Draft date: 10/27/2026

2026 Fall National Meeting
Dallas, Texas

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE
Tuesday, November 17, 2026
1:45 – 3:00 p.m.
Convention Center—Texas AB—Level 3

ROLL CALL

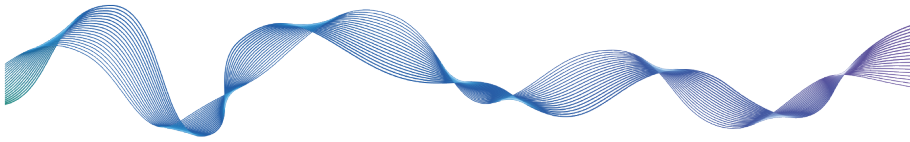
Michael Conway, Chair	Colorado	James E. Brown	Montana
Glen Mulready, Vice Chair	Oklahoma	D.J. Bettencourt	New Hampshire
Mark Fowler	Alabama	Jon Godfread	North Dakota
Peter M. Fuimaono	American Samoa	Remedio C. Mafnas	Northern Mariana Islands
Joshua Hershman	Connecticut	Larry D. Deiter	South Dakota
Michael Yaworsky	Florida	Tregenza A. Roach	U.S. Virgin Islands
Scott Saiki	Hawaii	Patty Kuderer	Washington
Timothy J. Temple	Louisiana		

NAIC Committee Staff Support: Aaron Brandenburg

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes — Attachment One
   —*Commissioner Michael Conway (CO)*

2. Consider Adoption of the Reports of its Task Forces and Working Groups—*Commissioner Michael Conway (CO)* — Attachment Two
   A. Casualty Actuarial and Statistical (C) Task Force—*Julie Lederer (MO)*
   B. Homeowners Market Data Call (C) Task Force
      —*Commissioner Michael Yaworsky (FL)*
   C. Surplus Lines (C) Task Force—*Director Larry D. Deiter (SD*)
   D. Cannabis Insurance (C) Working Group
      —*Commissioner Ricardo Lara (CA) and Katey Piciucco (CA)*
   E. Child Care Insurance (C) Working Group—*Commissioner Patty Kuderer (WA)*
   F. Terrorism Insurance Implementation (C) Working Group
      —*Martha Lees (NY)*
   G. Title Insurance (C) Working Group—*Connie Van Slyke (NE)*
   H. Transparency and Readability of Consumer Information (C) Working Group—*George Bradner (CT)*



I. Workers' Compensation (C) Working Group—*TBD*

3. Consider Adoption of its 2027 Charges — Attachment Three
   —Commissioner Michael Conway (CO)

4. Consider Adoption of the Casualty Actuarial and Statistical (C) Task Force White Paper on Rate Regulation—*Julie Lederer (MO)* — Attachment Four

5. Hear an Update on the Life Insurance and Annuities (A) Committee Criminal History Project—*Jeff Czajkowski (NAIC)*

6. Hear Presentations Related to Litigation Issues
   A. *Joe Petrelli (Demotech)*
   B. *Kenneth Klein (California Western School of Law—CWSL) and Peter Kochenburger (Southern University Law Center—SULC)*

7. Hear a Presentation on Mitigation from Wildfire Defense Systems (WDS) —*David Torgerson (WDS)*

8. Discuss Any Other Matters Brought Before the Committee —*Commissioner Michael Conway (CO)*

9. Adjournment

1. Consider Adoption of its Summer National Meeting Minutes

Attachment One

Commissioner Michael Conway (CO)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

7

Draft: 8/24/26

Property and Casualty Insurance (C) Committee
Columbus, Ohio
August 14, 2026

The Property and Casualty Insurance (C) Committee met in Columbus, OH, Aug. 14, 2026. The following Committee members participated: Michael Conway, Chair, and Kate Harris (CO); Glen Mulready, Vice Chair (OK); Mark Fowler (AL); Joshua Hershman and George Bradner (CT); Michael Yaworsky represented by Nicole Crockett (FL); Scott Saiki represented by Matt Tsujimura (HI); Timothy J. Temple (LA); James E. Brown represented by Erin Snyder (MT); Jon Godfread represented by Blaine Bergstedt (ND); D.J. Bettencourt represented by Keith E. Nyhan (NH); Larry D. Deiter represented by Tony Dorschner (SD); and Patty Kuderer (WA).

1. Adopted its Spring National Meeting Minutes

Commissioner Mulready made a motion, seconded by Commissioner Fowler, to adopt the Committee's Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Property and Casualty Insurance (C) Committee*). The motion passed unanimously.

2. Adopted the Reports of its Task Forces and Working Groups

Commissioner Hershman made a motion, seconded by Commissioner Mulready, to adopt the following task force and working group reports: 1) Casualty Actuarial and Statistical (C) Task Force; 2) Homeowners Market Data Call (C) Task Force; 3) Surplus Lines (C) Task Force; 4) Cannabis Insurance (C) Working Group; 5) Child Care Insurance (C) Working Group (Attachment One); 6) Terrorism Insurance Implementation (C) Working Group; 7) Title Insurance (C) Working Group (Attachment Two); 8) Transparency and Readability of Consumer Information (C) Working Group; and 9) Workers' Compensation (C) Working Group. The motion passed unanimously.

3. Adopted the *Affordability and Availability of Homeowners Insurance Playbook*

Harris presented the final draft of the *Affordability and Availability of Homeowners Insurance Playbook* on behalf of the drafting group. Harris said the playbook was developed as a practical, regulator- and policymaker-facing resource to help states consider a range of policy options, implementation considerations, and state-specific examples addressing homeowners insurance affordability and availability. She said the playbook does not endorse any single approach or direct states to take specific action, but is intended to be a living, non-prescriptive resource that each jurisdiction can apply based on its legal authority, market, consumer needs, funding, and regulations.

Harris said the drafting group began its work in August 2025, developed an outline, and invited feedback from Committee members, interested state insurance regulators, and interested parties, with participating states also drafting their own state-specific sections. She said the initial draft was exposed March 22, 2026, with comments due April 10. The drafting group reviewed written comments and suggested edits, and it met individually with many commenters to better understand their highest-priority concerns. Based on that feedback, the draft was revised to improve organization, add "how to use this document" language, include a detailed table of contents and a key-terms index, move detailed state legislation and regulation summaries into an appendix, and strengthen sourcing, while preserving state control over jurisdiction-specific content.

Harris said the playbook is organized into five parts: 1) addressing direct consumer impacts; 2) macro trends and factors that increase existing risks; 3) cross-cutting strategies; 4) peril-specific state innovation, action, and emerging protection gaps; and 5) strategies and implementation considerations. She said the final exposure draft was made available July 27, 2026, with comments due Aug. 7. Newly submitted comments were reviewed and

reflected in redlined revisions, and formatting will be completed by NAIC Communications staff after adoption. Harris recognized the comment review team for its work reviewing hundreds of comments and line edits.

Commissioner Kuderer made a motion, seconded by Commissioner Mulready, to adopt the *Affordability and Availability of Homeowners Insurance Playbook* (Attachment Three). The motion passed.

4. Heard a Presentation from the APCIA on Auto Insurance Trends

Commissioner Conway said the Committee has focused heavily on the homeowners insurance market over the past year and a half and wanted to review conditions in the automobile insurance market. Bob Passmore (American Property Casualty Insurance Association—APCIA) presented on personal automobile insurance trends. Passmore said the outlook for the auto insurance sector has improved. After AM Best assigned a negative outlook to both the auto and homeowners sectors in 2023 and 2024, the auto sector was upgraded from negative to stable, with combined ratios improving from a 12% net underwriting loss in 2022 to modest underwriting gains in each of the last two years. He said loss ratios, which had risen to their highest levels in 20 years in 2022, have declined consistently as insurers caught up to loss costs driven by inflation. Passmore said approved rate changes have been decreasing since 2023. S&P Global noted that the largest personal auto insurers, accounting for about 75% of countrywide premium, reduced rates by an average of 1.5% through mid-July 2026, with lower rates in 40 of 50 states.

Passmore said that, despite these improvements, fast-track data shows increasing severity for both bodily injury liability and vehicle damage claims over the last five years. He said vehicle damage claim frequency has declined while bodily injury frequency has increased. He suggested one possible explanation is that more consumers are increasing deductibles or dropping comprehensive and collision coverage to save money, a trend he said is supported by collision repair facilities reporting an increase in owner-paid repairs. He cautioned that some media coverage has mistakenly equated claims closed without payment with claim denials, noting that auto liability claims are often opened for all parties involved and later closed when it is determined the parties were not injured or no claim is presented.

Passmore said many auto loss cost drivers are increasing faster than overall inflation. He noted that the Consumer Price Index (CPI) rose 22.9% over the last five years while personal auto insurance rose 24%, the cost of auto parts rose more than 55%, and repair costs rose more than 34%. Used car prices, however, which affect total loss payments, have stabilized after spiking during the COVID-19 pandemic. Citing data from CCC Intelligent Solutions, he said the average total cost of repair continues to increase, though the rate of increase has slowed, mitigated by fewer parts and labor hours per repair and an increase in total losses. He said underlying factors, including labor rates, parts prices, and diagnostics, continue to pressure repair costs. He added that advanced driver assistance systems (ADAS) both increase repair costs and reduce crash frequency. He said that as vehicles become more automated, insurers face a paradigm shift in assessing driving risk and will increasingly need access to vehicle information and data. Questions remain about how liability will be apportioned when an automated system is engaged and whether insurance requirements need to change.

Citing data from Enlyte, Passmore said the amounts billed to auto insurers for medical care on third-party claims continue to outpace the health care CPI. First-party billed amounts, however, are increasing more slowly, likely because many personal injury protection and no-fault systems have built-in cost controls such as fee schedules. On legal system abuse, he said that over the last decade, CPI increased 35.8%, while commercial auto and auto liability insurance losses escalated roughly five times as fast. Additionally, nuclear verdicts have accelerated sharply over the last four years, and attorney involvement within the first 14 days of a claim climbed from 57% in 2020 to 75% in 2024. He said reforms in states, such as Florida, appear to be working, resulting in rate reductions, credits, and refunds. Georgia, Louisiana, and New York enacted significant reforms this year, and he referenced an APCIA white paper on the topic.

Passmore also said driving habits have deteriorated since the pandemic. While fatalities are down over the last three years, Cambridge Mobile Telematics reported improvements in speeding and phone use but increases in hard braking and handheld calls, and an AAA Foundation survey found that a large majority of drivers admitted to aggressive driving behaviors. He said auto insurance remains a relatively small share of total vehicle ownership costs compared with fuel, repairs, and car payments, and that overall ownership costs cannot be made significantly more affordable through regulatory limits on auto insurance. He said the APCIA advocates for auto accident cost mitigation measures, including supporting highway safety law enforcement, reducing legal system abuse, reducing regulatory costs, defending risk-based pricing, and reducing fraud.

Commissioner Conway asked how the paid amounts compared with the billed amounts shown relative to CPI. Passmore said he had not reviewed the actual paid amounts but expected them to track the billed amounts at a somewhat lower level. Commissioner Conway asked that the APCIA provide the paid data if available. Commissioner Mulready asked Passmore to expand on his comment that insurance requirements may need to change. Passmore clarified that he was referring to automated vehicles and the question of who or what was in control of a vehicle at the time of a crash, and whether insurance requirements need to change. Bradner asked whether the APCIA could share data on the states in which nuclear verdicts were occurring, noting that such information would be useful to state insurance regulators. Commissioner Conway asked that comprehensive coverage be included alongside liability when comparing auto insurance costs with other vehicle ownership costs.

5. Heard a Presentation from the SULC on the Use of Criminal History as a Rating Factor

Commissioner Conway said Peter Kochenburger (Southern University Law Center—SULC), a consumer representative, requested to present on a concern regarding the use of criminal history in personal property/casualty (P/C) insurance products. Kochenburger requested that the Committee consider sending insurers a voluntary survey to ask how they use criminal history data. He said a draft survey developed previously in connection with the Life Insurance and Annuities (A) Committee reached a second draft but was not issued, and that it could be adapted for P/C insurance. He said he had provided suggested material on the topic.

Kochenburger said that with the growth of big data and artificial intelligence (AI), more information, including local jurisdiction criminal records, is available online, and that while unsealed criminal records are public, how that information is used in insurance underwriting, claims, and fraud evaluation raises concerns. He said criminal record data is often inaccurate, particularly at the local level, and may include arrests regardless of their outcome, as well as minor matters, such as ordinance violations. He said there is limited oversight of how vendors and insurers use criminal history data, and he questioned whether the data is accurate, when it is appropriate to use, and whether vendors and insurers are complying with the Fair Credit Reporting Act (FCRA). Kochenburger said the use of criminal history data can undermine the purposes of expungement and rehabilitation when sealed records are still used, and he cited a 2021 National Council of Insurance Legislators (NCOIL) resolution that expressed concern about the use of arrests that do not result in a conviction. He said approximately one-third of adult Americans have a criminal record, which may consist only of an arrest, and he noted racial and ethnic disparities.

Commissioner Conway asked whether, given the complexity of insurers' models, banning the use of criminal history as a rating factor would achieve the intended result or whether models would substitute another proxy. Kochenburger said a substitute factor that achieves similar predictive power could be acceptable as long as it did not constitute proxy discrimination, and he noted that little is known about how criminal history data is currently used.

Director French asked about the status of the Life Insurance and Annuities (A) Committee survey. Kochenburger said the effort had evolved into a study by the Society of Actuaries (SOA), in coordination with the Center for Insurance Policy and Research (CIPR), on the effect of incarceration on life expectancy. He said that they are still

one to two years from producing a report and were not focused on P/C questions. Commissioner Fowler said that several years earlier, he had co-chaired the life-focused workstream of the NAIC Special (EX) Committee on Race and Insurance, which developed an optional survey that received few responses. He suggested asking the CIPR and the SOA about its status. McKenney commented that insurers use third-party criminal record data vendors for underwriting and rating, that state insurance regulators have generally not reviewed those data sets for accuracy and completeness, and that the Third-Party Data and Models (H) Working Group, led by Colorado, has faced significant pushback in attempting to establish a regulatory framework for third-party data and model vendors.

6. Heard a Presentation from ZestyAI on How Verified Mitigation Data Can Expand Eligibility and Improve Affordability in Homeowners Insurance

Commissioner Conway said the Colorado Division of Insurance has worked with ZestyAI over the past several years and invited the company to present. Bryan Rehor (ZestyAI) presented on how verified mitigation data can expand eligibility and improve affordability in homeowners insurance. Rehor described ZestyAI as an AI risk decision platform for property insurance that helps carriers assess property-level risk across underwriting, rating, renewals, and reinsurance, with more than 200 regulatory approvals. He said the central question of whether a homeowner who mitigates risk sees that reflected in their premium cannot reliably be answered in most states because the necessary data did not exist until recently.

Rehor said that Insurance Institute for Business & Home Safety (IBHS) FORTIFIED designations, which recently surpassed 100,000 nationally, demonstrate that verification in a scalable format works and can be captured at the point of quote. However, much mitigation, such as defensible space or a repaired roof, is not documented by any certificate. He said severe convective storms are now the leading driver of homeowners' catastrophe losses, making wind and hail mitigation important. He cited Colorado's House Bill 1182, now in force; California legislation committing to science-based updates; and the NAIC Natural Catastrophe Risk and Resiliency (EX) Task Force's consideration of a model law. He said the mitigation "loop" remains open for three reasons: 1) mitigation has historically been invisible to insurers, with the same action earning a credit in one state but not another; 2) inspections, while accurate, are expensive and episodic; and 3) mandated discounts, though a strong start, need to be paired with verified property-level facts.

Rehor said aerial imagery analyzed by AI can read attributes an inspector would record, such as building density, defensible space, and roof material. It can also produce a structural vulnerability score using manned-aircraft imagery captured several times per year rather than satellite photos, with full transparency and an appeals process that allows any input to be overridden. He said the same imagery reads roof attributes relevant to hail risk, creating a single data layer across wildfire, wind, and hail. Rehor noted that Alabama has regulated minimum discounts of up to 55% off the wind premium for FORTIFIED Gold, backed by a decade of loss experience. He described joint research by ZestyAI and IBHS covering more than 70,000 properties within more than 400 wildfire perimeters, which he said found that homes with heavy vegetation within five feet of the structure were destroyed roughly 73% of the time—nearly double the rate of homes that kept that zone clear. He noted that in the five- to 30-foot zone, the destruction rate ranged from 27% when cleared to 70% at heavy coverage. He illustrated the findings with two homes from the study, one that survived the 2018 Woolsey Fire with cleared vegetation and one destroyed in the 2017 Tubbs Fire with vegetation up to the walls.

Rehor described a five-step "flywheel": 1) scoring every property in the quote flow; 2) identifying the actions that matter; 3) simulating the premium impact before work is done; 4) verifying completion through refreshed imagery or a manual override; and 5) rewarding verified work through the rating plan. He said eligibility, not only pricing, is at stake, because without property-level facts, a well-mitigated home may be declined and placed in the Fair Access to Insurance Requirements (FAIR) plan. He cited a California carrier that became the first to put a California Department of Insurance (DOI)-approved AI wildfire model into underwriting, the California FAIR Plan's use of

property-level modeling to expand coverage in 2024, and the Colorado FAIR Plan's expectation that nearly 30,000 families previously classified as high risk would gain coverage with verified mitigation. He offered six tests for evaluating mitigation pricing proposals—granularity, objective and scalable verification, and transparency on the policy side, and cost, speed, and filing-grade quality on the operational side. Rehor asked that as new rules take shape, the Committee preserve the benefits these tools deliver to consumers rather than mandate a particular technology.

Commissioner Conway asked Rehor to address concerns that aerial imagery may be inaccurate. Rehor said ZestyAI partners with multiple imagery vendors to select the most recent, usable, clear image at the time of the quote. He said most properties receive a new image three to four times per year, and that because models are not always correct, the company has built in an appeals capability allowing a homeowner to provide evidence or a carrier to order an inspection and override the input. Commissioner Conway asked how the model treats rooftop solar panels. Rehor said solar panels are automatically detected by a computer vision model and are primarily relevant to wind and hail risk. This tends to increase hail premiums due to higher replacement costs, though coverage may depend on policy language and exclusions.

Amy Bach (United Policyholders—UP) asked whether a two-year-old image would be reliable. Rehor said two years is far too long and that imagery from the past few months is ideal to capture property conditions at the time of binding. Bach asked how a consumer could change their risk profile. Rehor said ZestyAI identifies the factors most influential in a property's score and embeds them in its data feed so carriers can provide that information. However, he said the company does not currently offer a consumer-facing portal. Commissioner Fowler said Alabama mandates wind mitigation discounts. He added that data from its Hurricane Sally report shows mitigated homes sustain less damage, while the degree of premium relief remains a difficult question for consumers on vulnerable coasts.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.

2. Consider Adoption of the Reports of its Task Forces and Working Groups

Attachment Two

A. Casualty Actuarial and Statistical (C) Task Force–*Julie Lederer (MO)*
B. Homeowners Market Data Call (C) Task Force–*Commissioner Michael Yaworsky (FL)*
C. Surplus Lines (C) Task Force–*Director Larry D. Deiter (SD)*
D. Cannabis Insurance (C) Working Group–*Commissioner Ricardo Lara (CA) and Katey Piciucco (CA)*
E. Child Care Insurance (C) Working Group–Commissioner Patty Kuderer (WA)
F. Terrorism Insurance Implementation (C) Working Group–*Martha Lees (NY)*
G. Title Insurance (C) Working Group–*Connie Van Slyke (NE)*
H. Transparency and Readability of Consumer Information (C) Working Group –*George Bradner (CT)*
I. Workers' Compensation (C) Working Group–*TBD*

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

8

2026 Fall National Meeting
Dallas, Texas

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE
Monday, November 16, 2026
9:30 – 11:00 a.m.

Meeting Summary Report

The Casualty Actuarial and Statistical (C) Task Force met Nov. 16, 2026. During this meeting, the Task Force:

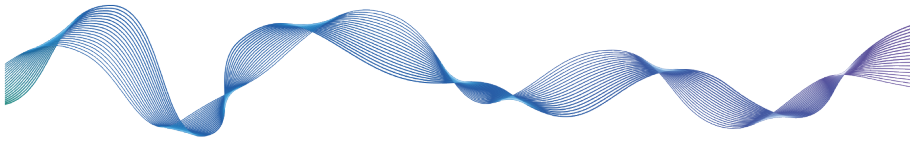
1. Adopted its Summer National Meeting minutes (*see NAIC Proceedings – Summer 2026, Casualty Actuarial and Statistical (C) Task Force*).

2. Adopted its Oct. 13 and Sept. 2 minutes. During these meetings, the Task Force took the following action:
   A. Adopted the *2024 Auto Insurance Database Average Premium Supplement*.
   B. Adopted the report of the Actuarial Opinion (C) Working Group.
   C. Adopted the report of the Statistical Data (C) Working Group.
   D. Heard a presentation from Georgia State University on quantifying social inflation in liability insurance.
   E. Adopted its 2027 proposed charges following a 21-day exposure period ending Sept. 30.
   F. Received an update its rate regulation white paper draft, which had been exposed on Sept. 25.
   G. Discussed its 2027 work plan.
   H. Received liaison reports.

3. Reported that the Task Force met Oct. 20, Sept. 15, and Aug. 18 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Task Force took the following action:
   A. Discussed rate filing issues.

4. Reported that the Task Force held a Predictive Analytics Book Club education session Oct. 27. The session included a presentation from Sam Kloese (NAIC) on accelerated failure time (AFT) and Cox proportional hazards (CPH) models.

5. Adopted the report of the Actuarial Opinion (C) Working Group, which met Oct. 22, Sept. 24, Sept. 22, Sept. 10, and Aug. 27. During these meetings, the Working Group took the following action:
   A. Adopted the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2026* (2026 Regulatory Guidance).
   B. Exposed proposed edits to the *2027 Title Statement of Actuarial Opinion Instructions*.
   C. Adopted the Property/Casualty (P/C) and Title Statement of Actuarial Opinion (SAO) worksheet in the *Financial Analysis Handbook*.



D. Adopted the *2027 Title Statement of Actuarial Opinion Instructions*.

6. Adopted the report of the Statistical Data (C) Working Group, which met Oct. 21 and Sept. 23. During these meetings, the Working Group took the following action:
   A. Discussed comments received on Sections 1, 2, 3, 5, 7, 8, and 14 of the *Statistical Handbook of Data Available to Insurance Regulators*.

7. Adopted its white paper on homeowners rate regulation and cross-state subsidization, with one abstention.

8. Discussed its 2027 work plan.

9. Received liaison reports.

10. Heard updates on activities and research from professional actuarial associations.

2026 Fall National Meeting
Dallas, Texas

JOINT MEETING OF THE HOMEOWNERS MARKET DATA CALL (C) TASK FORCE AND THE HOMEOWNERS MARKET REPORT (C) WORKING GROUP
Monday, November 16, 2026
4:00 – 5:00 p.m.

Meeting Summary Report

The Homeowners Market Data Call (C) Task Force met Nov. 16, 2026, in joint session with the Homeowners Market Report (C) Working Group. During this meeting, the Task Force and Working Group:

1. Adopted the Task Force's Summer National Meeting minutes (*see NAIC Proceedings – Summer 2026, Homeowners Market Data Call (C) Task Force)*.

2. Adopted the Task Force's Oct. 29 and Oct. 14 minutes During these meetings, the Task Force took the following action:
   A. Adopted its 2027 proposed charges.
   B. Discussed recommendations for the 2027 homeowners market data call from the Homeowners Market Data Call (C) Drafting Group.

3. Adopted the Working Group's Oct. 16 minutes. During this meeting, the Working Group took the following action:
   A. Received comments on proposed data elements.
   B. Adopted questions for its public report to answer along with initial data elements.

4. Reported that the Working Group met Sept. 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group took the following action:
   A. Reviewed examples of data visualization.
   B. Exposed the proposed data elements for a 22-day comment period ending Oct. 9.

5. Discussed a proposed roadmap for the homeowners market data call public report. The report will be drafted in the coming months, with public comment taken in 2027 and a goal of adopting the report by spring 2027.

6. Discussed adding surplus lines data for future homeowners market data calls. The American Property Casualty Insurance Association (APCIA), the Wholesale & Specialty Insurance Association (WSIA), and Lloyd's of London expressed interest in working with the Task Force in 2027 to provide state-level data elements and develop a plan to provide more granular data from the surplus lines industry in future years.

Draft: 10/20/26

Cannabis Insurance (C) Working Group
Virtual Meeting
October 14, 2026

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 14, 2026. The following Working Group members participated: Katey Piciucco, Chair (CA); Ravin Collins, Vice Chair (OR); Erick Wright (AL); Jimmy Harris (AR); Angela King (DC); Jennifer Welch (DE); Ryan Blakeney (MS); Ted Bidon (MT); Gennady Stolyarov (NV); Brian Downs (OK); Sebastian Conforto (PA); and Karla Nuissl (VT).

1. Adopted its Spring National Meeting Minutes

Downs made a motion, seconded by Stolyarov, to adopt the Working Group's March 25 minutes (*see NAIC Proceedings – Spring 2026, Property and Casualty Insurance (C) Committee, Attachment Two*). The motion passed unanimously.

2. Heard a Presentation on Recent Developments on DEA Rescheduling, Cannabis Coverage Issues, and Emerging Litigation Considerations

Ian Stewart (Wilson Elser) and Bradley Rutt (HUB International) discussed recent changes in the cannabis insurance market, noting that admitted carriers' interest in entering the market has declined compared with four or five years ago. Rutt said property insurance rates have fallen substantially as actuarial data has developed, but underwriters are beginning to tighten policy language, increase retentions, and require more detailed applications and warranties. They explained that much of the market remains in the excess and surplus lines sector because carriers and managing general agents can revise policy forms quickly as legal and regulatory conditions change.

Stewart reviewed federal cannabis rescheduling developments and explained that medical marijuana and certain approved cannabis-based drugs had moved to Schedule III, while adult-use marijuana remained in Schedule I. He said medical operators now must obtain DEA registration in addition to applicable state and local approvals, creating compliance issues for operators and requiring some insurers to revise policy forms. Stewart and Rutt said the change has not yet produced the anticipated influx of new insurance capacity, product lines, or admitted-market participants. Rutt added that underwriters generally continue to take a wait-and-see approach.

They also discussed the potential effects of federal safe-harbor legislation for insurers. Rutt said such legislation likely would not produce immediate market changes because existing cannabis insurers have established expertise and actuarial data, although broader changes affecting adult-use cannabis could attract additional admitted carriers over time. He noted that workers' compensation and commercial auto currently have more admitted capacity than other cannabis lines, but he has not observed significant new market entrants.

Turning to hemp, Stewart explained that forthcoming federal restrictions will apply a total THC standard and a per-container limit to intoxicating hemp products, with separate implementation dates for synthetic products and other covered products. He said uncertainty remains regarding the definition of a container and the cannabinoids subject to the limits. Stewart and Rutt reported that hemp businesses are unwinding contracts and reassessing inventory, transportation, and liability exposures, while insurers are considering whether and how to cover products that were lawful when manufactured or sold but later become federally prohibited. Rutt said new investment and insurance inquiries have declined, and that operators who continue under state law may face greater difficulty obtaining coverage.

Stewart and Rutt then addressed emerging cannabis litigation, including class actions alleging inadequate warnings and misleading marketing related to psychosis, cardiovascular injuries, and cannabis hyperemesis syndrome. Stewart said recent complaints include allegations of product liability, fraud, negligent misrepresentation, racketeering, and punitive damages, and may shape future coverage disputes. Rutt explained that many cannabis policies contain broad health-hazard exclusions that may create uncertainty about which bodily injury claims are covered. He emphasized the need for clearer policy language so insureds understand the scope of coverage.

Rutt said underwriters are increasingly asking operators to adopt stronger product warnings and safety practices as a condition for receiving favorable pricing and policy terms. He noted that large operators may receive the greatest scrutiny because their products are more widely distributed and they are more likely to be targets of litigation. Stewart and Rutt advised carriers and underwriters to review policy language, verify Drug Enforcement Administration (DEA) registration for medical operators, update hemp forms, and monitor litigation and federal enforcement. They also encouraged managing general agents and brokers to educate clients about transitional risks, distinguish medical from adult-use operations, and evaluate whether placements provide meaningful coverage.

Collins asked how clients are being advised when they express concerns about DEA registration. Stewart said medical marijuana operators must register with the DEA to handle Schedule III products and may risk losing insurance coverage if they do not comply. He said operators should weigh concerns about registration against the substantially greater legal risk of engaging in conduct involving a Schedule I substance without the required registration.

Having no other business, the Cannabis Insurance (C) Working Group adjourned.

Draft date: 11/10/26

Child Care Insurance (C) Working Group
Virtual Meeting
October 22, 2026

The Child Care Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 22, 2026. The following Working Group members participated: Patty Kuderer, Chair (WA); D.J. Bettencourt, Vice Chair, represented by Keith E. Nyhan (NH); Kathryn Taras (CA); George Bradner (CT); Jane Nelson and Richie Frederick (FL); Scott Saiki and Matt Tsujimura (HI); Mariam Hassan (IL); Jackie Horigan (MA); Angela L. Nelson (MO); Eric Bredeson (OR); Michael Humphreys and Michael McKenney (PA); and Elizabeth Kelleher Dwyer (RI). Also participating was: David Yetter (NC).

1. Heard a Presentation from Primex on Addressing Liability Risks with a Shared Risk Pool

Mike Ricker (New Hampshire Public Risk Management Exchange—Primex) said Primex is a quasi-governmental risk pool created under New Hampshire statute to provide reliable, affordable coverage to approximately 540 local government entities. He said Primex is governed by a board of trustees, is regulated by the state, and offers workers' compensation, unemployment, property, cyber, and public entity liability coverage. He said the liability package covers errors and omissions, employment practices, premises, auto, and sexual abuse and molestation (SAM) liability across police, fire, schools, nursing homes, and other functions. He said its statute also directs Primex to provide risk management, and it increasingly focuses on human resources (HR) practices because most losses stem from poor management or HR practices.

Ricker said SAM coverage is built into the liability package rather than offered as stand-alone coverage. He said Primex excludes offenders but may defend an accused individual when a claim appears questionable. He said Primex assigns interrelated occurrences to the policy period in which the activity began so that only one set of limits applies. He said limits are set at the state damages cap or, where the cap does not apply, at $2 million per occurrence and $10 million in the aggregate. He said this is a reduction from $5 million per occurrence with no aggregate four or five years ago, driven primarily by this risk. He said the coverage is backed by claim reserves, contingent reserves set at the regulatory maximum, reinsurance, and case management focused on resolving claims early.

Ricker said New Hampshire caps negligence claims against government entities at $325,000 per occurrence and $1 million in the aggregate per victim, bars punitive damages against them, and provides certain immunities. He said Primex offers occurrence-based coverage, which he compared to a policy the insured can put in a safe and return to if a claim later arises from that year. He said the commercial market, by contrast, largely excludes SAM from general liability policies and offers it as specialty claims-made coverage from a few carriers. He said this coverage carries many exclusions, strict underwriting, higher retentions, and scrutiny of screening, training, supervision, and HR practices.

Ricker said the legal environment drives these market conditions. He said perpetrators can be excluded from coverage, but entities connected to them face parallel risk and, in many jurisdictions, the same remedies as the perpetrator. He said contributing changes include extending or removing limitations periods, as New Hampshire did approximately six years ago; removing or raising damages caps; reducing immunities; expanding liability theories; changing joint and several liability; fee shifting, including through federal claims; and generous coverage rulings. He said these changes contribute to nuclear verdicts and social inflation.
Ricker said Primex can offer this coverage because its large, diversified, long-standing membership provides credible claims experience, a premium base that absorbs this risk, and the confidence of its reinsurers. He said he

was told that if Primex or its reinsurers experienced runaway verdicts, the coverage would quickly become claims-made, more expensive, and subject to strict underwriting. He said a small group of small organizations seeking coverage only for this risk would be expensive and difficult to underwrite and fund. He said these claims are low frequency but high severity.

Ricker said the policy challenge is to balance remedies for victims with a legal environment in which critical service providers can operate and obtain insurance. He said policymakers seeking to improve insurability should consider appropriate limitations periods for claims against entities, as distinct from perpetrators, and an appropriate blend of caps and immunities, such as caps for nonprofit providers with limited ability to pay. He said a pool for this group would need an adequate premium base, diversification, credible experience, initial funding or substantial reinsurance, a sound coverage document, and experienced staff and counsel. He said a state could help with initial funding and that such a pool is achievable.

Commissioner Kuderer asked whether Primex can offer this coverage because of damages caps or claim frequency. Ricker said diversification and caps matter most, as frequency mainly affects premiums and reinsurance costs. He said each member's premium covers all of its property and liability risk, not only SAM risk, and caps shape plaintiffs' expectations. He said plaintiffs can try to avoid the cap by alleging recklessness, which is difficult to prove, and multiple-victim claims often raise debate over how many caps apply.

Commissioner Kuderer noted that the caps apply only to government entities, not child care providers. Ricker agreed and said an ideal legal environment might apply caps to nonprofits and possibly higher caps to corporations, but legislatures would need to see evidence of a problem.

Commissioner Kuderer asked about the basis for claims Primex considered questionable. Ricker described a claimant with multiple prior false allegations whose new allegation the organization investigated and found not credible, so Primex defended the educator. He said Primex can drop an individual from coverage if discovery indicates the abuse occurred.

Commissioner Kuderer asked whether the state sets minimum hiring standards for the organizations it licenses to perform child welfare work. Ricker said he is not involved in state contracting but expected the state vets these entities and its contracts include conduct, indemnification, and additional insured requirements.

McKinney asked how Primex handles defense costs. Ricker said defense costs have increased and can reach $100,000 to $200,000 before trial, so Primex seeks early resolution. He said in his 20 years at Primex, it has never tried one of these cases because of the trial risk. He confirmed that defense costs are separate from the liability cap.

2. Heard a Presentation on Indemnification Legislation in Hawaii

Tsujimura said two bills introduced during Hawaii's 2026 legislative session addressed the liability exposure of child welfare service providers that contract with the Hawaii Department of Human Services (DHS). He said the underlying concern was the rising cost of liability insurance and the difficulty of obtaining adequate coverage. He said Hawaii law requires these providers to indemnify and hold harmless the state against claims arising from their acts or omissions, and the attorney general's office emphasized that indemnification clauses are required in all state contracts. He said Hawaii has also extended its statute of limitations for child abuse and sexual abuse cases, which he believed now extends to age 50.

Tsujimura said the Senate bill proposed prohibiting indemnification and additional insured requirements in these contracts, as well as joint and several liability, post-judgment interest, and punitive damages. He said the House

bill was amended during the session to prohibit indemnification and additional insured provisions. He said the indemnification language was removed based on the attorney general's long-standing position that taxpayers should not bear financial responsibility for harm caused by state contractors, and both bills died. He said a pause on liability caps following legislative discussions about wildfires appeared to influence the outcome.

Tsujimura said the Hawaii Insurance Division's position was that there was insufficient evidence the reforms would directly lower premiums or bring carriers back to the market. He said providers testified that the state contracts were giving insurers pause, and one provider said this was why its insurer did not renew its coverage. He said most providers cited affordability as the primary issue, with premiums increasing by almost 300%. He said the Hawaii Insurance Division proposed that DHS increase contract budgets to cover the cost of services, including liability insurance, but he did not know whether the proposal was adopted.

Commissioner Kuderer asked who requested the bills and whether providers said the contract provisions were limiting their access to coverage. Tsujimura said the bills came primarily from nonprofits. He said providers believed prohibiting indemnification and additional insured requirements should help, but neither they nor their insurers could guarantee lower premiums.

Commissioner Kuderer asked about the debate over joint and several liability. Tsujimura said the trial bar opposed abolishing it because injured victims might not fully recover. He said the Senate Judiciary Committee chair, a trial attorney, did not support abolishing it, which may have contributed to the bill not being heard. He said he expects the bills to be reintroduced in their original form, although committee chairs may change after the election.

3. Heard an Update on Industry Recommendations

Commissioner Kuderer said the Working Group heard initial insights in May from the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC) and would now hear their policy recommendations. David Snyder (APCIA) said the APCIA recognizes the importance of child care and wants to be part of the solution. He said these are liability issues by definition, so the liability system largely drives the availability of this coverage.

Eric Goldberg (APCIA) said Primex is not an apt comparison because it operates with damages caps and diversifies across property and workers' compensation, which specialty child care carriers cannot do. He said if all child care entities had similar caps, there would not be an availability crisis. He said trial lawyers increasingly sue entities that were not negligent, ask juries to send a message, and anchor juries to high verdict amounts. He said when every claim becomes a policy-limits claim, insurers must impose exclusions, seek to cap damages, or withdraw from the coverage.

Goldberg said the APCIA board adopted policy recommendations in June. He said the child care–specific recommendations include safe harbors from liability for entities in substantial compliance, a reasonable time to respond to time-limited settlement demands, and limits on excessive damages. He said general reforms include extending sovereign or charitable immunity to child-serving entities, non-economic damages caps, and an exception from revival statutes. He said third-party litigation financing and private equity are increasingly funding advertising to generate cases. He said the APCIA supports victim compensation funds and mediation programs but cautioned about fraud, citing the Los Angeles district attorney's concern that approximately 80% of claims to Los Angeles County's $4 billion fund were fraudulent.

Snyder cited a Texas law, effective Sept. 1, 2025, as an example of balanced reform. He said an entity that follows specified risk management practices is generally not subject to vicarious liability but remains liable for gross

negligence. He said the practices include timely criminal background checks, qualification reviews, reporting known allegations of misconduct, timely personnel action, and training on child sexual abuse and abuse reporting.

Erica Weyhenmeyer (NAMIC) said NAMIC shares many of APCIA's objectives. She said liability protections should be based on an entity's function and compliance rather than nonprofit status alone. She said these protections should include safeguards so they do not shield intentional or criminal misconduct, conscious disregard for child safety, or knowing concealment of abuse. She said NAMIC opposes laws reviving time-barred claims because they create legacy liabilities that were neither priced nor reserved for, and that any changes to limitations periods should be prospective. She said publicly funded compensation programs for historical claims should not be financed through insurer assessments, premium surcharges, or similar insurance-based mechanisms.

Weyhenmeyer said NAMIC supports reasonable limits on non-economic damages while preserving recovery of economic losses, restrictions on punitive damages except for egregious misconduct, limits on prejudgment interest, and proportionate liability. She said NAMIC also supports pre-suit notice, good faith settlement demands, and duties of care based on what an entity could reasonably foresee and control. She said NAMIC does not call for prohibiting post-judgment interest or replacing jury trials with bench trials. She said these recommendations are included in NAMIC's written comments and that she would also send her remarks.

Commissioner Kuderer asked whether there are front-end best practices nonprofits can adopt to prevent harm and improve access to insurance. Goldberg said the Texas law embeds several such practices, but risk management will not help unless the litigation environment changes. Commissioner Kuderer asked whether Texas agencies can now obtain affordable coverage. Snyder said APCIA would look into the market response, and Goldberg later said members have reported improvement in Texas.

Commissioner Kuderer said trial attorneys and legislators argue that caps hurt the most seriously injured and that claims could be aggregated to reach caps. Goldberg said caps are imperfect but strike an effective balance between fair compensation and keeping entities operating. Weyhenmeyer said caps make claims and rating more predictable, and she would follow up on whether caps could increase frivolous claims. Bradner suggested the Working Group review the effect of Texas' medical malpractice caps.

Bradner said Connecticut was told of a case in which the insured entity did everything right, but the insurer settled rather than go to trial. He asked whether the Working Group's efforts would change industry practice, and he said the industry prefers paying claims over incurring defense costs, including for summary judgment motions. Snyder said settlement decisions are made on a case-by-case basis. Paul Martin (NAMIC) said an insurer has a contractual obligation to settle within policy limits when a trial could expose the policyholder to an excess judgment.

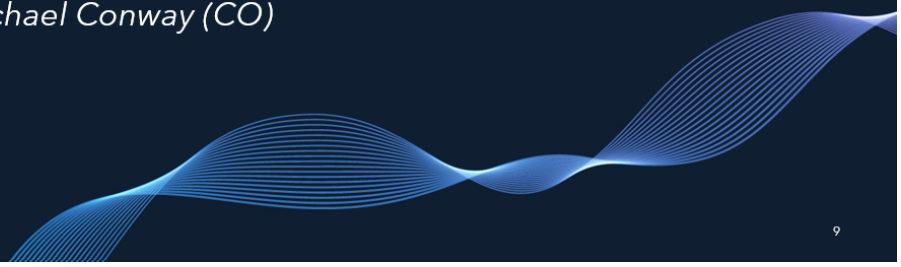
Martin said there is no silver bullet because insurers consider the entire claims, rating, and underwriting environment when deciding whether to write a coverage. He encouraged a holistic review of the market to identify barriers to attracting insurance capital. Snyder agreed and said states should examine whether the tort system balances fair compensation for victims with the need to avoid unintended social impacts, while also working to prevent losses.

Having no further business, the Child Care Insurance (C) Working Group adjourned.

3. Consider Adoption of its 2027 Charges

Attachment Three

Commissioner Michael Conway (CO)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

9

Draft: 11/10/26
Adopted by the Executive (EX) Committee and Plenary, , 2026
Adopted by the Property and Casualty Insurance (C) Committee, , 2026

2027 Revised Charges

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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

Ongoing Support of NAIC Programs, Products, or Services

1. The **Property and Casualty Insurance (C) Committee** will:

~~B. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.~~

~~C.~~ A. Monitor activities related to property and casualty insurance lines, including, but not limited to, homeowners insurance, auto insurance, workers compensation insurance, cannabis insurance, crop insurance, risk retention groups, and activities of ~~of~~ the Casualty Actuarial and Statistical (C) Task Force, the ~~Monitor the activities of the~~ Homeowners Market Data Call (C) Task Force, ~~.~~
~~Monitor the activities of the~~and the Surplus Lines (C) Task Force.

~~D.~~B. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the *Quarterly Listing of Alien Insurers*. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.

~~E. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:~~

~~i. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.~~

~~ii. Review law changes and court decisions, and, if warranted, make appropriate changes to the *Federal Crop Insurance Program Handbook: A Guide for Insurance Regulators*.~~

~~iii. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.~~

~~F. Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.~~

~~G. Provide a forum for discussing issues related to parametric insurance, and consider the development of a white paper or regulatory guidance.~~
~~Study and report on the availability and affordability of liability and property coverage for non-profit organizations.~~

~~H.~~C. Assist state insurance regulators in better assessing their markets and insurer underwriting practices by developing property market data intelligence so regulators can better understand how markets are performing in their states, and identify potential new coverage gaps, including changes in deductibles and coverage types, and affordability and availability issues. Provide analysis of property insurance markets to states.

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

~~Provide a forum for discussing issues related to the use of telematics in insurance, and consider the development of a white paper or regulatory guidance.~~

D. Consider effectiveness of current consumer-facing education materials and how to improve consumer understanding of insurance products and concepts.

~~I.~~E. Evaluate existing and future state P&C data call needs with respect to infrastructure / collection and quality of the data, as well as analytics, visualization, and reporting of the data, including the integration of relevant third-party data. Conduct a feasibility study of NAIC resources needed to provide additional data to state regulators to study markets, such as continuation of the Homeowners Market Data Call for future years.

~~2. The **Cannabis Insurance (C) Working Group** will:~~

~~A. Assess and periodically report on the status of federal legislation and regulation involving cannabis, especially as it pertains to protecting financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.~~

~~B. Support insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers, and reinsurers supporting the market, to ensure coverage adequacy in states where cannabis, including hemp, is legal.~~

~~C. Stay abreast of new products and innovative ideas that may shape insurance in this space. Provide insurance resources to insurance regulators and stakeholders, as needed.~~

~~Explore potential sources of constraint to coverage limits and availability of cannabis insurance products within the admitted and non-admitted market. Explore the effect of the use of cannabis and related products on P/C insurance lines of business.~~

~~3.~~2. The **Child Care Insurance (C) Working Group** will:

A. Evaluate the cost drivers and limitations that negatively affect the availability of liability insurance products for childcare services in admitted and non-admitted markets, and the necessary actions to address that impact. Focus work on insurance products for child-placing agencies, group foster homes, and other child social service-related insurance issues.

B. Make recommendations on possible solutions to address the cost drivers and limitations that may assist the insurance market. Provide potential recommendations for state insurance regulators to use with state legislatures or state agencies. Provide input to the Government Relations (EX) Leadership Council on potential recommendations to the federal government.

C. Support state insurance regulators' efforts to encourage the development of admitted market insurers, as well as the expansion of existing admitted market insurers, and reinsurers supporting the market.

D. Assess and periodically report on federal and state legislation and regulations that impact historical claims in the childcare line of business, particularly those affecting liability damages for legally operating childcare-related services.

E. Stay abreast of innovative ideas that may shape insurance in this space. Provide insurance resources to state insurance regulators and stakeholders, as needed.

3. The **P&C Emerging Issues (C) Working Group** will:

A. Monitor and discuss emerging property and casualty insurance issues, including autonomous vehicles, parametric insurance, telematics, and other specialty or availability-constrained P&C markets.

B. Stay abreast of innovative ideas that may shape P&C insurance. Develop reports, regulatory guidance, recommendations, or regulator/stakeholder resources as needed.

C. Host regulator-only sessions to explore emerging issues at an insurer level and how states handle product and rate filings.

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

D. Coordinate with other NAIC groups or outside entities, as appropriate.

4. The **Terrorism Insurance Implementation (C) Working Group** will:
   A. Coordinate the NAIC's efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury's (Treasury Department's) Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.
   ~~B.~~C. Monitor handling of cyber insurance policies under TRIP and engage with Cybersecurity (H) Working Group as necessary.

5. The **Title Insurance (C) Working Group** will:
   A. Discuss and/or monitor issues and developments affecting the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.
   B. Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities. Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces, and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies.
   C. Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information, education, and disclosure for mortgage lending, closing, and settlement services about the role of title insurance in the real estate transaction process.
   D. Update the Survey of State Laws Regarding Title Data and Title Matters report and the Title Insurance Consumer Shopping Tool Template as needed.
   E. Stay abreast of consumer issues and complaints submitted to states regarding title insurance. Consider regulatory best practices or standards related to consumer protection.
   F. Evaluate alternative title products and provide guidance to state insurance regulators as needed.

6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
   A. Facilitate consumers' capacity to understand the content of insurance policies and assess differences in insurers' policy forms.
   ~~B. Assist other groups with drafting language included within consumer-facing documents.~~
   ~~C. Monitor states that have implemented disclosures for premium increases related to P/C insurance products.~~
   ~~D.~~B. Update and develop web page and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*, as needed.
   ~~E. Develop a guidance document for states that requires companies to disclose what property attributes are on file for their property that impact premium.~~
   ~~F.~~C. Develop consumer information materials about concepts that consumers ~~don't readily understand, e.g. deductibles and how to calculate them.~~struggle to understand.
   ~~G.~~D. Study and evaluate ways to engage department of insurance (DOI) communication with more diverse populations, such as rural communities.

~~7. The **Workers' Compensation (C) Working Group** will:~~
   ~~A. Discuss issues with respect to advisory organizations, rating organizations, statistical agents, and insurance companies in the workers' compensation arena.~~

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

~~B. Monitor the movement of business from the standard markets to the assigned risk pools. Alert state insurance department representatives if the growth of assigned risk pools changes dramatically.~~

~~C. Follow workers' compensation issues regarding cannabis in coordination with the Cannabis Insurance (C) Working Group.~~

~~D. Discuss issues affecting workers' compensation.~~

~~E. Stay informed about workers' compensation issues by collaborating with various workers' compensation organizations, such as the International Association of Industrial Accident Boards and Commissions (IAIABC), the National Council on Compensation Insurance (NCCI), and state workers' compensation bureaus.~~

NAIC Support Staff: Aaron Brandenburg/Libby Crews

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

Adopted by the Casualty Actuarial and Statistical (C) Task Force—10/13/26

2027 Charges

CASUALTY ACTUARIAL AND STATISTICAL (C) TASK FORCE

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

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

Ongoing Support of NAIC Programs, Products, or Services

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

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

iii. With the NAIC Rate Model Review Team's assistance, discuss guidance for the regulatory review of models used in rate filings. Maintain the *Model Review Manual*.~~E. Monitor cyber liability insurance and discuss regulatory data needs.~~

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

~~G. Draft a white paper that explains how homeowners' insurance rates are regulated across states, with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses.~~

2. The **Actuarial Opinion (C) Working Group** will:
   Propose revisions to the following as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
   i. *Financial Analysis Handbook.*
   ii. *Financial Condition Examiners Handbook.*
   iii. *Annual Statement Instructions—Property/Casualty.*
   iv. Regulatory guidance to appointed actuaries and companies.
   v. Other financial blanks and instructions, as needed.

3. The **Statistical Data (C) Working Group** will:
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators* to improve data quality and reporting standards.
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically, evaluate the demand and utility versus the costs of production of each product.
      i. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance* (Homeowners Report).
      ii. *Auto Insurance Database Report* (Auto Report).
      iii. *Competition Database Report* (Competition Report).
      iv. *Report on Profitability by Line by State Report* (Profitability Report).
      v. *Auto Insurance Average Premium Supplement.*

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

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

Draft 10/21/26
Adopted by the Homeowners Market Data Call (C) Task Force—10/29/26

2027 Charges

HOMEOWNERS MARKET DATA CALL (C) TASK FORCE

1. The **Homeowners Market Data Call (C) Task Force** will:
   A. Oversee development and delivery of periodic communication to the NAIC membership on issues related to the Homeowners Market Data Call.
   B. ~~Develop a framework for the~~ Implement annual Homeowners Market Data Call, including data collection authority, confidentiality protections, and data sharing between states and the NAIC. Consider NAIC resource needs for continuation of annual data calls.
   C. Consider recommendations from the regulator-only drafting group and interested party input and approve any changes to the current scope and content of the data call for 2027.
   D. Oversee continued development of regulator tools and training related to the data call.
   E. Develop a national analysis report, for regulators only, with support from CIPR. Consider the nature and extent of such national analysis report that may be suitable for public release.

2. The **Homeowners Market Report (C) Working Group** will:
   A. Consider drafting and public release of a report analyzing data from the homeowners market data call.

NAIC Support Staff: Aaron Brandenburg/Libby Crews

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

Draft: 7/24/26
Adopted by the Executive (EX) Committee and Plenary—
Adopted by the Property and Casualty Insurance (C) Committee—
Adopted by the Surplus Lines (C) Task Force, 8/3/2026

2027 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products, or Services

The **Surplus Lines (C) Task Force** will:

A. Provide a forum for discussion of current and emerging surplus lines-related issues and topics of public policy and determine appropriate regulatory response and action.
B. Review and analyze industry data on U.S. domestic and non-U.S. surplus lines insurers participating in the U.S. market.
C. Monitor federal legislation related to the surplus lines market and ensure all interested parties remain apprised.
D. Develop or amend relevant NAIC model laws, regulations, and/or guidelines.
E. Oversee the activities of the Surplus Lines (C) Working Group.

The **Surplus Lines (C) Working Group** of the Surplus Lines (C) Task Force will:

A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings and in open session when discussing surplus lines topics and policy issues, such as amendments to the International Insurers Department (IID) Plan of Operation.
B. Maintain and draft new guidance within the IID Plan of Operation regarding standards for admittance and continued inclusion on the NAIC *Quarterly Listing of Alien Insurers*.
C. Review and consider appropriate decisions regarding applications for admittance to the NAIC *Quarterly Listing of Alien Insurers*.
D. Analyze renewal applications of alien surplus lines insurers on the NAIC *Quarterly Listing of Alien Insurers* and ensure solvency and compliance per the IID Plan of Operation guidelines for continued listing.

Provide a forum for surplus lines-related discussion among jurisdictions.

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November 6, 2026

Commissioner Michael Conway, Chair
Commissioner Glen Mulready, Vice Chair
National Association of Insurance Commissioners
Property and Casualty Insurance (C) Committee

RE: 2027 Revised Charges of the Property and Casualty Insurance (C) Committee

Commissioners Conway and Mulready,

Florida has reviewed the 2027 Revised Charges of the Property and Casualty (C) Committee (C Committee), and notes that charges for the Cannabis Insurance (C) Working Group, the Title Insurance (C) Working Group, and the Workers' Compensation (C) Working Group were deleted, as indicated by the track changes' comments in the margins of the document. It appears the intent may be to disband these three Working Groups and transition their responsibilities directly to C Committee.

Considering the above, Florida respectfully submits the following comments:

1. Florida recommends C Committee bring the possibility of disbanding these working groups before the full Committee so all members have the opportunity to fully consider the implications of making such a decision; and
2. Florida recommends the Title Insurance (C) Working Group remain its own working group, rather than moving its responsibilities directly under C Committee. The reasons for this recommendation are as follows:
    a. Even with its close connection to home ownership, title insurance doesn't fit neatly into the traditional P&C lines of business.
    b. Because of concurrent federal oversight of the real estate and lending industries, the CFPB, FHFA, RESPA, GSEs, Federal Insurance Office and other federal agencies have made decisions that affect the title insurance industry, and the NAIC and its members should maintain the ability to closely monitor those decisions.
    c. Under the Biden Administration, CFPB was poised to declare title insurance a "junk fee" and ban the inclusion of title insurance related charges on the Closing Disclosure Statement. The federal government also introduced the use of insured "Attorney Opinion Letters" through the GSEs to reduce closing costs and promote home ownership. The CFPB website still has a section with information on title insurance.
    d. On October 22, 2026, President Trump signed an Executive Order with the intent of "Decreasing Housing Costs For the American People". Section 4, revived, in part, an FHFA pilot program to replace or find alternatives to title insurance. The Executive Order specifically addresses refinance transactions and proposes use of automated public record searches. However, it requires the Director (FHFA) to "direct the Enterprises [GSEs] to

expand the title acceptance pilot into an ongoing program available nationwide." Section 4, in its entirety below:

> Sec. 4. Reducing Excessive Title Insurance, Especially in the Refinancing of Americans Homes. (a) The Director shall, if he determines that it is in the best interests of the Enterprises or the FHFA, and the American public, and consistent with financial safety and soundness, the Director's authorities as regulator and conservator, and applicable law, direct the Enterprises to expand the title acceptance pilot into an ongoing program, available nationwide through both Enterprises, under which an Enterprise may accept an automated title review or other title-risk assessment approved by the FHFA in lieu of a lender's title insurance policy on eligible refinance transactions.
>
> (b) In expanding the program, the Director shall consider:
> (i) extending eligibility to refinance transactions with loan-to-value ratios above the current 80 percent limit where title risk remains low;
> (ii) removing geographic limitations and certifying additional title-assessment providers to promote competition;
> (iii) waiving appraisals, income re-verification, and other documentation requirements for limited cash-out refinances that reduce the borrower's monthly payment, where the Enterprise's existing data support doing so; and
> (iv) reducing or eliminating loan-level price adjustments and other Enterprise fees on such refinances.
> (c) The Director shall require that cost savings resulting from the program be passed through to borrowers and that lenders inform borrowers of those savings.

e. Unregulated title insurance alternatives continue to arise. As the entity responsible for regulating title insurers and agents, consumers and title insurers will look to state-based insurance regulators to address claims issues or solvency matters.
f. The NAIC needs a dedicated working group to oversee the federal interaction with the title insurance industry and push back against any encroachment on state-based insurance regulation.

Florida appreciates the opportunity to provide comment. Florida respectfully submits these recommendations for C Committee's attention as it considers adoption of its 2027 charges.

Sincerely,

Jane Nelson
Deputy Commissioner, Property & Casualty
Florida Office of Insurance Regulation

From Michael DeLong:

"The P&C Committee should draft a model law on telematics programs and write a report on these programs. Telematics can encourage safer driving behavior and more accurately match rates to risk, but the programs also pose massive concerns about consumer data collection and consumer privacy. Furthermore, most states have no specific regulations or laws dealing with these programs. A model law would provide guidance for states and boost consumer confidence that insurance regulators are looking out for their best interests.

The report on telematics should be based on the Maryland Insurance Administration's 2025 study. It would include the following data points, for the entire United States of America and broken down by individual states:

- The number of and percentage of auto insurance policies that are enrolled in telematics programs
- The number of and percentage of telematics policies that experienced a premium rate increase, a premium rate decrease, and no change in premium
- The factors that go into each telematics program and the weight assigned to each factor, with its corresponding impact on premium
- The average premium increase for policyholders experiencing premium increases and the average premium decrease for policyholders experiencing premium decreases
- Data reflecting the income distribution of policyholders who participate in the telematics program, broken out by policies that provide liability only coverage and by policies that also include physical damage coverage."

From Erica: Eversman

- Provide a forum for discussing issues related to the allowance of non-auto maker parts in auto policies and insurer claims practices, and consider revisiting the NAIC's After Market Parts Model Regulation, MDL 891, given the significant changes to components of motor vehicles over the intervening years since adoption.

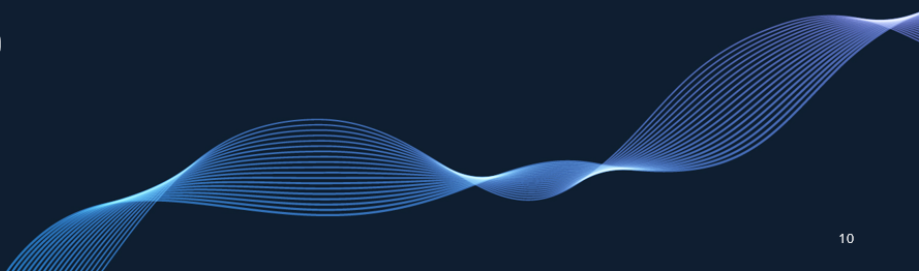
From Peter Kochenburger:

- The first is to issue an optional survey to insurers on how they criminal records (this is my ask in tomorrow's presentation at C Committee).
- The second is to place more focus on examining how AI is used in claims, similar to what I mentioned as a possible topic for the Summit.

4. Consider Adoption of the Casualty Actuarial and Statistical (C) Task Force White Paper on Rate Regulation

Attachment Four

Julie Lederer (MO)



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10

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U.S. Homeowners Insurance Rate Regulation–A Regulatory Perspective

Regulation, Consumer Protection, and Market Dynamics in the Modern Era

Casualty Actuarial and Statistical (C) Task Force

2026

Executive Summary

Insurance regulators are frequently asked if a multi-state insurer could try to charge more premium to homeowners in a state with lower risk of natural disasters to make up for heavy losses in a state with higher risk. This paper addresses this scenario, commonly referred to as "cross-state subsidization" and concludes that, under the state-based system of insurance regulation, homeowners rates are designed and reviewed to reflect the expected future cost of risk in the state where the policy is written, not to intentionally and systemically shift costs from one state's policyholders to another's.

State insurance regulators protect consumers by requiring insurers to justify rates with state-specific data and actuarial analysis. Although the regulatory framework varies by state, insurance rates are generally subject to standards requiring that they not be excessive, inadequate, or unfairly discriminatory. Actuaries evaluate data, assumptions, and methods used to estimate future losses, including inflation, catastrophe risk, and reinsurance costs. Although not all state laws require actuaries to be involved in the development of filed rates, state insurance laws or regulations often include language mandating that proposed rates be "actuarially sound" or justified by data that is "actuarially credible". Regulators assess rate filing support and its adherence to the Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board (ASB) and alignment with the Casualty Actuarial Society's (CAS) Statement of Principles Regarding Property and Casualty Insurance Ratemaking. Regulators also oversee how

insurers classify risk, ensuring that differences in price are tied to real differences in risk and are not arbitrary or unfair.

The existing regulatory frameworks in the United States are designed to constrain cross-state subsidization with the help of laws, actuarial standards, and markets.

So how would those legal, actuarial, and market challenges play out in the real world for our hypothetical multi-state insurer attempting cross-state subsidization?

First, insurers support their homeowners rates with state-specific data and actuarial analysis showing that the rates reflect the expected future cost to cover insured homes in that state.

Regulators review rate filings to identify anything unsupported or inconsistent with the state's actual risk and can challenge the rate, require revisions, or reject the filing altogether. Depending on the state, this process can happen before and/or after the rates go into effect. If an insurer inflates rates to account for losses in another state, it will show up in this review in inflated loss projections, excessive catastrophe loadings, or unsupported expenses.

Regulators look for mismatches between the risk in the state and the costs built into the rate. For example, if an insurer tried to hide cross-state subsidization by charging certain groups more without a risk-based reason, that would likely be deemed excessive or unfairly discriminatory and disallowed.

Second, oversight continues after rates take effect. Follow-up spot checks by regulators verify insurers are treating their customers fairly and help ensure insurers are actually charging the filed rates, not deviating from what was approved. Even if a rate filing is approved, companies could misapply rating factors, overcharge specific consumers, or use unfiled surcharges. Market conduct exams can catch those real-world deviations and protect consumers by, for example, requiring refunds to consumers, imposing fines or penalties, or requiring changes to rating practices. When a state takes regulatory action against an insurer as a result of a market conduct exam, it notifies regulators in other states where that insurer does business.

Third, competitive market pressures act as a backstop. Insurers that price above the risk of the market *in that state* will lose business to competitors *in that state*, making it difficult to sustain rates that are artificially high.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

These safeguards help explain why any attempts at cross-state subsidization would face several structural layers of protection designed to prevent them. Premiums are forward-looking estimates of future costs, not a way to recover past losses. Differences across states reflect local risks, timing, data limitations, coverage requirements, legal or regulatory requirements, or broader economic factors like inflation and reinsurance, not cross-state cost shifting. While major disasters *can* affect costs nationwide indirectly by raising rebuilding costs due to higher costs of materials and labor, or reinsurance prices, those are market-wide effects, not insurers shifting losses from one state to another.

In short, the regulatory system exists so that if an insurer tried to make one state pay for another, multiple layers of regulatory review are designed to catch it.

Overall, this paper concludes that state-based rate regulation supported by actuarial professionalism creates a holistic core consumer protection system; it ties rates to risk, subjects them to appropriate review, and helps ensure insurance remains both available and financially sound.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Table of Contents

Executive Summary 1
Introduction 5
I. What Is Homeowners Rate Regulation? 6
A. State Rating Statutes and Market Regulation 6
B. Homeowners Insurance and the Importance of Market Forces 8
II. How Homeowners Rates Are Built and Reviewed 8
A. Homeowners Insurance Rating 9
Homeowners Rating Overview 9
Homeowners Rating Influences 11
B. Catastrophe Pricing and Reinsurance Implications in Homeowners Rating 12
Catastrophe Risk and Pricing 12
Cost of Reinsurance 15
III. What is Cross-State Subsidization? 17
A. Defining Cross-State Subsidization 17
1. Market-Wide Distortion: 17
2. Not-Actuarially-Justified Rates in Both States: 18
B. Mischaracterizations of Cross-State Subsidization 19
1. Differences in Actuarial Assumptions and Methodologies from One State to Another State 19
2. Rate Filing Timing Differences and Non-Mandatory Rate Filings 19
3. Mix of Business Considerations 20
4. Regulator Disapproval of Rate Filings 20
The existence of a regulatory disagreement or filing disapproval should not be interpreted as evidence of cross-state subsidization. Rather, actuarial review is intended to help ensure that rates remain related to risk within the applicable jurisdictional and regulatory framework. 21
5. Credibility and Use of Non-State Data as the Complement of Credibility 21
IV. What State-Based Ratemaking Means for Consumers and Markets—Is there Cross-state Subsidization? 23
A. Catastrophe Losses and State-Based Ratemaking 24
B. How Insurers Deploy Capital and Reinsurance 24
C. What Pooling Does (and Does Not) Mean 25
D. Indirect Effects: How Catastrophe Losses May Affect Rates Elsewhere 26
Finally, catastrophes provide the opportunity for models to be updated for what is learned about resiliency. Insurers and third-party modelers may calibrate rating values associated with

certain types of construction, roof materials, mitigation efforts, etc., and use the revised discounts and factors throughout the country. 27
E. Could Companies Hide Cross-State Subsidization? 27
F. How Evolving Catastrophe Models Affect the Debate 29
G. Important Methodological Considerations for Researchers and Media 30
V. Conclusion: Rate Regulation as Layered Consumer Protection 34
References and Further Reading 36

Introduction

Regulators have been asked by legislators, researchers, media, and consumer advocates whether homeowners insurance policyholders in relatively low-risk states are financially subsidizing policyholders in states with high catastrophe exposure. The question is whether insurers spread catastrophic losses across their entire book of business, causing premiums in less disaster-prone states to rise to offset losses sustained in states with recent natural catastrophes.

At the 2026 Spring National Meeting, the NAIC Property and Casualty Insurance (C) Committee adopted the following charge for the Casualty Actuarial and Statistical (C) Task Force:

> ***Draft a white paper that explains how homeowners' insurance rates are regulated across states,[1] with particular attention to public questions and academic claims regarding potential cross-state subsidization of catastrophic losses.***

This white paper is intended to explain the framework of state-based homeowners insurance rate regulation in the United States and to examine how that framework addresses concerns regarding potential cross-state subsidization of catastrophe losses. The paper focuses on the legal, actuarial, regulatory, and market mechanisms that govern the development, review, and oversight of homeowners insurance rates. It discusses how rates are established, how catastrophe risk, reinsurance, credibility procedures, and other ratemaking components are evaluated, and how regulators assess whether rates comply with statutory standards. The paper is designed to provide a regulatory perspective on these issues and to describe the safeguards intended to promote rates that are risk-based, actuarially supported, and consistent with applicable state law.

[1] "States" refers to all 56 NAIC member jurisdictions throughout the paper.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

It is not intended to serve as an empirical study of insurer-specific conduct; it does not attempt to determine whether any particular company has engaged in cross-state subsidization; and it does not recommend or endorse any particular actuarial methodology for evaluating the actuarial soundness of rates. Such determinations are appropriately left to the professional judgment of the actuary, based on the specific facts, data, assumptions, and circumstances underlying each filing.

Accordingly, this paper should not be interpreted as concluding that insurer-specific cross-state subsidization is impossible or that empirical evidence could never support such a finding. Rather, the focus is limited to explaining how homeowners' insurance rates are regulated across states, with particular attention to safeguards that protect against cross-state subsidization of catastrophic losses.

I. What Is Homeowners Rate Regulation?

Homeowners rate regulation is the framework through which insurance regulators oversee the rates charged for homeowners insurance. It governs the filing and review of proposed rates, the actuarial support insurers must provide, the timing of rate implementation, and the regulator's assessment of whether rates are legal and not excessive, not inadequate, and not unfairly discriminatory. Although many insurers operate across multiple states, homeowners rates are regulated on a state-specific basis.

This section first describes the legal foundations of state-based insurance regulation, explains the core rate regulatory standards, and describes how market forces also impact homeowners rates.

A. State Rating Statutes and Market Regulation

Insurance regulation in the United States is conducted at the state level rather than the federal level. This decentralized structure traces its legal origin to the Supreme Court's 1944 decision in United States v. South-Eastern Underwriters Association, which held that insurance transactions crossing state lines constituted interstate commerce subject to federal regulation. Congress responded with the McCarran-Ferguson Act of 1945, which explicitly preserved the primacy of state regulation by providing that the continued regulation and taxation of the business of insurance by the several states is in the public interest, and that no act of Congress shall

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance.

Within each state, the legislature delegates primary regulatory authority over insurance to the Insurance Commissioner, Superintendent, or Director (collectively, the "commissioner"). That official, whether appointed by the governor or elected by the public, exercises broad authority over market entry and behavior, financial solvency, policy forms, and rates.

The cornerstone of rate regulation in nearly every American jurisdiction is a three-part standard derived from the All-Industry Bills and later the *NAIC Model Rating Law*, which is adopted across all states with variations. Under this standard, insurance rates must be: (1) not excessive, meaning they do not result in unreasonably high profits or financial gains to the insurer; (2) not inadequate, meaning they are sufficient to cover expected losses and expenses and maintain insurer solvency; and (3) not unfairly discriminatory, meaning they do not differentiate among similarly situated risks without actuarial or otherwise justifiable basis.[2]

Each state legislature also defines the rate regulatory filing frameworks which reflect different calibrations of regulatory oversight of the rate filing process itself. These are broadly categorized as prior approval, modified prior approval, flex rating, file and use, use and file, and no file. See "Rate Filing Methods for Property/Casualty Insurance, Workers' Compensation, Title"[3] for definitions. This filing framework varies by lines of business within the state. Included in the architecture of rate regulation are the filing requirements, support of rates (actuarial justification), and review authority.

Rate regulation, as conventionally understood, involves the review of prospective rates that insurers propose to charge. Market conduct regulation addresses a different but complementary set of concerns: whether insurers are, in practice, treating consumers fairly in their claims handling, underwriting, marketing, and billing practices. Market conduct regulation ensures that consumers are being charged premiums in accordance with filed rates and, in coordination or

[2] See state laws for definitions that apply in each state. For example, some state insurance laws specifically prohibit risk classification based upon race, religion, etc.
[3] https://content.naic.org/sites/default/files/model-law-chart-pa-10-rate-filing-methods-for-property-casualty-insurance-workers-comp-title.pdf

consultation with actuaries, may assess whether rates are excessive, inadequate, or unfairly discriminatory.

Homeowners rate regulation is a customizable framework for evaluating whether the rates charged to consumers are justified, sustainable, and fair. That framework matters because homeowners insurance affects not only the private transfer of risk, but also household financial security, mortgage lending, and the stability of insurance markets. Regulatory oversight of rates, forms, underwriting practices, and market conduct provides a layered system of consumer protection that compensates for the limitations of consumer sophistication and the vulnerability of individual homeowners to market failure.

B. Homeowners Insurance and the Importance of Market Forces

Insurers consider competitive dynamics when they price homeowners insurance. Thus, the market can discipline homeowners insurance pricing. This works best when there are a large number of insurers active in the homeowners markets and consumers shop around for insurance. Competitive market dynamics are meaningful, but do not always work efficiently because homeowners insurance policies are complex, making comparison between companies difficult, and there are market disruptions such as when there is withdrawal of coverage in high-risk markets, insolvencies following catastrophic events, and persistent availability and affordability problems in coastal and wildfire-exposed regions. There may also be other issues such as areas with vacant properties and high crime rates. Thus, regulatory engagement is a complement to competitive markets in affecting rates for the consumers' benefit.

Competition remains an important discipline on prices, but homeowners insurance presents conditions in which market forces alone may not fully protect consumers, preserve availability, or ensure that rates remain adequate and fair. The next question is how that balance is implemented in practice: how insurers develop homeowners rates, how those rates are supported actuarially, and how regulators evaluate the data, assumptions, and methods underlying them.

II. How Homeowners Rates Are Built and Reviewed

This section turns to the mechanics of regulatory oversight. Homeowners rates are not arbitrary charges, nor should they be retrospective attempts to recover past losses. They are prospective

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

estimates of the cost of providing coverage during a future policy period, supported by actuarial analysis and reviewed against applicable regulatory standards. The price paid for a homeowners policy provides the consumer with protection during the policy period, referred to as risk transfer, whether or not the policyholder has a claim. This is not a flaw of insurance pricing; it is the purpose of insurance. Rates are established before the outcome is known and are intended to fund the expected cost of coverage, the expenses of providing that coverage, the cost of capital and reinsurance needed to support the obligation, and a reasonable return for assuming the risk.

This section explains how those estimates are developed, how state-specific and broader data may be used, and how catastrophe risk and reinsurance are incorporated into the analysis.

A. Homeowners Insurance Rating

Homeowners Rating Overview

Homeowners insurance is a promise to cover uncertain future losses. The ultimate cost of an insurance policy is unknown at the time of sale, which complicates the pricing process[4]. As a result, the price consumers pay, referred to as the premium, is calculated based on the expected risk of loss to the home. The premium is an estimate of the future costs associated with transferring risk over the policy period. To support this estimation, insurers pool the risks of many policyholders, which allows losses to be financed by the premiums collected from many insureds. This results in diversification across risks and produces more stable outcomes.

A homeowners insurance premium generally includes provisions for expected losses, loss adjustment expenses, underwriting expenses, and profit and contingencies.

$$Premium = Expected\ Losses + Loss\ Adjustment\ Expenses + UW\ Expenses + Profit\ and\ Contingencies$$

For homeowners insurance, the largest component of the premium is the expected losses, also referred to as pure premium or loss cost. This is an estimate of the expected losses over a policy term. Historical loss data is typically used to estimate the expected losses of relatively high-frequency perils, such as fire or water damage. For lower-frequency but higher-severity events, such as hurricanes, wildfires, and earthquakes, insurers may rely on catastrophe models, as discussed in the catastrophe pricing in Section II. The premium is expected to cover future losses;

[4] https://www.casact.org/sites/default/files/old/studynotes_werner_modlin_ratemaking.pdf

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

thus, adjustments are made to the historical data to ensure it is predictive of future costs. Trending, the process of adjusting historical data to reflect expected future conditions, is one of the principal tools used in that process. Actuarial Standard of Practice 13[5] (ASOP No. 13), which is part of a comprehensive set of standards promulgated by the Actuarial Standards Board to govern ratemaking analysis, addresses trending procedures in property/casualty (P/C) insurance and states that actuaries can consider historical insurance and non-insurance data when estimating future expected values. In homeowners insurance, that is especially important because the cost to repair or rebuild a home may change materially between the historical experience period and the future period for which the filed rates are intended to apply. In addition to trending, actuaries adjust historical data for development (the maturation of claims over time) and on-level factors (the conversion of historical premiums to current rate levels).

Insurers also typically refine premiums based on characteristics of the home and the policyholder that are associated with differences in loss experience. These characteristics, known as rating factors, may include such things as the home's construction type, age of the home, geographical location, credit-based insurance score, , and roof type. For example, houses with clay tile roofs tend to be more fire resistant than houses with architectural shingle roofs, and thus usually receive lower premiums if all other characteristics are the same. When developing these rating factors, actuaries consider applicable actuarial standards, including ASOP No. 12[6], Risk Classification. All of the rating factors need to be supported by analyses showing differences in expected loss experience. In addition to expected losses, the premium should also cover the cost of adjusting claims and the expenses associated with issuing, servicing, and administering the policy. Additionally, the premium includes a provision for profit and contingencies, which reflects the need to support the business amid uncertainty. Actuaries consider applicable actuarial guidance, including ASOP No. 30[7], when developing such provisions. The level of that provision may be influenced by expected after-tax investment income and the return required on the capital supporting the insurer's operations.

[5] https://www.actuarialstandardsboard.org/asops/trending-procedures-propertycasualty-insurance-2/, Effective Date: Nov. 1, 2009.
[6] https://www.actuarialstandardsboard.org/asops/risk-classification-practice-areas/, Effective Date: May 1, 2006.
[7] https://www.actuarialstandardsboard.org/asops/treatment-profit-contingency-provisions-cost-capital-propertycasualty-insurance-ratemaking/, Effective Date: Dec. 1, 1997

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Homeowners Rating Influences

Although the general actuarial methodology used to determine homeowners premiums is consistent across lines and jurisdictions, homeowners ratemaking is fundamentally state-based. Expected losses are usually derived from expected state experience and from the conditions affecting insured risks in that state, such as local peril exposure, geographic concentration of risk, construction characteristics, legal environment, and claims settlement patterns. However, this does not mean that every input to a homeowners filing is derived from purely local data or is unaffected by broader market conditions. Some influences on the indicated rate level can extend beyond a single state, even where the filing itself remains state-specific. One example is repair-and-rebuild cost inflation. Homeowners claim severity is directly affected by the cost of labor, construction materials, transportation, and related rebuilding inputs, some of which can be affected by regional, national, and even worldwide conditions.

Another broader influence is reinsurance. Reinsurance is part of the mechanism through which insurers manage the impact of catastrophes on their enterprise solvency and, consequently, their ability to pay claims. Changes in reinsurance conditions can affect the cost structure underlying homeowners filings.

Broader inputs may also arise for other components of a homeowners rate indication. For example, underwriting expense provisions are often supported by company or countrywide analyses rather than a single state's experience alone. Likewise, where company-specific state data is limited, actuaries may supplement that experience with industry data and apply credibility-weighting[8], a technique that blends limited state data with broader experience to produce more reliable estimates of future loss and projected loss trends.

Given that insurance companies derive their profits from both underwriting and investment income, capital market conditions can also affect homeowners ratemaking. When anticipated investment income is projected to be high, companies often need lower future underwriting profits and vice versa. Higher expected after-tax investment returns can lead to the need for a lower profit provision in the ratemaking process, and ultimately lower rates.

[8] ASOP No. 25 provides guidance concerning credibility procedures and relevant experience. The use of broader information does not eliminate the need for the selected data and resulting adjustments to be appropriate for the risks being rated in the state.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

In summary, homeowners rates are derived based on the expected future cost of losses and expenses associated with the insured risks in the state being rated, including catastrophe exposure where applicable. However, some inputs relevant to a state filing may be influenced by broader economic and insurance-market conditions, including rebuilding-cost inflation, reinsurance conditions, capital market expectations, nationwide expense analyses, and updates to catastrophe models. Regulators reviewing rate filings are expected to examine each element of the ratemaking analysis: the adequacy of the historical period; the credibility procedures used to blend the insurer's state-specific experience with other data or experience; the appropriateness of the assumptions used to bridge from broader datasets to the specific risks of the state in question; the reasonableness of development factors; the appropriateness of trend selection (particularly in a period of rapidly changing loss cost environments); the justification for expense loads; the support for the profit provision; and more. A filing that relies exclusively on nationwide data without any state-specific adjustments, or that applies implausible adjustment factors, raises legitimate regulatory concerns regardless of the ultimate rate level requested. States vary in the depth and formality of this review, but the actuarial framework provides a common language for insurer submissions and for regulatory responses. Two of these influences, catastrophe risk and reinsurance, warrant closer examination because of their significance to homeowners ratemaking and their relevance regarding cost distributions across states.

B. Catastrophe Pricing and Reinsurance Implications in Homeowners Rating

Catastrophe Risk and Pricing

Catastrophe risk is one of the most important and most challenging components of homeowners insurance ratemaking. Catastrophe risk fits within that same prospective pricing framework described in the homeowners rating section but requires unique treatment because catastrophe losses are materially different from the types of losses that occur regularly and independently from house to house. A kitchen fire, theft, non-weather water loss, or isolated liability claim may affect one policyholder at a time. In contrast, a hurricane, wildfire, earthquake, tornado outbreak, hailstorm, or other event can produce concentrated losses across thousands of policyholders. That potential for concentrated losses creates pricing, capital, solvency, and reinsurance considerations that are not fully captured by traditional pricing techniques.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Catastrophe losses are not synonymous with all severe weather or other high-severity losses. Certain catastrophe perils, such as hurricanes, earthquakes, wildfires, and severe convective storms (SCS), are commonly evaluated using catastrophe models, although model availability and usage vary by peril and jurisdiction. Other weather-related or high-severity losses may instead be evaluated using historical experience, other models, scenario analysis, or a combination of methods. Accordingly, "severe weather," "high-severity loss," and "modeled catastrophe peril" should not be treated as interchangeable terms.

Because catastrophe losses may be relatively infrequent, severe, and spatially correlated, historical pricing techniques may be insufficient on their own for evaluating these perils. A state may not experience any major hurricane, earthquake, or wildfire losses during a five-, 10-, or even 20-year historical experience period, even though the risk of such an event remains material. Conversely, one or more unusually severe events may dominate a recent experience period and produce an estimate that is not representative of the long-run expected cost for the risk. ASOP No. 39[9]provides guidance to actuaries in evaluating catastrophe exposure and determining a provision for catastrophe losses and loss adjustment expenses in property/casualty insurance ratemaking. It defines a catastrophe as a relatively infrequent event or phenomenon that produces unusually large aggregate losses and defines catastrophe ratemaking procedures as procedures that adjust for catastrophe losses in experience data and determine a provision for catastrophe losses and loss adjustment expenses.

For these reasons, catastrophe risk is often evaluated separately from non-catastrophe homeowners losses. Non-catastrophe losses may be estimated using several years of historical claim experience, adjusted for trend, coverage changes, claim settlement practices, inflation, and other changes in conditions as described in the prior section. For catastrophe losses, historical data remain relevant but may be incomplete or insufficient because the historical period may not include the full range of possible events or may not reflect current exposures, building characteristics, property locations, and environmental conditions. For perils for which suitable models are available, catastrophe models are one commonly used method of addressing these limitations.

[9] https://www.actuarialstandardsboard.org/asops/treatment-catastrophe-losses-propertycasualty-insurance-ratemaking/, Effective Date: Dec. 15, 2000.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

A natural catastrophe model is a computerized process that simulates many scientifically plausible catastrophic events and estimates their financial impact on a portfolio of insured properties. For commonly modeled perils, the catastrophe provision included in the overall indicated rate level in a homeowners rate filing may be based in whole or in part on the long-term expected annual cost generated by a catastrophe model. Other rate components, such as retained risk or reinsurance provisions, are also often based at least in part on catastrophe models.

Because catastrophe models are complex and rely on specialized scientific and engineering assumptions, their use in ratemaking requires judgment and review. Depending on the purpose and materiality of the model output, applicable actuarial standards, and jurisdiction-specific filing requirements, relevant filing support and regulatory review may address the specific model or models used, the exposure data entered into the model, the treatment of policy terms, the inclusion or exclusion of secondary perils (e.g., storm surge or wildfire smoke), demand surge, loss adjustment expenses, secondary uncertainty, the selection of model options, and any adjustments made to the model results. This list is illustrative, intending to show the importance of regulatory review of assumptions, and is not intended to suggest that every item is required in every filing by regulation or an ASOP.

Actuaries performing actuarial services involving catastrophe models should consult applicable standards, including ASOP No. 38[10], which addresses the selection, use, review, and evaluation of catastrophe models; ASOP No. 39[11], which addresses the treatment of catastrophe losses in property/casualty ratemaking; and ASOP No. 41[12], which addresses actuarial communications. As relevant under applicable filing requirements, regulators may also review the vendor model documentation, the insurer's use and validation of the model, as well as any rating factors, surcharges, or discounts that may have been informed by catastrophe model output.

The use of catastrophe modeling, when used appropriately, is consistent with the broader actuarial principle that rates should reflect expected future costs. ASOP No. 53[13] states that

[10] https://www.actuarialstandardsboard.org/asops/actuarial-standard-of-practice-no-38-revised-edition/, Effective Date: December 1, 2021.
[11] https://www.actuarialstandardsboard.org/asops/treatment-catastrophe-losses-propertycasualty-insurance-ratemaking/, Effective Date: December 15, 2007.
[12] https://www.actuarialstandardsboard.org/asops/actuarial-communications/, Effective Date: May 1, 2011
[13] https://www.actuarialstandardsboard.org/asops/estimating-future-costs-prospective-propertycasualty-risk-transfer-risk-retention/, Effective Date: August 1, 2018.

actuaries estimating future costs should select appropriate methods or models, use reasonable assumptions, consider adjustments for changes in conditions, and consider the treatment of catastrophes and reinsurance when those items are reflected in future cost estimates. For example, a home with materially greater wildfire, hurricane, earthquake, or SCS exposure is expected to incur greater losses than an otherwise similar home with lower exposure. Cost-based rating attempts to reflect these differences through rating variables such as territory, construction, roof characteristics, deductible, coverage, and mitigation discounts, among other factors.

This risk differentiation is also tied to the regulatory standard that rates should not be excessive, inadequate, or unfairly discriminatory. In actuarial terms, unfair discrimination does not mean that all policyholders pay the same rate. Rather, it generally concerns whether differences in premiums bear a relationship to differences in expected losses and expenses. For catastrophe risk, rating factors such as location, roof characteristics, construction type, or mitigation are often appropriate when supported by data, catastrophe modeling, or other credible evidence showing differences in expected costs.

Cost of Reinsurance

Reinsurance is closely related to catastrophe pricing because catastrophe risk can threaten an insurer's surplus, profitability, and solvency. Reinsurance is insurance purchased by an insurer to transfer part of its risk to a reinsurer. In other words, it is often necessary for insurers to have reinsurance which allows them access to market capital in the event of a catastrophic loss. In homeowners insurance, catastrophe reinsurance often protects against losses on a per-risk basis, losses arising from an individual event or occurrence, aggregate losses over a defined period, or a blend of these structures.

The cost of reinsurance is an actuarial component of the cost of providing homeowners insurance, though its inclusion in the price is subject to state insurance laws and regulations. When reinsurance is considered, reinsurance costs must be allocated carefully. Many insurers purchase reinsurance at a portfolio level rather than separately for each state. A single catastrophe reinsurance program may cover homeowners exposures in multiple states and may respond to losses from multiple perils which has the effect of diversifying the insurer's catastrophic risk. For purposes of allocating reinsurance cost to the states in the reinsurance program, it should not be interpreted that the cost should be spread evenly across all policyholders or all states. The actuarially sound approach is to allocate the cost in a manner that reflects the expected benefit

and risk contribution of the business being rated. Relevant measures may include modeled catastrophe losses, expected reinsurance recoveries, contribution to reinsured layers, exposure distribution, premium, coverage, peril, and other risk characteristics.

Because the cost of reinsurance ultimately flows into homeowners rating, fluctuations in the cost of reinsurance can cause homeowners rates to change, particularly in catastrophe-exposed markets. The reinsurance market is global, with many reinsurers operating internationally to provide coverage for multiple insurers and risks. On a fundamental basis, reinsurance pricing is risk-based, just as for primary insurers, and reinsurance protection is not unlimited. The market generally has limited capacity for taking on risk before reinsurance may become unavailable or unaffordable. Recent loss experience on a global scale can impact reinsurer profitability and short-term capacity. As such, seemingly unrelated catastrophe events can affect U.S. homeowners insurance rates. For example, if a major typhoon were to impact Japan, reinsurers would likely pay out on reinsurance contracts and potentially would have lower capacity in the following years to take on additional risk, even in the U.S. This constrained reinsurance market can drive general reinsurance costs upward, causing U.S. insurers to pay more for their reinsurance, and thus pass these higher costs on to their policyholders. While global events may impact the overall reinsurance market conditions and capacity, the reinsurance cost for an individual insurer's program remains specific to the risk characteristics of the underlying exposures.

Reinsurance also interacts with the profit and contingency provision and the cost of capital. Catastrophe-exposed homeowners insurance requires capital because actual losses can deviate substantially from expected losses. Reinsurance can provide an insurer with some relief from required capital by transferring tail risk, but it has a cost. Conversely, retaining more catastrophe risk may reduce reinsurance premium but increase required capital and earnings volatility. A rate indication should avoid double-counting by treating modeled losses, reinsurance recoveries, reinsurance premiums, retained risk, and profit or cost-of-capital provisions consistently. ASOP No. 53 specifically states that when reinsurance is reflected in future cost estimates, the actuary should select appropriate methods or models and reasonable assumptions for estimating the cost associated with expected reinsurance arrangements.

In summary, catastrophe pricing in homeowners insurance applies the same risk-based prospective ratemaking framework used for other homeowners costs, but with additional tools

and considerations. Catastrophe models help estimate losses that are too infrequent, severe, and correlated to be measured reliably using only recent historical experience. Reinsurance helps insurers manage the volatility and capital strain created by those losses, and its cost is an appropriate part of homeowners premiums when it is actuarially supported and allocated in relation to risk and expected benefit. Together, catastrophe modeling, risk classification, reinsurance allocation, and capital provisions support the central ratemaking objective: premiums should be an actuarially sound estimate of the expected future cost of the risk being transferred during the policy period.

III. What is Cross-State Subsidization?

A. Defining Cross-State Subsidization

It is important for researchers and others to define cross-subsidization. At the May 12, 2026, meeting of the Casualty Actuarial and Statistical (C) Task Force, Mike Goldman (Perr & Knight) identified three distinct claims of cross-subsidization. The first was residual markets, such as the Fair Access to Insurance Requirements (FAIR) plan and the Texas Windstorm Insurance Association, where costs are spread within the same state. The second was cross-state subsidization within national carrier portfolios. The third was a federal cross-subsidization through the National Flood Insurance Program (NFIP) and disaster aid, which can be analyzed with NFIP subsidies. This paper is only focused on the second type.

In theory, cross-state subsidization could be structural and systemic across the market or could be focused on an individual company's actions. For purposes of this white paper, the question is whether there is systemic cross-subsidization between states. Structural cross-state subsidization can be described as follows:

> Policyholders in one state systematically pay rates that are inadequate for their own expected costs while policyholders in another state pay more than their expected costs to offset it.

In order for **structural** cross-state subsidization to occur, two conditions need to be met:

1. **Market-Wide Distortion:**
   Structural cross-state subsidization is a market-wide phenomenon. If an individual company determines rates in a way that causes one state to subsidize another, and the

subsidization exists only within that company's portfolio, that would likely not be considered structural cross-state subsidization (unless the insurer was of significant, material size). *(Note: This is still an issue regulators address; it just doesn't meet the definition of structural cross-state subsidization.)*

2. **Not-Actuarially-Justified Rates in Both States:**
   If rates in one or both states are determined to be actuarially justified, structural cross-state subsidization has not occurred. In a market that is structurally cross-state subsidized, one or more states would experience inadequate rates while other state(s) would experience excessive rates.

The above definition and Task Force charge focus on explaining how homeowners' insurance rates are regulated across states, with particular attention to questions regarding potential cross-state subsidization of catastrophic losses.

Because cross-state subsidization is central to the Task Force's charge, only scenarios involving subsidization are evaluated. Scenarios involving high rates in one or multiple states that do not involve inadequate rates in another state fall outside the definition of cross-state subsidization. If rates are excessive in one state but actuarially sound in another, the result is more appropriately characterized as excess profitability rather than cross-state subsidization. Cross-state subsidization requires a transfer effect in which policyholders in one state pay rates above their own expected costs to offset rates that are inadequate to cover expected costs in another state. Policyholders paying actuarially sound rates are not subsidized by policyholders in another state merely because an insurer earns higher profits elsewhere. Accordingly, scenarios in which policyholders are charged actuarially sound rates, even if an insurer earns higher profits in another state, are not considered cross-state subsidization under the framework contemplated by the CASTF charge.

Actuarial work inherently involves professional actuarial judgment, ranges of reasonable outcomes, evolving claims experience, and uncertainty. As discussed in Section III, Part B, Item 6 below, risk or experience in one state may, for legitimate actuarial reasons, affect the expected cost of providing insurance in another state without constituting structural cross-state subsidization. Whether such impacts are appropriate depends on their consistency with

applicable actuarial standards and state law. Sometimes, actuarially justified scenarios may lead to the incorrect perception of cross-state subsidization.

B. Mischaracterizations of Cross-State Subsidization

There are numerous scenarios commonly mischaracterized as cross-state subsidization, including the following:

1. Differences in Actuarial Assumptions and Methodologies from One State to Another State

Actuarially justified rates may reasonably differ state by state based on assumptions, credibility treatments, catastrophe loadings, trend selections, development methodologies, expense allocations, reinsurance strategies, or differing views of emerging risk conditions.

Rates in one state may reflect more conservative assumptions or greater provision for uncertainty than rates in another state, while both remain actuarially justified. Actuarial standards do not require uniform assumptions or outcomes across jurisdictions. Reasonable actuarial judgment may support materially different assumptions and levels of conservatism based on each state's unique risk profile, data characteristics, regulatory environment, and market conditions. Consequently, significant differences in indicated or approved rates between states do not, by themselves, imply that one state's rates are more actuarially appropriate than another's. Rather, the relevant consideration is whether the assumptions and methodologies used for each state are reasonable, adequately supported, and appropriate for that state's risks and circumstances.

2. Rate Filing Timing Differences and Non-Mandatory Rate Filings

In many jurisdictions, insurers are not required to submit a rate filing unless they are voluntarily revising rates. A company may choose to absorb year-to-year cost fluctuations rather than regularly adjusting rates. Similarly, a company may delay or sequence filings due to operational considerations, such as competing priorities and limited resources, or regulatory considerations, such as the anticipated time needed for review and approval. These timing differences may create temporary differences between indicated and implemented rate levels across states without the systematic transfer of costs from one

state's policyholders to another's and therefore, do not constitute structural cross-state subsidization.

3. Mix of Business Considerations

Differences in rate change decisions across states may also reflect varying growth dynamics within an insurer's portfolio, rather than structural cross-state subsidization.

When a book of business is experiencing rapid growth, insurers may elect to utilize more conservative pricing assumptions to account for uncertainty associated with changing policyholder composition. Historical experience may also be less predictive for a rapidly growing book of business, as the risks being insured today may differ materially from those reflected in prior years' experience.

Conversely, a shrinking or more stable book of business may support less-conservative assumptions where the insurer believes the underlying risk profile is better understood or more predictable.

As new business enters or existing policyholders exit, the distribution of risks, geographic concentrations, coverage selections, or underwriting characteristics may shift in ways that reduce the predictive value of historical experience.

4. Regulator Disapproval of Rate Filings

Regulatory actuaries are tasked with reviewing a rate indication based on information provided in the rate filing to determine whether it complies with actuarial, legal, and regulatory standards.

Rate regulation is prospective in nature and evaluates whether the proposed rates are adequately supported under the applicable statutory framework and reasonably reflect the underlying risk.

Importantly, regulatory disagreement does not necessarily indicate that an insurer's proposed rates represent a significant departure from accepted actuarial practice. Reasonable actuarial and regulatory differences may arise even when all parties are operating within accepted actuarial and legal frameworks. Different actuaries may reasonably select different assumptions related to trend, credibility, expense provisions, catastrophe and reinsurance provisions, profit provisions or other relevant assumptions.

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Additionally, regulatory actuaries are highly familiar with the statutory requirements, market considerations, public policy objectives, approved actuarial methodologies, and other constraints unique to their jurisdiction.

In many cases, a regulator's concern may relate to the sufficiency of supporting data, the reasonableness of selected assumptions, the applicability of a methodology, or compliance with a statutory or procedural requirement unique to the jurisdiction. A filing disapproval may also reflect a determination that additional actuarial support or alternative actuarial treatment is necessary before the proposed rates can be approved.

Examples of situations that could result in filing disapproval without establishing that the proposed rates are not actuarially sound include circumstances where sufficient support was not provided, deadlines for submission of additional information were not met, or statutory and procedural requirements were not satisfied.

Insurance markets perform differently across jurisdictions. A rate that is actuarially sound in one state is often not actuarially sound in another state due to differences in laws, regulations, litigation environments, catastrophe exposure, consumer profiles, risk characteristics, and other market conditions.

The existence of a regulatory disagreement or filing disapproval should not be interpreted as evidence of cross-state subsidization. Rather, actuarial review is intended to help ensure that rates remain related to risk within the applicable jurisdictional and regulatory framework.

5. Credibility and Use of Non-State Data as the Complement of Credibility

A common challenge in ratemaking is determining the extent to which an insurer should rely on its own experience as compared to broader company, industry, or other supplemental data sources. Actuaries use credibility procedures to determine the appropriate weight to assign to a particular set of insurance data when developing rates. For example, a large insurer with many years of experience in a given state may receive high credibility on its own statewide data, while a smaller insurer or more niche program may rely more heavily on countrywide data or may rely on other benchmarks that are relevant to the product.

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ASOP No. 25[14], titled “Credibility Procedures”, provides definitions for terms such as credibility, credibility procedure, full credibility, and relevant experience, among other concepts important to actuarial credibility analysis.

Credibility procedures are intended to balance responsiveness to actual experience with the statistical reliability needed to support stable and predictive rate indications. These procedures help reduce volatility and lessen the likelihood that isolated or short-term fluctuations disproportionately affect indicated rates.

When an insurer’s statewide experience is not considered fully credible under actuarial credibility procedures, the statewide experience may be weighted together with a complement of credibility, often referred to simply as the “complement”. ASOP No. 25 discusses the importance of the complement reflecting relevant experience, including risk characteristics that are reasonably similar to the product being analyzed.

The complement of credibility may include experience from a broader geographic area or from an industry data source, when the insurer's own experience is not considered sufficiently credible. However, the purpose of a credibility-weighted complement is not to transfer costs from one state to another, but rather to improve the statistical reliability and predictive value of the rate indication. The actuarial appropriateness of a complement depends on whether the underlying data is considered relevant to the risks being evaluated, consistent with the principles described in ASOP No. 25.

Actuarial literature can be consulted for additional guidance regarding credibility procedures and selection of the appropriate complement.

Because professional judgment is required in determining the appropriate credibility treatment and selection of complement, insurer practices may reasonably differ depending on the circumstances and underlying data. Overreliance on broad averages may obscure meaningful emerging trends, while overreliance on limited experience may produce indications that are less predictive of future costs. Actuaries are expected to apply credibility procedures in a manner consistent with applicable actuarial standards and guidance, including the principles in ASOP No. 25 regarding the use of relevant experience and selection of an appropriate complement. Differences among insurers in

[14] https://www.actuarialstandardsboard.org/asops/credibility-procedures/, Effective Date: May 1, 2014.

the application of credibility procedures or selection of complements do not imply that either insurer's rates are not actuarially sound, nor do such differences, by themselves, establish the existence of cross-state subsidization.

6. Market-Wide Changes in Future Cost Estimates

Changes in rates may also result from evolving assessments of future risk and expected costs rather than cross-state subsidization. Rate indications are routinely updated to reflect new information, including changes in catastrophe models, reinsurance costs, loss trends, rebuilding costs, litigation patterns, and other factors that affect expected future losses and expenses.

These changes are prospective in nature and are intended to estimate the future cost of providing coverage. Although such updates may result in higher indicated rates in one or more states, they do not represent a transfer of costs from policyholders in one state to policyholders in another state. Rather, they reflect revised assessments of the expected costs associated with insuring risks in the applicable jurisdiction.

A common mischaracterization of cross-state subsidization arises when a significant catastrophe in one state contributes to rapidly evolving market conditions that affect insurers' assessments of future risk across multiple states. Large catastrophe events may influence catastrophe model outputs, reinsurance costs, capital requirements, rebuilding cost assumptions, and other prospective ratemaking inputs. As a result, indicated rates may increase in jurisdictions that did not experience the loss event. Such changes generally reflect updated expectations regarding future costs and risks rather than a transfer of costs from policyholders in one state to policyholders in another.

IV. What State-Based Ratemaking Means for Consumers and Markets—Is there Cross-state Subsidization?

Section II explained how homeowners rates are developed and reviewed: as prospective estimates of expected loss, expense, catastrophe exposure, reinsurance cost, and other elements associated with the risk being insured. This section applies that ratemaking framework to a recurring question in public discussion: whether catastrophe losses in one state are being shifted into rates charged to policyholders in another. The answer requires distinguishing direct loss

shifting from broader market effects. State-based ratemaking does not support the direct allocation of one state's catastrophe losses to another state's policyholders, but catastrophe events may still affect broader inputs such as rebuilding costs, reinsurance pricing, capital costs, and catastrophe model assumptions.

A. Catastrophe Losses and State-Based Ratemaking

A recurring theme in academic research, media coverage, and consumer advocacy is the concern that homeowners insurance policyholders in relatively low-risk states may be financially subsidizing policyholders in states with high catastrophe exposure. These sources suggest that insurers spread catastrophic losses across their entire book of business, causing premiums in less disaster-prone states to rise to offset losses sustained in states like California, Florida, or Louisiana.

Several academic studies have examined insurer pricing behavior and rate-change patterns across states following major catastrophe events. Media investigations—particularly following the 2017–2018 California wildfire seasons, Hurricane Ian in 2022, and repeated hurricane seasons in Florida—have amplified these concerns, with reporting suggesting that consumers in other states are bearing costs attributable to coastal or wildfire-zone losses. Consumer advocacy organizations have similarly raised concerns that insurers are insufficiently transparent about cost allocations and that policyholders lack the information necessary to evaluate whether their premiums reflect local risk or a national pooling of catastrophic exposure.

These concerns deserve serious engagement. However, several important methodological limitations and industry structural features are frequently overlooked in both academic and media treatments of this issue and understanding them is essential to evaluating the subsidization hypothesis fairly.

B. How Insurers Deploy Capital and Reinsurance

While catastrophe pricing is state-specific, as discussed in Section II, insurers deploy capital and reinsurance on an enterprise-wide basis to ensure claims-paying ability regardless of where a catastrophe occurs. A national insurer writing policies in all 50 states maintains a single pool of surplus capital that supports its obligations everywhere and for every line of business it writes. When a hurricane causes billions in losses in Florida, the same surplus that backs policies in Ohio is drawn upon—if necessary—to pay those claims.

Additionally, capital supports the entire company and not just its homeowners' line of business. Most insurers do not write only homeowners' insurance policies, and those few that do rely very heavily on reinsurance because of the extreme risk associated with a monoline portfolio. Like the way carriers manage their adopted risk from policyholders by diversifying their exposure geographically, they also mitigate their risk by writing other types of insurance. Most homeowners' carriers will also sell a wide variety of property and casualty coverages including personal auto and personal umbrella policies. Furthermore, these same carriers may sell a wide portfolio of commercial insurance products including commercial auto and property, plus commercial liability and workers' compensation policies. A carrier's surplus built up by underwriting and investment income associated with all these products is then available to them in the unlikely event of a catastrophic loss.

This enterprise-level capital deployment, however, is not equivalent to Ohio policyholders subsidizing Florida policyholders. The surplus is the insurer's own capital, contributed by shareholders and accumulated from retained earnings. It is the mechanism by which the insurer guarantees its financial promises; it is not a transfer of premium dollars from one state's policyholders to another's.

The reinsurance program layered above the insurer's retained risk functions similarly: reinsurance is purchased at the enterprise level, but its cost is allocated back to individual states based on the catastrophe exposure each state contributes to the reinsurance need. A state with low catastrophe exposure contributes less to the reinsurance cost allocation and, therefore, should have a smaller reinsurance load in its rates.

Different layers of reinsurance protection serve different purposes. Per-risk or per-occurrence excess-of-loss treaties respond to large single-event losses. Aggregate covers respond to the accumulation of smaller losses over a policy period. Catastrophe bonds and other capital market instruments provide additional protection against tail events. The cost of each layer is reflected in state-level rates in proportion to the catastrophe exposure that creates the demand for that layer of protection.

C. What Pooling Does (and Does Not) Mean

Insurance is, by design, a pooling mechanism. A homeowners insurer pools the risks of many policyholders so that the losses of the few are spread across the premiums of the many. This

within-state pooling is the core economic function of insurance and is what makes coverage affordable for individual policyholders who could not self-insure against a catastrophic loss.

Cross-state pooling within a national insurer operates on a different principle. The insurer is not pooling the catastrophe losses of State A and State B policyholders together and averaging the cost across both groups. Rather, the insurer is pooling the uncertainty about whether State A losses will be higher or lower than expected, against the uncertainty about whether State B losses will be higher or lower than expected. The insurer benefits from the fact that these two sources of uncertainty are not perfectly correlated. The economic benefit of this diversification accrues primarily to the insurer's shareholders in the form of reduced capital requirements and to policyholders in the form of improved insurer financial stability; it does not translate into State B policyholders paying for State A losses.

D. Indirect Effects: How Catastrophe Losses May Affect Rates Elsewhere

While direct cross-state premium subsidization does not occur through normal ratemaking, there are legitimate indirect pathways through which a catastrophe in one state can affect premium levels in other states, and these indirect effects are important to acknowledge.

The most significant indirect effect operates through supply chain economics. Following a major catastrophic event, such as a hurricane, wildfire, or flood, the demand for building materials, skilled labor, and construction equipment surges in the affected region. Lumber prices, roofing material costs, drywall, and structural components all experience sharp price increases, driven by both genuine supply constraints and demand concentration in the affected area. These elevated material costs do not remain geographically confined. A homeowner in Indiana filing a non-catastrophic claim, such as a burst pipe, a fallen tree, or a kitchen fire, may find that the cost of repairs has risen meaningfully because the same lumber being used to rebuild Gulf Coast homes is now more expensive everywhere. Insurers writing homeowners policies across the country may experience increased claim severity in all states following a major catastrophe, and this elevated severity can feed into the loss experience used to support future rate changes nationwide. This is a real, quantifiable, and economically rational indirect linkage between catastrophe losses in one state and premium levels in others, and it deserves recognition in the research literature as a legitimate channel distinct from, and not confused with, direct subsidization.

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Catastrophic events can also affect reinsurance pricing globally. A particularly severe hurricane season or a large wildfire loss may increase reinsurance costs for the subsequent policy year, and those increased costs are reflected in rate filings across all states that purchase catastrophe reinsurance — even states that were not directly affected by the event. This is not to compensate reinsurance carriers for losses sustained in a prior event; rather, the severe event serves as an additional data point that could cause reinsurers to adjust their predictions of future loss.

As with the rebuilding-cost effects discussed above, this is a market-driven indirect effect, not a regulatory or actuarial mechanism for cross-state subsidization.

Finally, catastrophes provide the opportunity for models to be updated for what is learned about resiliency. Insurers and third-party modelers may calibrate rating values associated with certain types of construction, roof materials, mitigation efforts, etc., and use the revised discounts and factors throughout the country.

E. Could Companies Hide Cross-State Subsidization?

A more sophisticated version of the cross-state subsidization hypothesis asserts that even if rate filings are state-specific, insurers might use the flexibility within ratemaking to shift value between states in ways that are difficult for regulators to detect. For example, an insurer might inflate the profit provision in low-catastrophe states to build a surplus that effectively offsets losses in high-catastrophe states. Or an insurer might systematically understate the catastrophe load in a high-exposure state by using older, less sensitive catastrophe models, while compensating with higher expense loads in other states.

The Center for Insurance Policy and Research (CIPR) performed a qualitative analysis of rate filings to explore the hypothesis that carriers are subsidizing catastrophic losses incurred in one state with higher rates in another state. If the hypothesis were true, the expectation is rate filings would either 1) directly include out-of-state catastrophe losses in the development of the indicated rate need or 2) indirectly increase the indication by changing methodology (e.g. using more conservatism) after catastrophic loss in another state. The analysis, while qualitative and limited in scope, did not support the hypothesis that carriers are raising rates in one state to support losses in another state.

Minnesota Hail Event: Found No Effect on Iowa Rates

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For example, in 2017 there was a hail event (part of a June Derecho) in Minnesota. Iowa rate filings were examined for some companies writing insurance in both Minnesota and Iowa. No Minnesota loss data (or any other out-of-state losses) were reflected in five Iowa rate filings prior to Derecho and six after Derecho. Rate provisions and methodologies were also reviewed to test for any indirect cross-state subsidization via selection of more conservative factors or changes in methodology intended to yield a higher indication in the post event filings.

The methodologies and provisions reviewed were: 1) Indication methodology: number of years of experience, weighting of years; 2) Loss and Trend: development and selection of; 3) Catastrophe provision development including which CAT models were used; 4) Reflection of reinsurance; 5) Development of underwriting profit and contingencies provision; 6) Other expense development; 7) Indicated vs proposed rates; 8) Credibility methodology and the selected complement of credibility; 9) Premium Trend; and 10) Other factors (e.g., Large loss procedure that may be impacted by out-of-state losses). No methodology changes were observed that would indicate an indirect allocation of losses from the catastrophe events into Iowa rate indications. "Indirect effects" such as reinsurance costs, countrywide expenses or profit provision selection did not appear to be affected by the experience of out-of-state losses. When indications were higher in the post period, the driver was an increase of in-state losses or loss trends. Changes observed were due to companies having more internal experience to rely on, updates to catastrophe models, updated factors such as profit provisions, or other methodology changes that adhere to standard actuarial principles.

With changes to profit provisions, carriers maintained a consistent methodology to develop their profit provisions, but some updated inputs such as the rate of return, which resulted in small changes in the underwriting profit. In some cases, the underwriting profit provision increased from pre-to-post event filings. One carrier increased their profit provision from 6% to 7%. In some cases, the underwriting profit provision decreased: one carrier decreased its profit provision from 7.2% to 5.4% and another from 7% to 5%.

Regarding methodology changes, one company changed its credibility procedure which resulted in a small increase in the credibility attributed to its own statewide data; the complement of credibility was applied to a trended permissible loss ratio (not to loss experience from other states).

Hurricanes Harvey & Irma and 2018 California Wildfires: Found No Effect on Virginia Rates

Using the same methodology, four Virginia rate filings were studied before and four after the hurricanes Harvey & Irma in 2017 and eight filings before and eight after the 2018 California wildfires (7/23/18-8/30/18). Findings in the Virginia rate filings were consistent with the findings from the review of Iowa rate filings: There were no out-of-state losses included in any of the rate filings in Virginia. There were no methodology changes or rate provision selections that would indicate an indirect allocation of loss experience from the catastrophes to Virigina.

While these are only two limited scope case studies, CIPR has not found support for the subsidization hypothesis. Analyses of profit provisions, expense ratios, and loss ratios across states have not revealed the systematic patterns that would be expected if insurers were deliberately routing value from low-catastrophe to high-catastrophe states. This does not foreclose the possibility that individual insurers in specific circumstances might engage in such behavior. The available evidence from the CIPR study does not support cross-state subsidization as a widespread or systematic phenomenon.

F. How Evolving Catastrophe Models Affect the Debate

One final dimension that is essential to understanding the cross-state subsidization debate is the evolution of catastrophe modeling. Insurers and their actuaries rely on probabilistic catastrophe models to estimate the expected losses from hurricanes, wildfires, earthquakes, and other catastrophic perils. These models, developed and maintained by specialized vendors and insurers, translate meteorological, geophysical, and engineering science into probabilistic loss distributions for any portfolio of insured properties.

Catastrophe models have changed significantly over time, and the transitions between model generations can create large changes in rate levels. When a major vendor releases a new version of a hurricane model that substantially increases estimated loss costs for Gulf Coast exposures, insurers using that model will file for rate increases in the affected states. The timing and magnitude of those increases may differ across insurers depending on when they transition to the new model, how much credibility they give to the model versus their own historical data, and how their reinsurance programs respond to the updated loss estimates. A researcher observing this pattern without knowledge of the model transition might incorrectly attribute the rate increases to a redistribution of costs rather than to an improved scientific understanding of the underlying peril.

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The practical implication for the subsidization debate is that large, sudden shifts in catastrophe-state rate levels, particularly following a major loss event or a model update, do not indicate that prior rates in those states were subsidized by other states. They indicate that the industry's understanding of the catastrophe risk has changed, and that rates are being updated to reflect that improved understanding. The absence of prior rate increases does not mean policyholders elsewhere were overpaying; it may mean that the risk was systematically underestimated by the best available models at the time.

G. Important Methodological Considerations for Researchers and Media

It is worth flagging several recurring misconceptions that appear in research and reporting on this topic, because they can significantly distort conclusions about cross-state subsidization.

1. Rate Filings Are Not "Exact Rate Needs."

A rate filing reflects an indicated rate need and the proposed rates. Actuarial rate indications involve projecting future (unknown prospective) losses and expenses from historical data using loss development factors, trend factors, and catastrophe load adjustments, and other factors—all of which carry significant uncertainty. The "indicated rate change" in a filing is meant to be a single point estimate within a range of reasonable estimates. No actuary, regulator, or researcher knows with certainty how many claims will occur in a future policy period, or what those claims will cost. After-the-fact comparisons of predicted losses to actual losses do not establish that charged rates were excessive or inadequate. The nature of catastrophes alone renders such comparisons moot; a pricing environment that would react each year to the catastrophes that did or did not occur in the year prior would lead to enormous rate swings that would be not only actuarial unsound but also harmful to consumers.

2. Claim Count Definitions Vary Across Insurers and Datasets.

Comparisons of claim frequencies across companies or states often encounter the problem that insurers define and count claims differently. Some insurers record a claim for each person injured, each site damaged, each coverage affected, etc. Zero-payment claims (opened and closed without indemnity, such as claims below the policyholder deductible or not caused by a covered peril) may or may not be included in reported counts. Researchers using industry databases or statutory filings should account for these

definitional differences, as unadjusted comparisons can produce false or misleading conclusions about relative loss frequency and severity, or average claim amounts.

3. The Indicated Rate vs. Rate Received: A Critical Assumption.

Much of the academic literature on cross-state subsidization implicitly or explicitly assumes that the indicated rate need in a filing, represents the true economic cost of risk in that state, and that any gap between the indication and the filed and/or approved rate must be recovered elsewhere, including (potentially) from policyholders in other states. This assumption does not withstand careful examination. First, as previously described, the rate indication in a filing is but one point estimate among a range of reasonable estimates, a range that is likely to include the proposed rate level when it deviates from the filed point estimate indication. Second, even very large insurers write only a small fraction of the policies in any given state. An insurer whose indicated rates are outside the range of their competitors has to consider whether their estimates are missing the mark. State insurance regulators should be skeptical as well. The impacts of going to market at rates that are too competitive or not competitive enough can be catastrophic. An insurer that charges uncompetitive rates could start an adverse selection spiral that ultimately results in the failure of the product and its withdrawal from the market. Needing to account for adverse selection risk in one state but not another does not mean one state's policyholders are subsidizing the other's.

4. Catastrophe Pricing Is a State-Level Construct.

A foundational principle of property insurance pricing, and one that is frequently misunderstood in cross-state subsidization discussions, is that catastrophe loss costs are estimated for the state where they are expected to occur. California wildfire claims experience does not enter the rating calculation for a homeowners policy in the Midwest. Each state's rate level is derived from that state's own expected loss experience, adjusted for trend and development (among other things), with catastrophe loads built from catastrophe models calibrated to the geographic exposures within that state. State insurance regulators enforce this principle by requiring that rates be filed and justified on a state-specific basis.

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Confusion arises because state insurance rating laws may allow insurers to use both state-specific and other data, such as regional or nationwide data. In practice, an insurer will use state-specific data to the extent it is credible and will supplement it with other credible, relevant information where needed. To be "relevant," that data must be a reasonable estimate of expected losses and expenses for the policies to be written in the state.

This distinction is especially important for catastrophe risk. Updated catastrophe models may incorporate new scientific understanding, new claims information, changes in exposure, or changes in environmental conditions that affect more than one state. For example, a major hurricane in Florida may reveal that certain types of structures perform more poorly than expected, or that loss amplification effects are more significant than previously understood. Though these findings came from experience in Florida, hurricane catastrophe models used across the entire Atlantic coast will be updated to reflect these new learnings, which could impact rates in all states with hurricane risk. While this may appear at the surface to be cross-state subsidization, there is a distinct difference: this is not insurers using out-of-state losses to increase rates (cross-state subsidization), but rather a best practice of using the latest science – catastrophe events in other states that may teach insurers, modelers, and regulators something new about the risk that is relevant to other states exposed to the same peril.

When it comes to certain parts of the insurer's rating plan, such as determining the rates for customers based on their individual risks, insurers are encouraged to use their most credible data, which may include nationwide or regional information on issues such as how fire damages buildings, what roofing materials perform best when neighborhoods burn, etc. When discussing state cross-subsidization, it is the overall indication by coverage or peril that is most relevant and the overall indication is a state-based number. A filing that attempted to recover California wildfire losses through Midwest premiums would be actuarially unsound and unlikely to survive regulatory scrutiny. The regulatory architecture of state-based insurance oversight, therefore, provides a structural barrier to the kind of direct cross-state subsidization that researchers and media often allege, while still allowing insurers and regulators to recognize credible, relevant scientific information that improves the assessment of catastrophe risk within each state.

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5. Actuarial standards play an important role in insurance pricing.

The vast majority of property and casualty insurance companies use credentialed actuaries to determine pricing. Those actuaries are bound by professional standards and a Code of Conduct and are subject to discipline if they depart materially from those expectations of professionalism. The standards provide guidance about how actuaries should provide a rate that is the expected value of all future costs associated with an individual risk transfer. Precept 8 of the Code of Professional Conduct specifically states that an actuary "shall take reasonable steps to ensure that such services are not used to mislead other parties," which can include regulators. Deliberate implementation of cross-state subsidization while developing rates would be in violation of the ASOPs and actuarial principles which may constitute a violation of the Code of Professional Conduct. Such violations could lead to disciplinary review and/or action by the Actuarial Board for Counseling and Discipline (ABCD).

For homeowners insurance, actuaries are not required to provide an attestation as to the appropriateness of rates. However, the actuarial standards are still used by regulators as the expected standard for ratemaking.

6. Refer to the CIPR website for considerations when using insurance data.

This section has distinguished the direct allocation of catastrophe losses from the broader market effects that may influence homeowners rates. That distinction matters because it shows why rate regulation must both recognize genuine cost pressures and require that those costs be reflected through supported, risk-based, and reviewable ratemaking. Section II places that role in the broader architecture of homeowners insurance regulation: a layered system designed to protect consumers, preserve market stability, and maintain actuarial discipline.

The longstanding statutory standard that insurance rates shall not be excessive, inadequate, or unfairly discriminatory provides a rich foundation for future research in insurance rate regulation, including more in-depth study of cross-subsidization and numerous other topics. Building from this white paper, research could examine catastrophe exposure, model updates, and proper use of the models; reinsurance practices; insurer capital allocation; market competition; company filed

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rate changes vs. implemented rate changes; target underwriting profit provisions vs. historical profitability, and more.

V. Conclusion: Rate Regulation as Layered Consumer Protection

Rate regulation is a calibrated system that supplements the competitive market forces that exist in most states with regulatory oversight proportionate to the degree of market imperfection and the magnitude of consumer vulnerability.

The architecture of state-based regulation described in Sections I through IV, with its uniform three-part legal standard for insurance rating, delegation of authority to state insurance commissioners, and diverse rate filing requirements, and with a complement of market conduct oversight, reflects the accumulated wisdom of more than a century of insurance regulatory experience.

Rate regulation can and should ensure that cost trends are accurately measured, that actuarial justification is genuine, that unfair discrimination is absent, and that insurers are not exploiting information asymmetries or market concentration to extract excessive profits.

Present regulatory needs include attention to using sophisticated actuarial staff (as rate filing models and support continue to get more complex) and effective market monitoring. The engagement of the actuarial profession, through its standards, its certifications, and its independent professional obligations, is indispensable to the integrity of the rate regulatory process. Actuaries who conduct rate indication analysis in rate filings occupy a position of public trust and professional obligation, and the regulatory system depends on the actuarial community's commitment to honest, rigorous analysis as a foundation for sound ratemaking.

The homeowners insurance market faces significant challenges in the years ahead, from increasing catastrophic disasters to rising replacement costs to the evolving legal environment. Rate regulation, when properly designed and effectively administered, will remain an important tool for ensuring that these challenges are met in a manner that protects consumers, maintains market stability, and preserves the availability of coverage that protects the most important financial asset most American families will ever own.

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The goal of property and casualty ratemaking is to predict the rates that need to be charged on a specific cohort of insurance policies that will be written in the future. The application of appropriate actuarial practices and techniques ensures that those rates are adequate, but not excessive or unfairly discriminatory for covering the expected losses and expenses on those policies, while also allowing for a reasonable return for the risk undertaken. Ratemaking is inherently a prediction of unknown future values. To the untrained eye, a year with few severe storms and catastrophic events might make it seem as if the rates were excessive. And a year with many severe storms and catastrophic events might look like the rates were inadequate. But the ratemaking process accounts for such random fluctuation and prices to the expected frequency of, and claim values associated with, these events in any given year.

Insurers typically use their own state-specific experience to the extent possible for ratemaking purposes. But that experience often needs to be supplemented with additional information to make credible predictions about future losses and expenses on policies that haven't yet been written. This supplemental information can include catastrophe models, other insurers' experience and their rates, experience and statistics made available by advisory and rating organizations, and regional or even countrywide experience and statistics. However, it is important to understand that supplemental information must be adjusted and used only to the extent that it helps predict expected losses and expenses on a specific set of policies in a specific state that will be written in the future. An insurer that would attempt to charge excessive rates in one state to make up for inadequate rates in another would be in violation of state insurance laws and their actuaries would be in violation of actuarial standards of practice. Complaints about the insurer's actuaries (e.g., submitted by state insurance regulators) to the Actuarial Board on Counselling and Discipline could result in professional discipline, up to and including the revocation of their credentials and ability to practice. The insurer's proposed rates would be subject to regulatory scrutiny, and the insurer would likely fail to meet their business objectives.

Property and casualty insurance ratemaking is a complex endeavor undertaken by professionals with standards of practice governing their work. Those studying the actuarial soundness of insurance rates, and effectiveness of state-based rate regulation, would produce more accurate and beneficial research by meeting with state insurance regulators to discuss their methodology and findings as part of their research and in advance of publishing any reports.



Finally, the authors recognize this paper does not conclusively prove that no cross-state subsidization exists between policyholders in any states. That would require significant additional study well beyond the scope of the charge given to the Task Force which produced this paper. Instead, this paper describes the plethora of safeguards in place that are designed to prevent cross-state subsidization from occurring.

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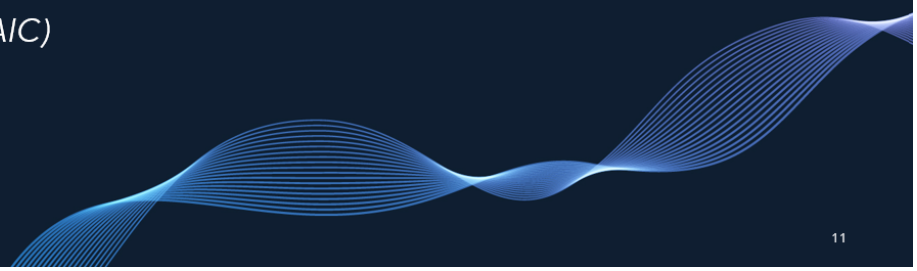
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United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944).

Actuarial Standards of Practice: https://www.actuarialstandardsboard.org/standards-of-practice/#filter=*

5. Hear an Update on the Life Insurance and Annuities (A) Committee Criminal History Project

Jeff Czajkowski (NAIC)



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11

6. Hear Presentations Related to Litigation Issues

Joe Petrelli (Demotech)
Kenneth Klein (California Western School of Law–CWSL)
Peter Kochenburger (Southern University Law Center–SULC)

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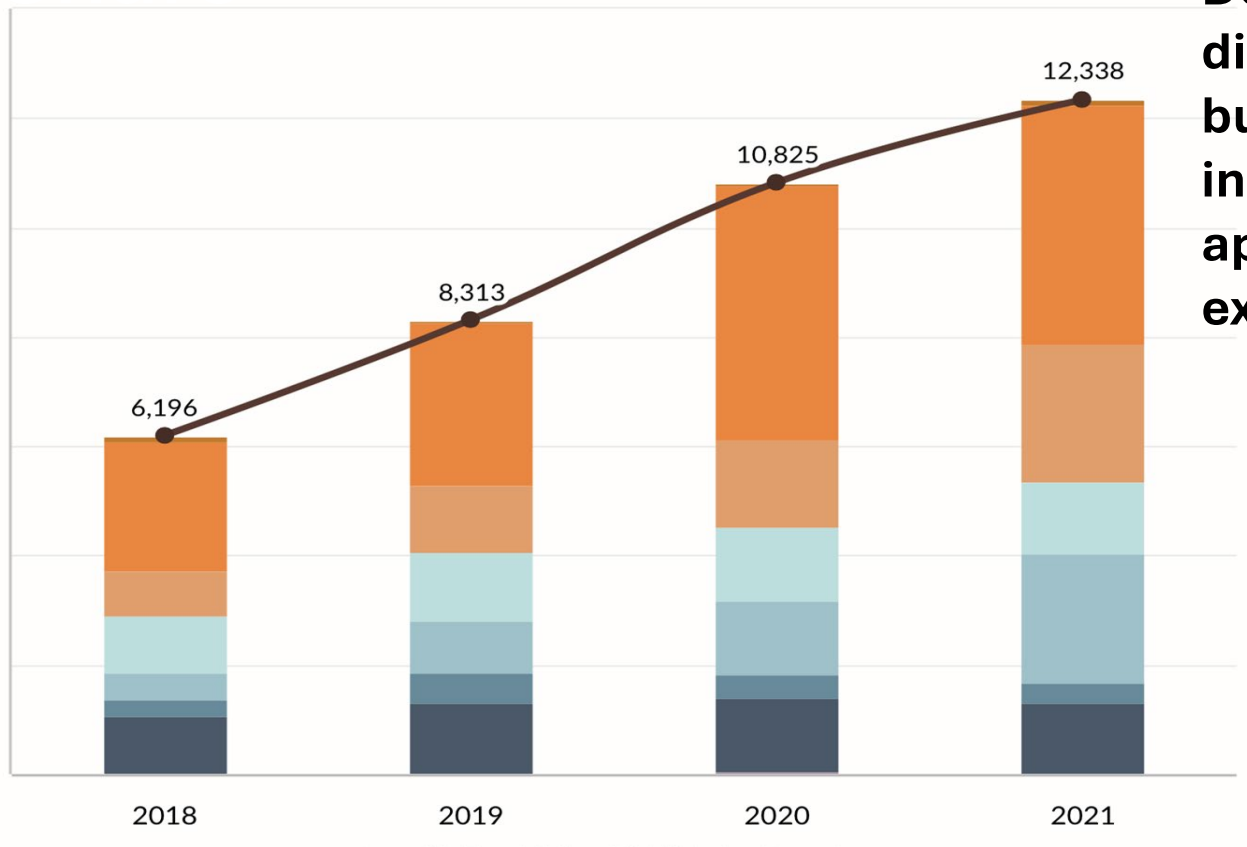
12

Granularity in the Presentation of Advisory Loss Costs Will Assist Regulators Monitor Emerging Causes of Loss

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Disproportionate Litigation Levels Relative to Constant 4%



Demotech's research project led to the discovery of a previously covert online business model of tech-enabled litigation instigation. Disproportionate litigation appeared before traditional reporting fully explained the pressure.

Source: Chief Financial Officer of Florida's Service of Process Reports https://apps.fldfs.com/LSOPReports/Reports/Report.aspx.

What Our Research Project Unearthed

Previously Presented at NAIC, Louisville, KY in March 2023

Litigation Levels Increased at Industrial Scale

Litigation frequency rose disproportionately prior to insurer failure, including American Capital Assurance Corporation, rated A by AM Best. No notification in prior period independent audits or statements of actuarial opinion on loss and LAE reserves.

How? Online Searches Were Redirected

Online advertising, pay-per-click, search manipulation, AI content, litigation platforms, often financed by third-party litigation funding, covertly redirected searches intended for insurers toward sites focused on transitioning claims to contested or litigated status.

Litigated Claims Cost More, and the Anticipated Frequency was Underestimated

Litigated claims cost substantially more than non-litigated claims, nearly 4X for Florida HO, per Florida OIR study. Even if they noticed this, the carriers could not have adjusted rates quickly enough to offset the emerging cost pressure.

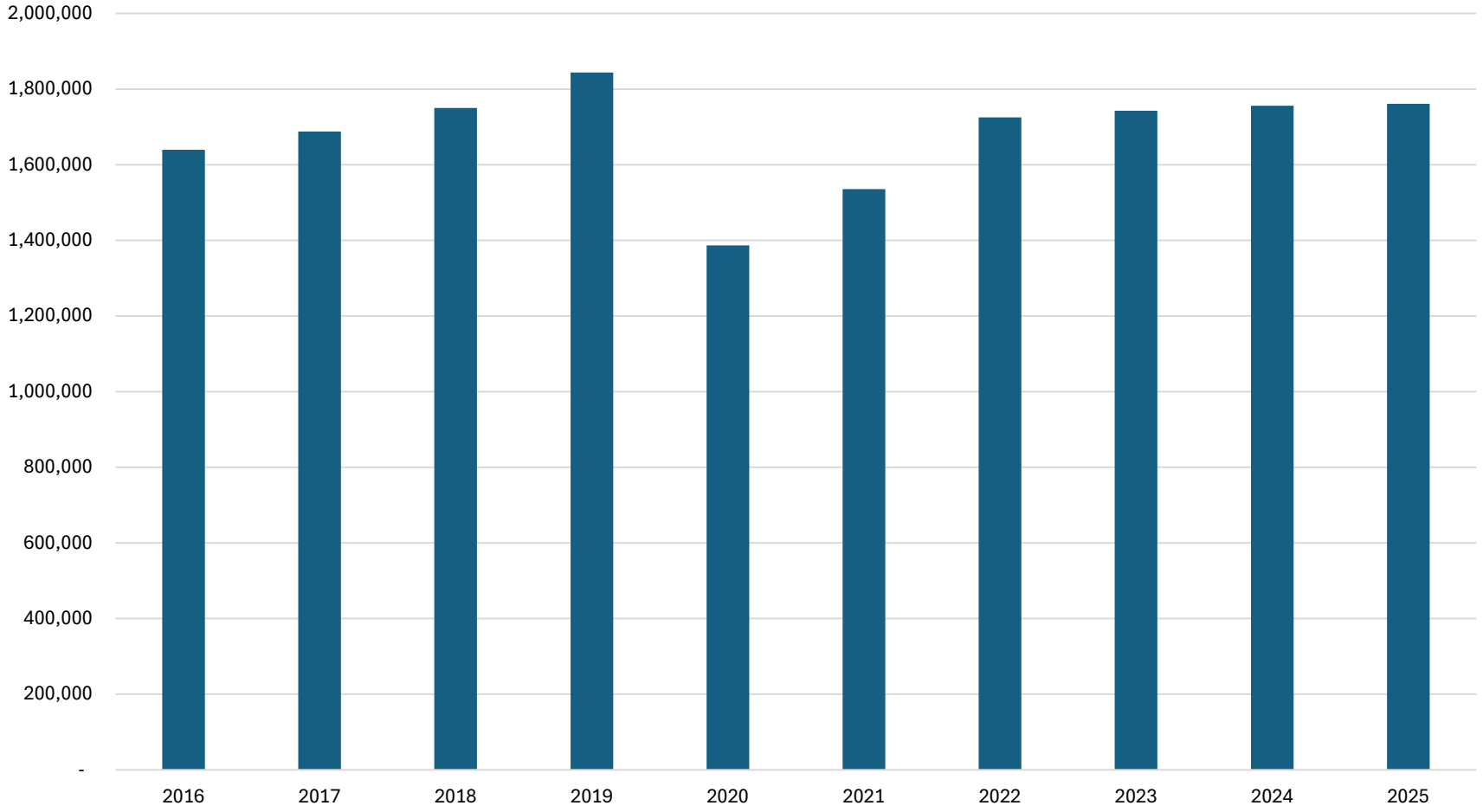
Claim Transitioning - Insurance Data

2025 Schedule P – Part 5 C – Commercial Automobile Liability Claim Counts

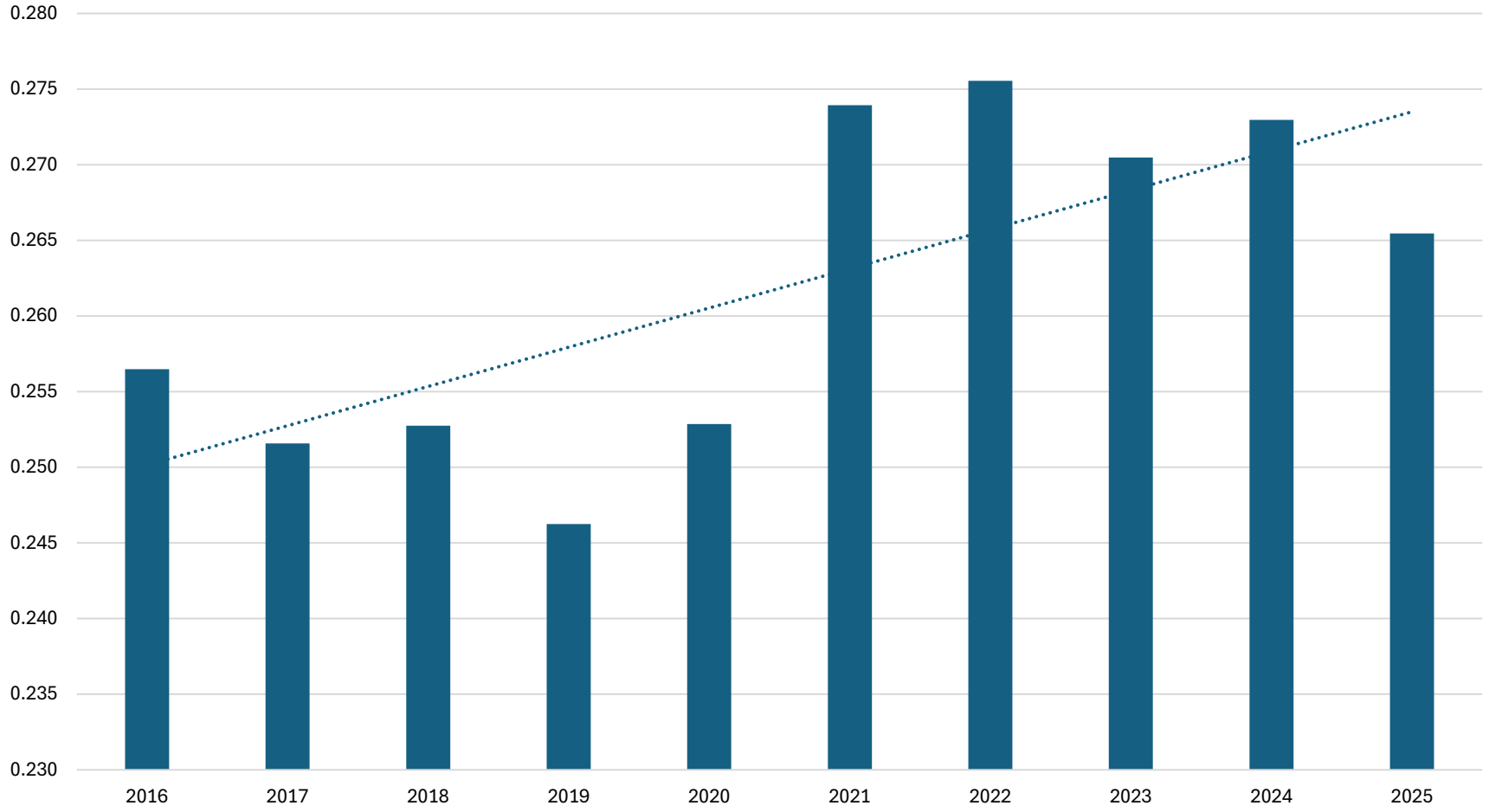
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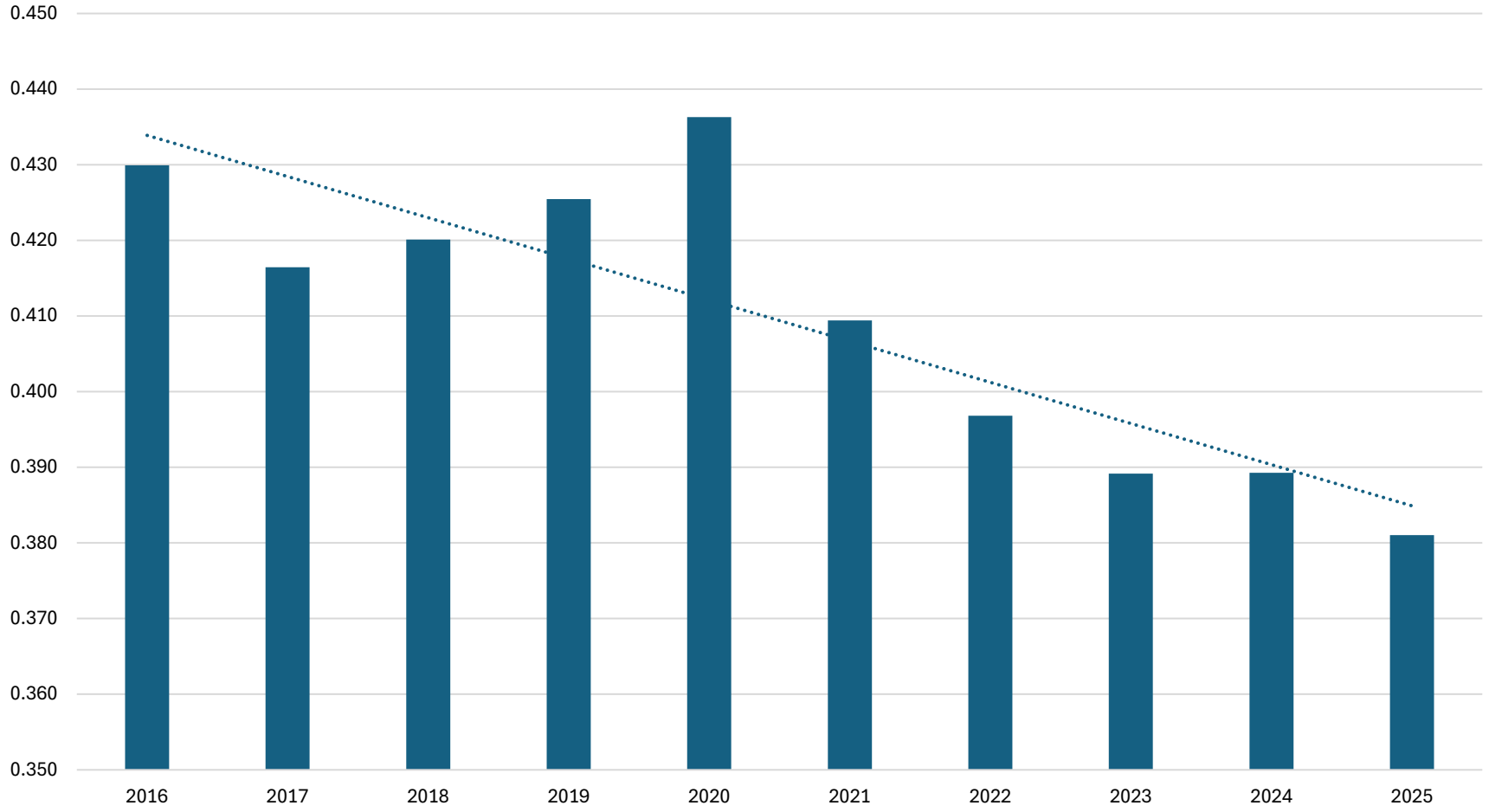
Claims Reported at Year-End



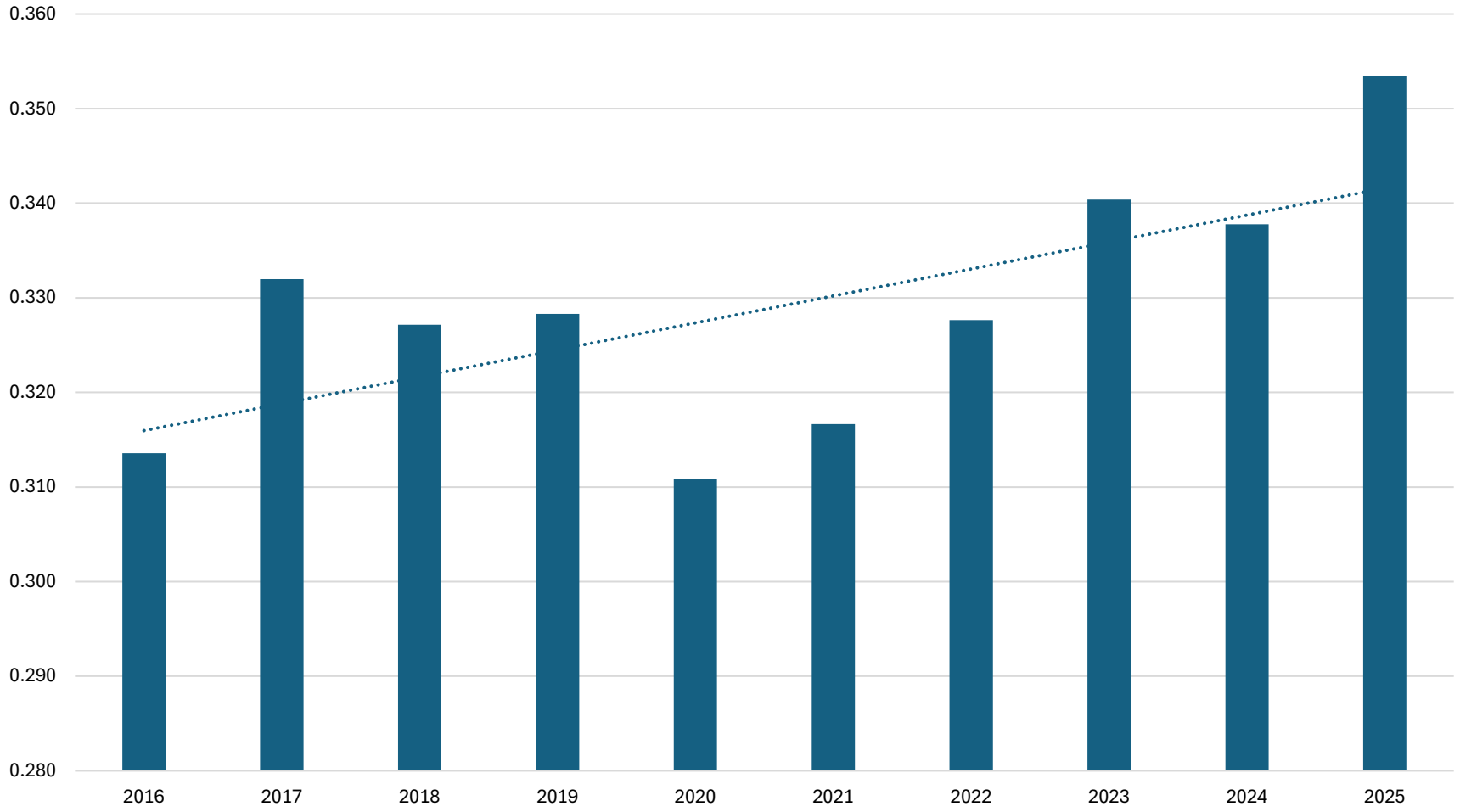
Outstanding - First Report



Closed and Settled - First Report



Closed Without Payment - First Report



Why Litigation Frequency Will Continue to increase

- Alternative Business Structures
- Managed Services Organizations
- Emerging Perspectives within the Legal Profession
- Billions of dollars in Private Equity and Hedge Funds Available
- Proliferation of Litigation Platforms
- Litigation Marketing Companies
- Legal firms transitioning into Technology Firms
  - AI-augmented law firms operating under Arizona's Alternative Business Structure program – First was Eudia in 2025.
- Profits from TPLF are not uniformly taxed at the federal level.

Origin of the Loss Cost Formula

How the Math Works

Composite Loss Cost =
Composite Claim Frequency × Composite Claim Severity

Claim Frequency:
How often
claims occur
% of policyholders

Claim Severity:
The average cost
per claim

Loss costs are the key to the ultimate premium.

However, composite loss costs do NOT reflect Claim Transitioning.

This is A "Composite" Loss Cost

- The formula introduced in the 1980s had an implicit assumption that there was an equilibrium between the Claim Frequency of claims presented by and settled with the policyholder, and the percentage of claims that were litigated.
- The composite Claim Frequency does not discern between the frequency of litigated claims and the frequency of policyholder presented claims.
- There is no measurement of changes by type of claim.

How Changes in Litigation Frequency Can Change Loss Costs

Illustrative example - not a forecast

Measure	Before Reform	After Reform
Total policies	10,000	10,000
Total claims	600	600
Litigated claims	**180**	**120**
Non-Litigated claims	420	480
Average Litigated claim cost	**$49,000**	**$49,000**
Average Non-Litigated claim cost	$15,000	$15,000
Litigated loss cost component	$882	$588
Non-Litigated loss cost component	$630	$720
Total loss cost per policy	**$1,512**	**$1,308**

Fewer litigated claims and the lower severity of policyholder settled claims reduced the loss cost

What Current Reporting Does Not Fully Isolate

Did more of what type claim occur?

Did each type of claim cost more?

Did more claims move to litigated status?

Frequency | Severity | Inflationary Trend | By Claim Status

Will provide information on directional changes that do not exist today

Demotech's Proposed Approach Assists Regulators by Monitoring Claim Transitioning and Changes in Litigation Frequency

- Identify each type of claim as a component, not a composite.
- Closed without pay, litigated, non-litigated claims, and other claim-status categories as appropriate.
- Monitor changes in frequency, severity, and inflationary assumptions by component, by claim status; not aggregate.

Granular measurement leads to better data and insights sooner. Better decisions will also come sooner.



DRAGONFLY:
300 MILLION YEARS OLD



T-REX:
EXTINCT

Nature knows size and survival are independent.

Demotech, Inc. had to prove that to the insurance industry.

Covert Lawyers Destroying Innocent Insurers – Is this really a simple story of good and evil?



Let's start with common ground:

- We (Ken Klein and Peter Kochenburger) support the idea of healthy, private insurance markets that price risk fairly and pay claims promptly.
- We are not cheerleaders for plaintiff's lawyers and in the private sector we both worked on the defense side, including Peter managing coverage and bad faith litigation on behalf of insurers.
  - Lawsuits add expense and may put pressure on insurance affordability and availability. Lawsuits also can expose, repair, and disincentivize improper insurer behaviors. This is one of the major purposes of our tort liability system. There are many procedural mechanisms in place to deter excessive damage and punitive damage verdicts, and to reverse them if they occur.
  - In simplest terms, in the context of insurance, frivolous lawsuits can make things worse; merited lawsuits can make things better.
- We support getting more data. We are very pro-data. Policymaking should not be grounded in intuition and emotional rhetoric. Policymaking should be grounded in data.

But we do have our differences with our friends at Demotech

Consider eight small insurance companies:

- One of these small insurers is AM Best rated as A- (Excellent) until early March 2021. AM Best then cut it to C (Weak) and put it under review with negative implications. On March 25, 2021, AM Best cut it again to D (Poor) and withdrew the rating at the company's request. The *Insurance Journal* reported that per AM Best, the cause of the precipitous ratings collapse was underwriting losses from late-2020 storms, especially in Louisiana.
- A second of these small insurers is AM Best rated B (Fair) and put under review with negative implications on November 19, 2019. On October 21, 2020, AM Best took it off review and kept the B (Fair) rating with a negative outlook. On November 4, 2020, AM Best withdrew the rating at the company's request.
- The remaining six of these eight small insurers have never been AM Best rated.



- As insurance regulators, all eight of these small insurers may be welcome additions to your stressed insurance markets, but certainly we can agree that from a consumer protection perspective, they each merit scrutiny before reaching that conclusion. Because they present higher than ideal risk of failure.
- And I presume we also can agree that we don't want lawyers who specialize in consumer protection lawsuits to sue everyone and anyone willy nilly; rather it would make sense for lawyers to give closer scrutiny to these companies, where there is a stronger incentive for bad behaviors because there is a stronger likelihood of otherwise going out of business..

How does this story end?

- All eight of these small insurers did in fact get sued a lot.
- All eight of these small insurers did in fact go into liquidation.
- Demotech see this as evidence of a “covert online business model of tech-enabled litigation instigation” harming consumers and necessitating immediate lawsuit reform.
- But it is equally possible that these are precisely the companies that most likely were doing things that harm consumers and so need to be held to account.
- Policymaking should rest on a foundation of data over a foundation of intuition.
- Time doesn’t allow for a comprehensive discussion right now. We will limit the remainder of our time to a discussion of a couple of the data points you were presented in 2023, a couple you just heard about, and some conclusions we think already have emerged.

Placing the collection and use of data and so-called covert litigation instigation within the context of social inflation

Social Inflation – A construct, and a successful multi-year public relations and lobbying strategy, so that its existence is assumed, and as defined by its advocates. But how many of these claims are based on accurate data, fair and unbiased assumptions, and objective analysis? Social inflation arguments:

- *Nuclear verdicts:* The number of large plaintiffs' verdicts are increasing. Many of the the verdicts frequently referred to as excessive are later reduced or overturned. Most of these verdicts result from product liability, trade secrets, intellectual property, breach of contract and premises liability litigation. [Marathon Strategies, 2025, 2026 reports]

Question: How do these verdicts influence or affect the cost of homeowners and private automobile insurance?

August 2026 Consumer Liaison Presentation (Amy Bach, Ken Klein, Peter Kochenburger, "*The importance of analyzing complete data related to alleged 'nuclear' verdicts*," pp. 94-115, https://content.naic.org/sites/default/files/national_meeting/snm-materials-cons-liaison-8.10.26.pdf)

Nuclear Verdicts, and the Reptile

- *Claims of litigation abuse* assume that many large plaintiff's verdicts are the result of juries and courts unable to fairly adjudicate claims and control attorney conduct, rather than the merits of the plaintiff's claim or the defendant's actions.
- *Reptile Theory*: The neuroscience first describing the "reptile brain:" has been rejected for years and not considered a viable physiological phenomena. Yet this theory lives on in some sectors, notably tort lawyers and tort litigation. Some of the practices attributed to it are as old as oral advocacy, newer ones are often based on social science. Courts have the authority and have used it to reign in inappropriate jury arguments whether made by counsel for the plaintiffs or the defendants.



Using this Data and the Insurance Promise

- Access to the courts and legal counsel are essential rights and insurance consumers should not be discouraged or penalized through higher insurance rates when doing so, whether individually or collectively in an insurance underwriting pool.
- Tracking and modeling how attorney involvement may increase claim costs and litigation is not new and can provide useful insights for liability insurers defending policyholders in tort litigation. However, using policyholder data to model and predict the *likelihood that the policyholder will sue its insurer* is neither an appropriate risk classification in underwriting, nor appropriate information to consider when negotiating claims with their policyholders, where the insurers' promise is to pay covered claims at their full value not to exceed the policy limits. Modelling "low-balling" (claim optimization) in this context violates state insurance laws..

Litigation Reform arguments often are built on equating correlation to causation. Correlation cannot prove causation nor sort through multiple correlates.

Cost Drivers by Affordability of Home Insurance

Red highlights show less favorable rankings; green highlights show more favorable rankings. See notes on previous pages.

	Expenditure Share	Claim Frequency (CAT)	Claim Frequency (NonCAT)	Claim Severity (CAT)	Claim Severity (NonCAT)	Weather Risk	Other Natural Hazard Risk	Expense Index	Claims Litigation
Florida	3.79	4.02	4.12	$15,933	$14,691	$2,291	$83	19.3%	4.39%
Louisiana	3.84	11.55	4.16	$15,335	$11,705	$1,724	$14	13.4%	3.83%



This is IRC data showing a correlation between Homeowner Insurance premium affordability and claims litigation frequency. Triple-I argues that this correlation is proof that litigation causes unaffordability. But premium unaffordability correlates just as strongly to Weather Risk.

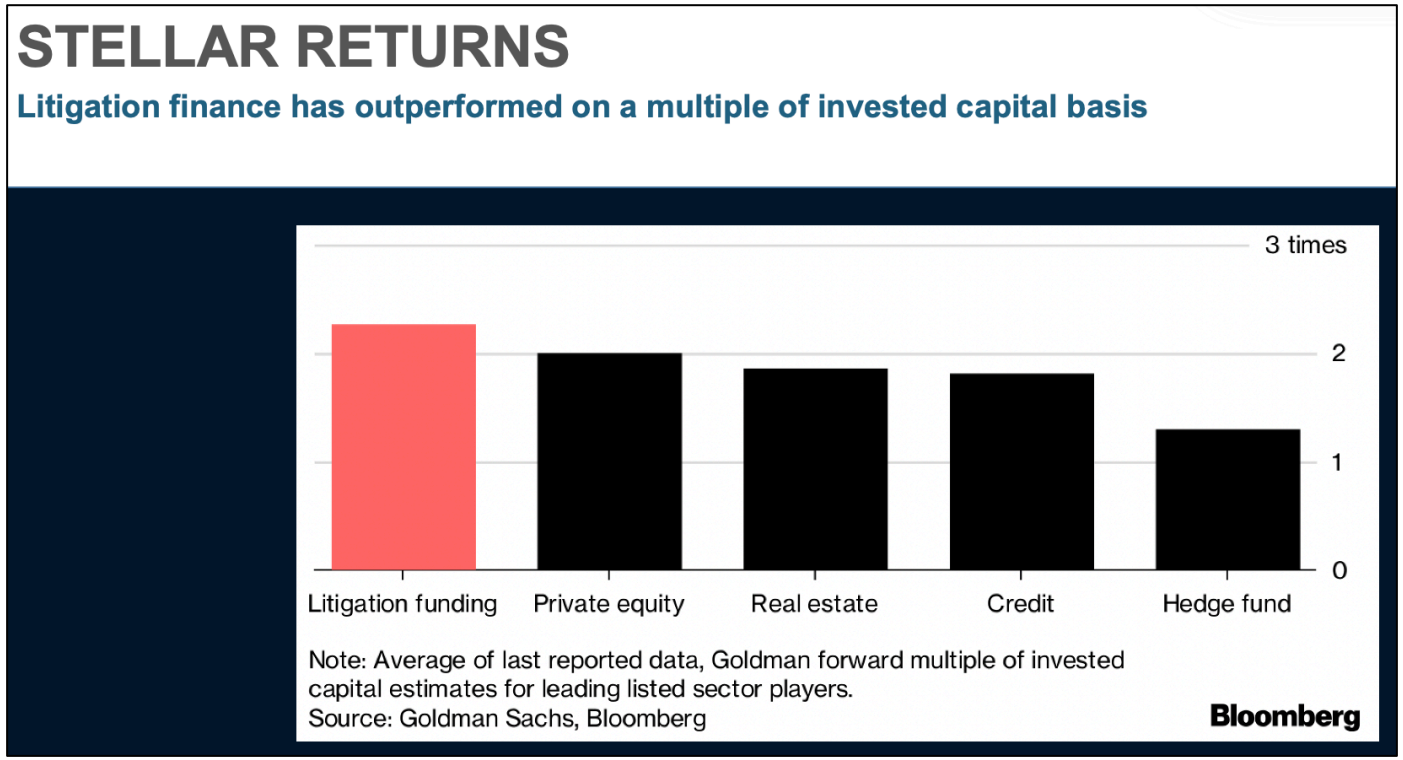
Lack of correlation can disprove causation.

And if we look at the whole chart then the correlation of Claims Litigation to premium unaffordability appears to fall apart, while the correlation to Weather Risk remains strong.

	Expenditure Share	Claim Frequency (CAT)	Claim Frequency (NonCAT)	Claim Severity (CAT)	Claim Severity (NonCAT)	Weather Risk	Other Natural Hazard Risk	Expense Index	Claims Litigation
Utah	0.92	1.03	3.71	$9,255	$11,161	$21	$387	13.2%	0.23%
Oregon	0.99	0.73	2.35	$26,812	$17,563	$5	$129	12.9%	0.41%
Wisconsin	1.16	1.50	2.02	$10,939	$14,140	$174	$4	12.9%	0.20%
Washington	1.18	0.28	2.68	$10,782	$18,014	$4	$189	13.9%	0.33%
New Hampshire	1.19	0.23	1.62	$5,419	$14,714	$303	$7	13.1%	0.43%
Maryland	1.23	2.11	4.84	$9,078	$12,312	$404	$7	13.0%	0.23%
Idaho	1.25	1.14	3.91	$9,745	$12,245	$13	$326	12.6%	0.23%
Delaware	1.31	0.82	3.29	$10,238	$11,709	$303	$9	13.3%	0.27%
Alaska	1.32	0.04	2.35	$7,074	$20,325	$3	$169	13.1%	0.23%
Virginia	1.32	2.05	4.12	$8,430	$11,495	$415	$8	12.9%	0.17%
Pennsylvania	1.33	1.47	3.55	$8,778	$11,308	$139	$4	14.4%	0.65%
Arizona	1.34	0.76	3.58	$8,303	$11,804	$18	$162	13.4%	0.23%
Nevada	1.39	0.17	3.10	$7,213	$13,031	$3	$197	14.2%	0.33%
D.C.	1.46	0.69	4.52	$6,045	$12,234	$53	$1	13.7%	0.39%
Iowa	1.47	6.41	3.34	$12,379	$12,013	$436	$5	12.2%	0.15%
Ohio	1.47	2.04	3.02	$8,980	$11,499	$148	$4	13.1%	0.24%
Maine	1.49	0.52	2.24	$4,536	$14,028	$386	$5	13.1%	0.46%
Vermont	1.49	0.37	2.70	$4,784	$13,914	$117	$10	12.7%	0.33%
New Jersey	1.51	1.64	3.56	$7,399	$13,320	$311	$15	14.4%	0.79%
Illinois	1.56	4.22	2.68	$11,628	$15,131	$180	$1	12.7%	0.25%
Indiana	1.57	2.25	3.02	$9,853	$12,778	$199	$2	12.8%	0.29%
Hawaii	1.59	0.11	2.88	$49,796	$14,993	$112	$159	14.9%	0.37%
Michigan	1.60	1.59	3.22	$7,750	$13,670	$181	$3	13.0%	0.39%
California	1.65	0.92	2.47	$56,785	$21,965	$5	$209	15.7%	0.59%
South Dakota	1.77	2.36	4.77	$12,474	$10,925	$512	$144	12.2%	0.06%
North Carolina	1.78	2.73	3.80	$7,177	$10,715	$897	$13	12.5%	0.14%
West Virginia	1.80	0.56	2.93	$11,995	$15,265	$91	$32	13.8%	0.32%
Massachusetts	1.90	0.58	0.93	$5,530	$16,473	$355	$3	14.7%	0.52%
Minnesota	1.92	4.03	2.98	$17,564	$15,269	$273	$29	12.2%	0.09%
North Dakota	1.97	1.82	4.73	$11,327	$10,534	$583	$52	12.2%	
New York	1.99	1.47	2.79	$7,339	$17,533	$202	$2	14.5%	
Kentucky	2.03	2.48	4.20	$7,749	$10,116	$237	$26	13.0%	0.27%
Connecticut	2.07	2.17	3.27	$9,755	$17,155	$365	$2	13.9%	0.85%
Colorado	2.09	6.35	3.86	$12,750	$14,061	$376	$115	12.4%	0.22%
Kansas	2.12	2.98	4.23	$11,950	$11,401	$404	$29	12.3%	0.09%
Wyoming	2.14	2.71	5.00	$13,427	$13,044	$86	$121	11.8%	0.13%
Rhode Island	2.15	2.24	4.69	$6,199	$13,185	$314	$2	14.0%	0.62%
Missouri	2.16	3.18	3.29	$11,320	$13,765	$279	$12	12.5%	0.31%
Nebraska	2.20	4.46	3.90	$11,725	$9,394	$674	$13	11.9%	0.06%
South Carolina	2.20	2.25	3.50	$7,843	$11,398	$1,514	$15	13.7%	0.27%
New Mexico	2.29	1.71	4.85	$10,883	$10,130	$38	$211	12.8%	0.28%
Georgia	2.30	3.54	4.55	$8,968	$12,769	$485	$12	12.9%	0.19%
Tennessee	2.33	2.07	3.88	$12,803	$12,642	$173	$6	13.1%	0.24%
Montana	2.45	1.64	3.73	$18,356	$15,871	$39	$203	12.9%	0.33%
Alabama	2.68	2.94	4.26	$10,080	$12,651	$840	$9	12.8%	0.23%
Texas	2.86	6.88	3.75	$11,435	$12,332	$750	$48	13.6%	0.50%
Arkansas	2.91	3.03	5.24	$10,396	$11,209	$394	$43	12.4%	0.06%
Mississippi	3.64	2.45	4.45	$10,325	$12,494	$1,010	$32	12.5%	0.20%
Oklahoma	3.66	3.76	4.06	$13,023	$13,446	$509	$116	13.0%	0.26%
Florida	3.79	4.02	4.12	$15,933	$14,691	$2,291	$83	19.3%	4.39%
Louisiana	3.84	11.55	4.16	$15,335	$11,705	$1,724	$14	13.4%	3.83%

Another example of correlation≠causation

This is a slide Demotech showed you in 2023. They argued it was evidence of the need for more litigation reform.



Another interpretation, however, is that insurers are so frequently unfairly adjusting claims that investing in suing them is a better risk-adjusted rate of return than private equity, real estate, credit, or hedge funds.

In other words, here the correlation could establish that insurers, not TPLFs are the problem needing a cure.

Two conclusions that data will never change:

- Both insurers and lawyers seek to access all data tools they can to identify the best devotion of their time and resources. For lawyers, it is pre-filing investigation to determine whether the likely return will cover the cost. For insurers, it is underwriting to determine whether to write the risk and if so, then at what price. Regardless of the bumper sticker label we put on it, insurers and lawyers are engaging in the same business practice.
- Not all litigation is bad litigation. Making all litigation harder to file and harder to win:
  - Harms the most impacted victims, and
  - Creates a moral hazard incentive for insurers to engage in more misbehaviors.
  - Could cause more harm than good.

Or put another way…

We already can and should reject the simplistic narrative: "Insurance good; lawsuits bad."

More data will allow us to know where that narrative is wrong (or right), and what to do about it.

But it is worth recalling that insurers already have that data and aren't resting their argument on it; this may already tell us a lot about what the data shows.

For more detail or if you would like to discuss further:

Peter.kochenburger@sulc.edu

860-655-8612

kklein@cwsl.edu

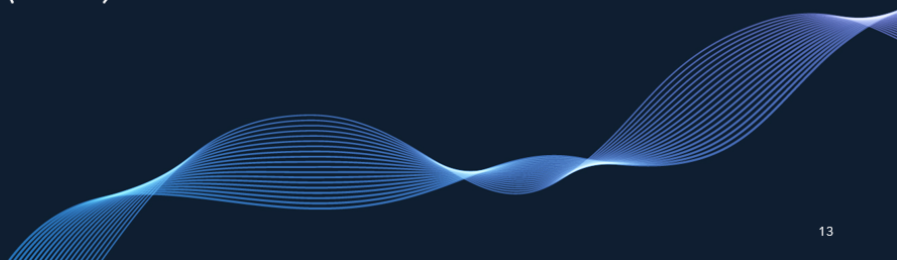
858-212-5365

Kenneth S. Klein, *The First Thing We Do Is Kill All the Lawsuits*, 44:1 REV. LITIG. 47 (2024).

Kenneth S. Klein, *The Case for Pausing Any Immediate Embrace of the Social Inflation Argument for Legal System Reforms*, 42 J. INS. REG. 160 (2023).

7. Hear Presentation on Mitigation from Wildfire Defense Systems (WDS)

David Torgerson (WDS)



NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

13







CONFLAGRATION

Community Resiliency Requires More Than Mitigation Alone

David Torgerson, P.E., Executive Chairman, *Wildfire Defense Systems, Inc.*

November 17, 2026

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Conflagration risk is materially different from wildfire.

Traditional mitigation alone is unlikely to stop or slow community-scale fire spread once it transitions into conflagration, with the largest losses increasingly occurring in high-density built environments.





	WILDFIRE	CONFLAGRATION
Risk Drivers	Embers and direct flames	Radiant heat and structure-to-structure ignitions
Loss Potential	Localized, moderate	Enterprise-wide, catastrophic, cascading
Heat Exposure	2 – 10 *minutes* (from burning vegetation)	1 – 2 *hours* (from burning structures)
Key Thresholds	Conduction and Convection	<30 ft. between structures + >15 kW/m^2 radiant heat

Key Takeaway

Preventing catastrophic insured losses requires disrupting structure-to-structure fire spread once a community is ignited.

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Mitigation works on wildfire but not conflagration.

Wildfire mitigation measures support community resiliency and reduce ignition risk – but not conflagration.


Ignition-resistant construction


Strategic community firebreaks


Ember-resistant vents


Distributed water systems


Fire resistant or noncombustible roofs


Elimination of connective fuels


Noncombustible zone zero standards near structures


Subdivision-scale hardening


Backup power for suppression infrastructure

Key Takeaway

Despite mitigation investment, communities still face conflagration risk.

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Wildfire safe ≠ conflagration safe.

Mitigation alone is insufficient to address community-scale conflagration risk.

MITIGATION CAN...

- ✓ **Reduce** the likelihood of structure ignition
- ✓ **Limit** the conditions that allow wildfire to spread
- ✓ **Increase** structural resiliency before wildfire threat emerges

MITIGATION CANNOT...

- × **Change** the separation distance between homes
- × **Disrupt** radiant heat
- × **Eliminate** the tail risk of conflagration



CONFLAGRATION REQUIRES ENGINEERING CONTROLS

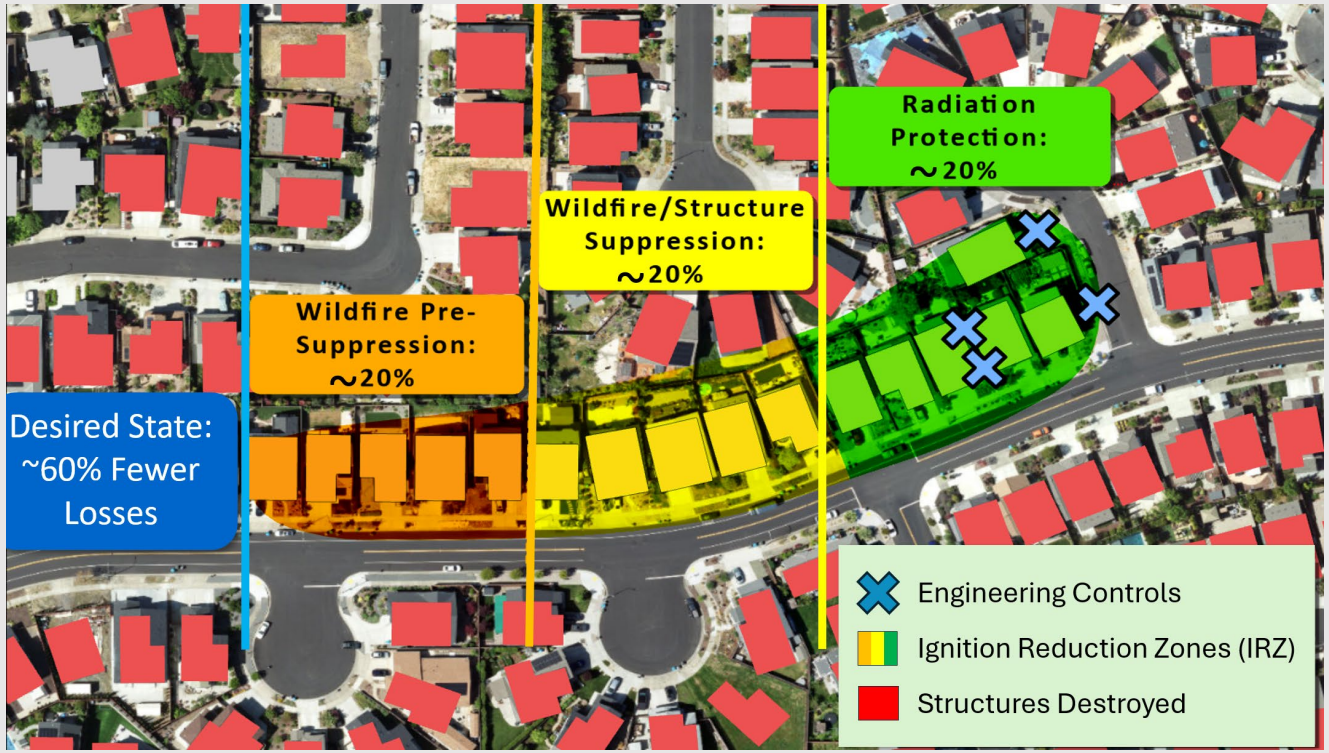
- ➢ **Mitigation addresses** individual ignition scenarios
- ➢ **Engineering controls address** broader conflagration risk
- ➢ **Climate change increases** the number and frequency of severe wildfire starts

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Engineering Controls Tame Conflagration Radiation

To tame conflagration, you must break radiation. To break radiation, you need engineering controls.

Recent Conflagration Events		
Washington	Old Trails Fire	2026
California	Palisades/Eaton	2025
Canada	Jasper Fire	2024
Hawaii	Lahaina Fire	2023
Colorado	Marshall Fire	2021
California	Camp Fire	2018
California	Woolsey Fire	2018
California	Thomas Fire	2017
California	Tubbs Fire	2017



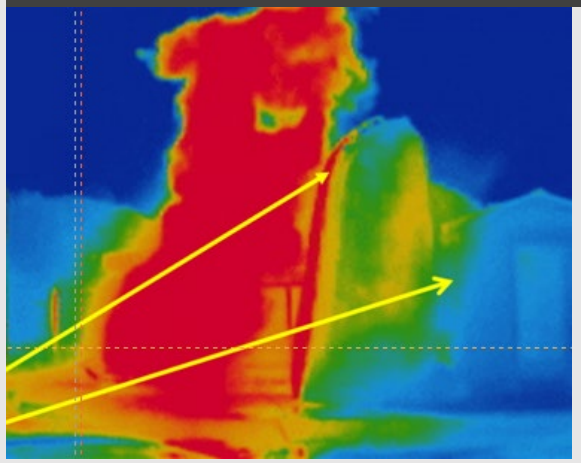
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Engineering Controls Disrupt Radiant Heat Transfer



MORE STRUCTURES PRESERVED
from engineering controls disrupting structure-to-structure ignitions

RADIANT HEAT EXPOSURE



Temperatures

Structure Shield
948˚F

Target Structure
85˚F

Engineering controls **can**

- ✓ **Disrupt** radiant heat which causes conflagration
- ✓ **Respond** to environmental factors
- ✓ **Preserve** life safety by being self-operable

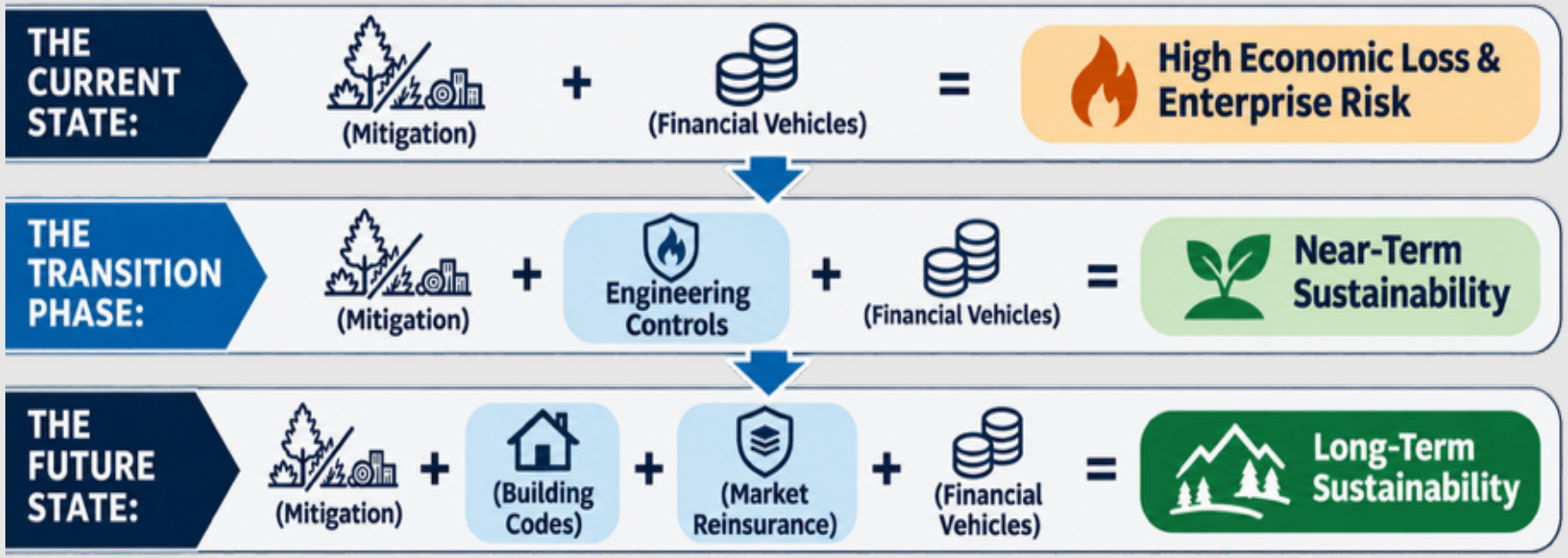
» WDS has developed an engineering control with service trucks across the West available to clients

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Changing Outcomes by Taming Conflagration

Building codes are a type of engineering control, however…

It will take **50-80 years** for the built environment to adapt and yield conflagration-resilient communities.



RADIANT HEAT OCCLUSION ZONES



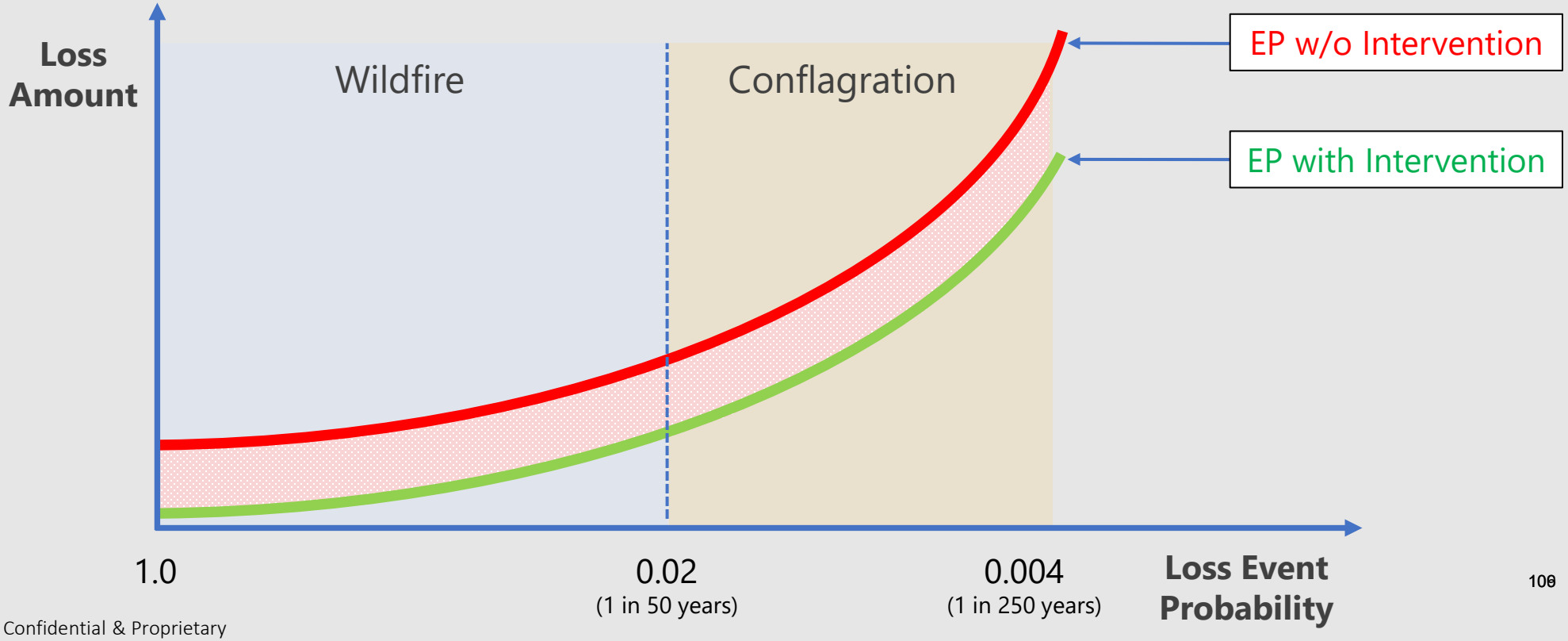
"Miracle Homes" exist naturally due to radiant heat occlusion zones.

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Active loss intervention creates sustainability in the near-term.

Reducing the conflagration risk factor to a more manageable level makes insurance more available across communities and promotes market stability.

Total Value at Risk Decreases by Taming Conflagration

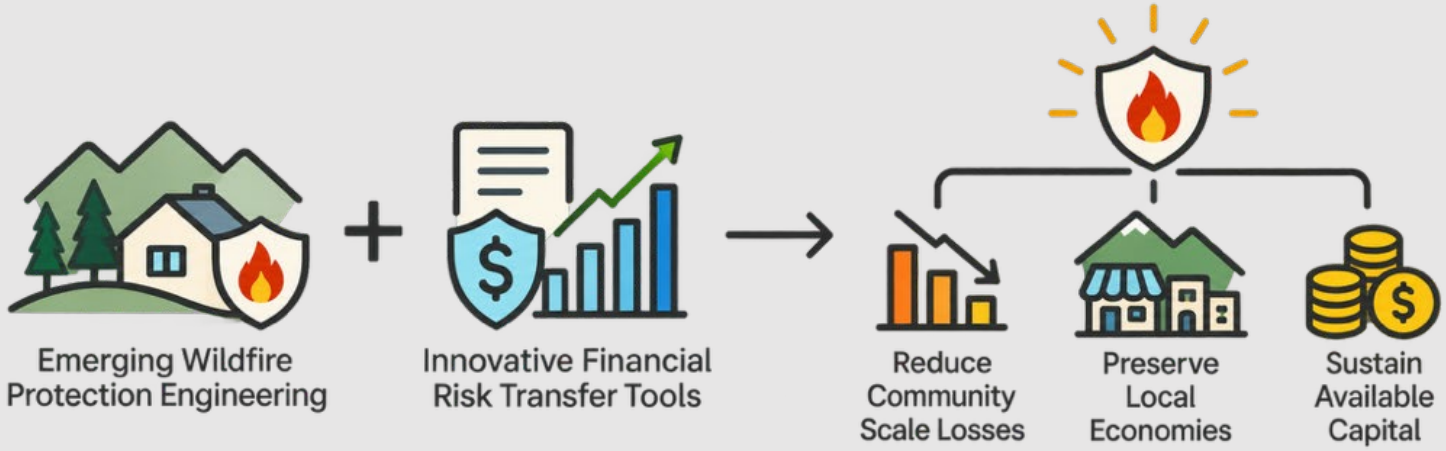


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The Goal is Community Resilience.

Capital alone will not solve the challenges of conflagration or eliminate its risks.

A NEW WAY FORWARD



Key Takeaway

Engineering moves communities from conflagration loss to resilience.

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Together, we can turn wildfire risk into greater readiness and community resilience.

Questions: Please reach out to Nick Lauria – nlauria@wildfire-defense.com

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