvency proceedings, including the size of each insolvency and a description of the related outcomes (e.g., reinsurer rehabilitated or liquidated, payout percentage of claims to priority classes, payout percentage of claims to domestic and foreign claimants).
- d. Up to a 10-year history of any significant industry-wide fluctuations in capital or profitability with respect to domestic reinsurers.

Drafting Note: The NAIC will determine the appropriate time period for review on a case-by-case basis with respect to this information.

Section F: Enforcement of Final U.S. Judgments

The NAIC has previously collected information from a number of jurisdictions with respect to enforcement of final U.S. judgments. The jurisdiction is also requested to provide a current description or explanation of any restrictions with respect to the enforcement of final foreign judgments in the jurisdiction. Based on the foregoing information, the NAIC will make an assessment of the effectiveness of the ability to enforce final U.S. judgments in the jurisdiction. This will include a review of the status, interpretations, application and enforcement of various treaties, conventions and international agreements with respect to final judgments, arbitration and choice of law. The Mutual Recognition of Jurisdictions (E) Working Group will monitor the enforcement of final U.S. judgments and the Qualified Jurisdiction is requested to notify the NAIC of any developments in this area.

Section G: Solvent Schemes of Arrangement

The jurisdiction is requested to provide a description of any legal framework that allows reinsurers domiciled in the jurisdiction to propose or participate in any solvent scheme of arrangement or similar procedure. In addition, the jurisdiction is requested to provide a description of any solvent scheme of arrangement or similar procedure that a domestic reinsurer has proposed or participated in and the outcome of such procedure.

V. Appendices: Specific Guidance with Respect to Section A and Section B

It is important to note that Part IV, Section A: Laws and Regulations, and Part IV, Section B: Regulatory Practices and Procedures, are derived from the NAIC Financial Regulation Standards and Accreditation Program, which is intended to establish and maintain standards to promote sound insurance company financial solvency regulation among the U.S. states. As such, the NAIC Accreditation Program requires the states to employ laws, regulations and administrative policies and procedures substantially similar to the NAIC accreditation standards in order to be considered an accredited state.

However, it is not the intent of the Evaluation Methodology to require applicant jurisdictions to meet the standards required by the NAIC for accreditation. Instead, Section A and Section B (and their corresponding appendices) are intended to provide a framework to facilitate an outcomes-based evaluation by the NAIC and state insurance regulators of the effectiveness of the jurisdiction's supervisory authority. This framework consists of a description of the jurisdiction's laws, regulations, practices and procedures applicable to the supervision of its domestic reinsurers. The amount of detail provided within these appendices should not be interpreted as specific requirements that must be met by the applicant jurisdiction. Rather, the information is intended to provide direction to the applicant jurisdiction in an effort to facilitate a complete response and increase the efficiency and timeliness of the evaluation process.

Appendix A: Laws and Regulations

1. Examination Authority

Does the jurisdiction have the authority to examine its domestic reinsurers? This description should address the following:

- a. Frequency and timing of examinations and reports.
- b. Guidelines for examination.
- c. Whether the jurisdiction has the authority to examine reinsurers whenever it is deemed necessary.
- d. Whether the jurisdiction has the authority to have complete access to the reinsurer's books and records and, if necessary, the records of any affiliated company.
- e. Whether the jurisdiction has the authority to examine officers, employees and agents of the reinsurer when necessary with respect to transactions directly or indirectly related to the reinsurer under examination.
- f. Whether the jurisdiction has the authority to share confidential information with U.S. state insurance regulatory authorities, provided that the recipients are required, under their law, to maintain its confidentiality.

2. Capital and Surplus Requirement

Does the jurisdiction have the authority to require domestic reinsurers to maintain a minimum level of capital and surplus to transact business? This description should address the following:

- a. Whether the jurisdiction has the authority to require reinsurers to maintain minimum capital and surplus, including a description of such minimum amounts.
- b. Whether the jurisdiction has the authority to require additional capital and surplus based on the type, volume and nature of reinsurance business transacted.
- c. Capital requirements for reinsurers, including reports and a description of any specific levels of regulatory intervention.

3. Accounting Practices and Procedures

Does the jurisdiction have the authority to require domestic reinsurers to file appropriate financial statements and other financial information? This description should address the following:

- a. Description of the accounting and reporting practices and procedures.
- b. Description of any standard financial statement blank/reporting template, including description of content/disclosure requirements and corresponding instructions.

4. Corrective Action

Does the jurisdiction have the authority to order a reinsurer to take corrective action or cease and desist certain practices that, if not corrected or terminated, could place the reinsurer in a hazardous financial condition? This description should address the following:

- a. Identification of specific standards which may be considered to determine whether the continued operation of the reinsurer might be hazardous to the general public.
- b. Whether the jurisdiction has the authority to issue an order requiring the reinsurer to take corrective action when it has been determined to be in hazardous financial condition.

5. Regulation and Valuation of Investments

What authority does the jurisdiction have with respect to regulation and valuation of investments? This description should address the following:

- a. Whether the jurisdiction has the authority to require a diversified investment portfolio for all domestic reinsurers as to type, issue and liquidity.
- b. Whether the jurisdiction has the authority to establish acceptable practices and procedures under which investments owned by reinsurers must be valued, including standards under which reinsurers are required to value securities/investments.

6. Holding Company Systems

Does the jurisdiction have laws or regulations with respect to supervision of the group holding company systems of reinsurers? This description should address the following:

- a. Whether the jurisdiction has access to information via the parent or other regulated group entities about activities or transactions within the group involving other regulated or non-regulated entities that could have a material impact on the operations of the reinsurer.
- b. Whether the jurisdiction has access to consolidated financial information of a reinsurer's ultimate controlling person.
- c. Whether the jurisdiction has the authority to review integrity and competency of management.
- d. Whether the jurisdiction has approval and intervention powers for material transactions and events involving reinsurers.
- e. Whether the jurisdiction has authority to monitor, or has prior approval authority over:
 - i. Change in control of domestic reinsurers.
 - ii. Dividends and other distributions to shareholders of the reinsurer.
 - iii. Material transactions with affiliates.

7. Risk Management

Does the jurisdiction have the authority to require its domestic reinsurers to maintain an effective risk-management function and practices? This description should address the following:

- a. Whether the jurisdiction has Own Risk and Solvency Assessment (ORSA) requirements and reporting.
- b. Any requirements regarding the maximum net amount of risk to be retained by a reinsurer for an individual risk based on the reinsurer's capital and surplus.
- c. Whether the jurisdiction has authority to monitor enterprise risk, including any activity, circumstance, event (or series of events) involving one or more affiliates of a reinsurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the reinsurer or its insurance holding company system as a whole.
- d. Whether the jurisdiction has corporate governance requirements for reinsurers.

8. Liabilities and Reserves

Does the jurisdiction have standards for the establishment of liabilities and reserves (technical provisions) resulting from reinsurance contracts? This description should address the following:

- a. Liabilities incurred under reinsurance contracts for policy reserves, unearned premium, claims and losses unpaid, and incurred but not reported (IBNR) claims (including whether discounting is allowed for reserve calculation/reporting).
- b. Liabilities related to catastrophic occurrences.
- c. Whether the jurisdiction requires an opinion on reserves and loss and loss adjustment expense reserves by a qualified actuary or specialist for all domestic reinsurers, and the frequency of such reports.

9. Reinsurance Ceded

What are the jurisdiction's requirements with respect to the financial statement credit allowed for reinsurance retroceded by its domestic reinsurers? This description should address the following:

- a. Credit for reinsurance requirements applicable to reinsurance retroceded to domestic and non-domestic reinsurers.
- b. Collateral requirements applicable to reinsurance contracts.
- c. Whether the jurisdiction requires a reinsurance agreement to provide for insurance risk transfer (i.e., transfer of both underwriting and timing risk).
- d. Requirements applicable to special purpose reinsurance vehicles and insurance securitizations.
- e. Affiliated reinsurance transactions and concentration risk.
- f. Disclosure requirements specific to reinsurance transactions, agreements and counterparties, if such information is not provided under another item.

10. Independent Audits

Does the jurisdiction require annual audits of domestic reinsurers by independent certified public accountants or similar accounting/auditing professional recognized in the applicant jurisdiction? This description should address the following:

- a. Requirements for the filing of audited financial statements prepared in conformity with accounting practices prescribed or permitted by the supervisory authority.
- b. Contents of annual audited financial reports.
- c. Requirements for selection of auditor.
- d. Allowance of audited consolidated or combined financial statements.
- e. Notification of material misstatements of financial condition.
- f. Supervisor's access to auditor's workpapers.
- g. Audit committee requirements.
- h. Requirements for reporting of internal control-related matters.

11. Receivership

Does the jurisdiction have a receivership scheme for the administration of reinsurers found to be insolvent? This should include a description of any liquidation priority afforded to policyholders and the liquidation priority of reinsurance obligations to domestic and non-domestic ceding insurers in the context of an insolvency proceeding of a reinsurer.

12. Filings with Supervisory Authority

Does the jurisdiction require the filing of annual and interim financial statements with the supervisory authority?
This description should address the following:

- a. The use of standardized financial reporting in the financial statements, and the frequency of relevant updates.
- b. The use of supplemental data to address concerns with specific companies or issues.
- c. Filing format (e.g., electronic data capture).
- d. The extent to which financial reports and information are public records.

13. Reinsurance Intermediaries

Does the jurisdiction have a regulatory framework for the regulation of reinsurance intermediaries?

14. Other Regulatory Requirements with respect to Reinsurers

Any other information necessary to adequately describe the effectiveness of the jurisdiction's laws and regulations with respect to its reinsurance supervisory system.

Appendix B: Regulatory Practices and Procedures

1. Financial Analysis

What are the jurisdiction's practices and procedures with respect to the financial analysis of its domestic reinsurers? Such description should address the following:

- a. Qualified Staff and Resources
The resources employed to effectively review the financial condition of all domestic reinsurers, including a description of the educational and experience requirements for staff responsible for financial analysis.
- b. Communication of Relevant Information to/from Financial Analysis Staff
The process under which relevant information and data received by the supervisory authority are provided to the financial analysis staff and the process under which the findings of the financial analysis staff are communicated to the appropriate person(s).
- c. Supervisory Review
How the jurisdiction's internal financial analysis process provides for supervisory review and comment.
- d. Priority-Based Analysis
How the jurisdiction's financial analysis procedures are prioritized in order to ensure that potential problem reinsurers are reviewed promptly.
- e. Depth of Review
How the jurisdiction's financial analysis procedures ensure that domestic reinsurers receive an appropriate level or depth of review commensurate with their financial strength and position.
- f. Analysis Procedures
How the jurisdiction has documented its financial analysis procedures and/or guidelines to provide for consistency and continuity in the process and to ensure that appropriate analysis procedures are being performed on each domestic reinsurer.
- g. Reporting of Material Adverse Findings
The process for reporting material adverse indications, including the determination and implementation of appropriate regulatory action.
- h. Early Warning System/Stress Testing
Whether the jurisdiction has an early warning system and/or stress testing methodology that is utilized with respect to its domestic reinsurers.

2. Financial Examinations

What are the jurisdiction's practices and procedures with respect to the financial examinations of its domestic reinsurers? Such description should address the following:

- a. Qualified Staff and Resources
The resources employed to effectively examine all domestic reinsurers. This should include whether the jurisdiction prioritizes examination scheduling and resource allocation commensurate with the financial strength and position of each reinsurer, and a description of the educational and experience requirements for staff responsible for financial examinations.
- b. Communication of Relevant Information to/from Examination Staff
The process under which relevant information and data received by the supervisory authority are provided to the examination staff and the process under which the findings of the examination staff are communicated to the appropriate person(s).
- c. Use of Specialists
Whether the supervisory authority's examination staff includes specialists with appropriate training and/or experience or whether the supervisory authority otherwise has available qualified specialists that will permit the supervisory authority to effectively examine any reinsurer.
- d. Supervisory Review
Whether the supervisory authority's procedures for examinations provide for supervisory review.
- e. Examination Guidelines and Procedures
Description of the policies and procedures the supervisory authority employs for the conduct of examinations, including whether variations in methods and scope are commensurate with the financial strength and position of the reinsurer.
- f. Risk-Focused Examinations
Does the supervisory authority perform and document risk-focused examinations and, if so, what guidance is utilized in conducting the examinations? Are variations in method and scope commensurate with the financial strength and position of the reinsurer?
- g. Scheduling of Examinations
Whether the supervisory authority's procedures provide for the periodic examination of all domestic reinsurers, including how the system prioritizes reinsurers that exhibit adverse financial trends or otherwise demonstrate a need for examination.
- h. Examination Reports
Description of the format in which the supervisory authority's reports of examinations are prepared, and how the reports are shared with other jurisdictions under information-sharing agreements.
- i. Action on Material Adverse Findings
What are the jurisdiction's procedures regarding supervisory action in response to the reporting of any material adverse findings.

3. Information Sharing

Does the jurisdiction have a process for the sharing of otherwise confidential documents, materials, information, administrative or judicial orders, or other actions with U.S. state regulatory officials, provided that the recipients are required, under their law, to maintain its confidentiality?

4. Procedures for Troubled Reinsurers

What procedures does the jurisdiction follow with respect to troubled reinsurers?

5. Organization, Licensing and Change of Control of Reinsurers

What processes does the supervisory authority use to identify unlicensed or fraudulent activities? The description should address the following:

- a. Licensing Procedure
Whether the supervisory authority has documented licensing procedures that include a review and/or analysis of key pieces of information included in a primary licensure application.
- b. Staff and Resources
The educational and experience requirements for staff responsible for evaluating company licensing.
- c. Change in Control of a Domestic Reinsurer
Procedures for the review of key pieces of information included in filings with respect to a change in control of a domestic reinsurer.

W:\National Meetings\2021\Summer\Plenary\Att 8 QF Jurisdiction Process_AdoptedAug14.pdf



Date: 7/26/21

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. One state has enacted this model.

Life Insurance and Annuities (A) Committee

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

Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act (#170)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Amendments to the *Health Maintenance Organization Model Act (#430)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.
- Amendments to the *Insurance Holding Company System Regulatory Act (#440)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)*—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Adoption of the *Limited Long-Term Care Insurance Model Act (#642)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.
- Adoption of the *Limited Long-Term Care Insurance Model Regulation (#643)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.

Property and Casualty Insurance (C) Committee

- Adoption of the *Real Property Lender-Placed Insurance Model Act (#631)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2021 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.
- Adoption of the *Travel Insurance Model Act (#632)*—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Financial Condition (E) Committee

- Amendments to the *Credit for Reinsurance Model Law (#785)*—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019 conference call. 38 states have enacted this model.
- Amendments to the *Credit for Reinsurance Model Regulation (#786)*—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019 conference call. Three states have enacted this model.

W:\National Meetings\2021\Summer\Plenary\Att 9 2021 SNM StatusReportAdoptedModels.pdf