Life Amendments Adopted by the Life Insurance and Annuities (A) Committee July 13, 2026
Pending Adoption by the joint Executive (EX) Committee and Plenary, Aug. 14, 2026

Amendments for the 2027 Valuation Manual

LATF VM Amendment	Valuation Manual Reference	Valuation Manual Amendment Proposal Descriptions	LATF Adoption Date	Page Number
2025-05	Guidance notes under VM-20 Section 9.G.8 and VM-21 Section 4.A.5	This amendment provides clearer definitions and examples of what constitutes as "contractually guaranteed" revenue sharing income.	10/2/25	3
2025-13	VM-20 Section 3.C.1.h.i	This amendment clarifies the timing and documentation requirements for companies seeking approval to use a non-U.S. valuation mortality table in compliance with the *Valuation Manual*.	11/6/2025	6
2025-15	VM-20 Sections 9.F.3, 9.F.4, and Appendix 2	This amendment updates guidance for credit rating mapping to use the more granular NAIC Designation Category and corrects how NAIC tables are accessed.	1/29/2026	8
2025-12	VM-22 Section 3.C and VM-31 Section 3.F.14	This amendment strengthens disclosure expectations and clarifies the role of the VM-22 Standard Projection Amount (SPA). It also reinforces credibility standards for company assumptions and confirms that the SPA is not a safe harbor.	2/26/2026	12
2025-16	VM-20 Section 7.E.1.g, VM-21 Section 4.D.4.b, and VM-22 Section 4.D.3.b	This amendment implements a consistent credit quality blend for the reinvestment guardrail across VM-20, VM-21, and VM-22.	3/21/2026	15
2025-17	VM-20 Section 5.G	This amendment allows reflection of an aggregation benefit in the VM-20 stochastic reserve.	3/22/2026	17
2024-12	VM-50 Sections 2.B and 4.B VM-51 Sections 2, New Section 3, Appendices 1-4, and New Appendix 5	This amendment establishes a Statistical Plan for Group Annuity Mortality and designates the NAIC as the Experience Reporting Agent.	4/9/2026	18
2026-02	VM-21 Sections 4.A.7 and 4.D.1 and VM-22 Sections 4.A.7 and 4.D.1.iii	This amendment updates VM-21 and VM-22 references to reflect IMR being attributed to a group of policies or contracts, not a group of assets.	4/30/2026	49
2026-03	VM-22 Section 6.C.5	This amendment clarifies calculation mechanics in the VM-22 SPA dynamic lapse formula, specifically in the Market Factor and Rate Factor formulas.	4/30/2026	52
2025-14	Section II, VM-21 Section 6.C.9, and VM-V Section 1.B	This amendment clarifies the reserving treatment for variable annuities in payout, specifically permitting classification as either variable annuities (consistent with their pre-annuitization treatment, subject to domiciliary commissioner approval) or as fixed annuities.	6/11/2026	54
2026-04	VM-M Section 1.H.1	This amendment clarifies that the 2017 CSO refers to the Loaded version of the tables unless Unloaded tables are specifically referenced.	6/11/2026	59
2026-05	Various Sections of VM-20, VM-21, VM-22, VM-31, VM-50, and VM-51	This amendment corrects editorial inconsistencies across multiple sections of the Valuation Manual, including reference errors and formatting discrepancies, to ensure clarity, consistency, and technical accuracy.	6/11/2026	61
2025-18	VM-22 Sections 1.A and 2.A	This amendment clarifies the scope of VM-22 with respect to deposit-type contracts.	6/11/2026	67
2025-20	VM-22 Section 3.F and VM-31 Section 3.F.14.	This amendment removes aggregation criteria for payout and deferred annuities in VM-22 and adds a disclosure in VM-31 for the aggregation benefit.	6/11/2026	68

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

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

   Identification:
   Rachel Hemphill, Texas Department of Insurance
   Jacob Allensworth, Texas Department of Insurance
   Elaine Lam, California Department of Insurance
   Ben Slutsker, Minnesota Department of Commerce

   Title of the Issue:
   Modify the guidance notes under VM-20 Sections 9.G.8 and VM-21 Sections 4.A.5 to provide clearer definitions and examples of what constitutes as "contractually guaranteed" revenue sharing income

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

   Guidance notes under VM-20 Sections 9.G.8 and VM-21 Sections 4.A.5

   January 1, 2025 NAIC Valuation Manual

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

   See attached.

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

   This APF adds additional examples of provisions in a revenue-sharing agreement that would prevent the revenue-sharing income from being considered "contractually guaranteed". Specifically, the new examples highlight provisions where revenue-sharing payments depend on the status or balance of a particular plan or fund, making the income non-guaranteed. These additions aim to clarify what qualifies as "contractually guaranteed" revenue-sharing income and what does not.

   Revise to take out of guidance notes and make regular text, as they clarify revenue-sharing requirements.

Dates: Received	Reviewed by Staff	Distributed	Considered
02/10/2025	S.O.		
Notes: APF 2025-05 2/20/25:Revised to include cover letter question on appropriateness of guidance note vs. language in body and clarification of including both affiliated and nonaffiliated entities. 3/22/25: Add a clarifying sentence in two places, and update to move text out of guidance notes. 4/24/25: replaced "level" with "rate" when referring to revene-sharing income in two additional places for consistency 7/21/2025: After ACLI comment and discussion with a company, updates highlighted in yellow			

VM-20, Section 9.G.8 (Editorial Note: also remove boxing around text.)

~~**Guidance Note:**~~ Provisions ~~such as one~~ that give~~s~~ the entity (affiliated or non-affiliated) paying the revenue-sharing income ~~GRSI~~ the option to unilaterally stop or change the ~~level~~ rate of income paid would prevent the income from being guaranteed. Similarly, if the revenue-sharing income is contingent upon the status of a particular plan or fund, and that plan or fund can be terminated, replaced, or not renewed by the paying entity without being replaced by a plan or fund that would result in the same level of guaranteed revenue-sharing income, the revenue-sharing income would not be considered guaranteed. Furthermore, if the ~~level~~rate of revenue-sharing income is tiered or otherwise depends on the total balances of a particular plan or fund, a portion or the entirety of the income (depending on the structure of the performance-based provisions) would not be considered guaranteed beyond the lowest tier unless all the tiers are guaranteed and explicitly modeled at such level of granularity. If the portion of the revenue-sharing income that is contingent can't be readily identified and separated, then the entirety of revenue sharing for the agreement should be considered non-guaranteed. However, if such ~~an~~ option~~s~~, contingencies, or dependencies become~~s~~ available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed ~~up to the time~~until the point ~~the option first becomes available.~~at which any such options, contingencies, or dependencies first become available.

~~**Guidance Note:**~~ If the agreement allows the company to unilaterally take control of the underlying fund fees that ultimately result in the revenue sharing, then the revenue is considered guaranteed up until the time at which the company can take such control. Since it is unknown whether the company can perform the services associated with the revenue sharing agreement at the same expense level, it is presumed that expenses will be higher in this situation. Therefore, the revenue-sharing income shall be reduced to account for any actual or assumed additional expenses.

VM-21, Section 4.A.5 (Editorial Note: also remove boxing around text.)

~~**Guidance Note:**~~ Provisions ~~such as one~~ that give~~s~~ the entity (affiliated or non-affiliated) paying the revenue-sharing income the option to unilaterally stop or change the ~~level~~ rate of income paid would prevent the income from being guaranteed. Similarly, if the revenue-sharing income is contingent upon the status of a particular plan or fund, and that plan or fund can be terminated, replaced, or not renewed by the paying entity without being replaced by a plan or fund that would result in the same level of guaranteed revenue-sharing income, the revenue-sharing income would not be considered guaranteed. Furthermore, if the ~~level~~rate of revenue-sharing income is tiered or otherwise depends on the total balances of a particular plan or fund, a portion or the entirety of the income (depending on the structure of the performance-based provisions) would not be considered guaranteed. If the portion of the revenue-sharing income that is contingent can't be readily identified and separated, then the entirety of revenue sharing for the agreement should be considered non-guaranteed beyond the lowest tier unless all the tiers are guaranteed and explicitly modeled at such level of granularity. However, if such ~~an~~ option~~s~~, contingencies, or dependencies become~~s~~ available only at a future point in time, and the revenue up to that time is guaranteed, the income is considered guaranteed ~~up to the time the option first becomes available~~until the point at which any such options, contingencies, or dependencies first become available.

~~**Guidance Note:**~~ If the agreement allows the company to unilaterally take control of the underlying fund fees that ultimately result in the revenue sharing, then the revenue is considered guaranteed up until the time at which the company can take such control. Since it is unknown whether the company can perform the services associated with the revenue sharing agreement at the same expense level, it is presumed that expenses will be higher in this situation. Therefore, the revenue-sharing income shall be reduced to account for any actual or assumed additional expenses.

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

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

   Identification:
   Rachel Hemphill, Texas Department of Insurance
   Fei Jiang, Texas Department of Insurance

   Title of the Issue:
   Modify VM-20 Sections 3.C.1.h.i to clarify the timing and documentation requirements for companies seeking approval to use a non-U.S. valuation mortality table in compliance with the Valuation Manual.

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

   2025 Valuation Manual, VM-20 Sections 3.C.1.h.i

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

   See attached.

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

   This proposal is necessary because, during the first instance in which LATF was asked to consider the use of non-U.S. mortality tables, the review process revealed two major challenges: (1) the requests were not submitted early enough in the review cycle, and (2) the supporting documentation provided was insufficient to establish confidence in the appropriateness of the proposed tables. As the use of non-U.S. mortality assumptions may become more frequent, this amendment aims to establish clearer expectations around both timing and the minimum supporting materials required for such requests, thereby improving transparency, consistency, and efficiency in future reviews.

Dates: Received	Reviewed by Staff	Distributed	Considered
9/18/25	SO		
Notes: 2025-13			

VM-20, Section 3.C.1.h.i

The company shall use a non-U.S. valuation mortality table based on a non-U.S. industry mortality table developed as described in Section 9.C.3.b.i. Companies using these tables shall seek approval from the Life Actuarial (A) Task Force by addressing to the chair of the Life Actuarial (A) Task Force. For t~~T~~he non-U.S. mortality tables that are to be used in the year-end YYYY valuation the company shall submit its request by June 1st of YYYY accompanied by the following supporting documentation:

a) An analysis of the valuation results before and after applying the non-U.S. mortality table and historical mortality improvement rates, with and without any adjustment factors.
b) For any proposed adjustment factors (e.g., multiplicative scalars) to the published non-U.S. mortality table or historical mortality improvement rates, the company shall provide robust support that the resulting table and historical mortality improvement factors for the non-U.S. country are at least as conservative as the 2017 CSO and historical mortality improvement developed by the SOA and adopted by LATF for the U.S. population. For proposed adjustment factors that result in a lower mortality level than the base non-U.S. mortality table, the company shall provide robust support that there are large geographic or other clear segments of the non-U.S. country that have significantly more heterogeneous mortality than can be found in the U.S. population. Showing the company's A/E relative to the non-U.S. base table is not sufficient for this purpose.
c) An Actual-to-Expected (A/E) analysis based on the company's historical experience and the proposed non-U.S. mortality table and historical mortality improvement rates, with and without any adjustment factors.
d) Discussion and support for why mortality levels and mortality improvement rates are higher or lower in the local jurisdiction than in the relevant U.S. insured population.
e) Copies of external studies or publications to provide support, whenever available.

The non-U.S. mortality tables that are to be used in the year-end YYYY valuation should be approved by the Life Actuarial (A) Task Force before September 30 of YYYY. ~~should be approved the Life Actuarial (A) Task Force before September of YYYY.~~ If this timeline is not met, the company shall use the relevant non-U.S. mortality tables used in the prior year; if there ~~is~~are no relevant prior year non-U.S. mortality tables used, the company shall use the relevant U.S. mortality tables.

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

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

   Identification:
   Rachel Hemphill, Texas Department of Insurance

   Title of the Issue:
   Update VM-20 Section 9.F.3 and 9.F.4 and Appendix 2 to use the NAIC Designation Category

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

   2026 Valuation Manual, VM-20 Sections 9.F.3 and Appendix 2

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

   See attached.

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

   As noted in the older guidance notes, PBR credit ratings gave a more granular designation than what was used for NAIC designations. Now that the more granular NAIC Designation Category is available, a separate more granular determination is no longer needed.

   Note that updates to VM-20 will automatically update what is used for VM-21 and VM-22, which point to these sections of VM-20.

   Proposed mappings for residential mortgage loans and insured or guaranteed commercial or guaranteed loans are based on comparison of the RBC factors for these assets to those for commercial mortgages.

   This APF also corrects references to which tables are currently published on the NAIC website and which are available upon request. The NAIC publishes the factors that are to be used. The tables documenting interim steps of the calculation are available upon request, but are not published to avoid inadvertent errors.

Dates: Received	Reviewed by Staff	Distributed	Considered
10/28/25	SO		
Notes: 2025-15			

VM-20, Section 9.F.3 and 9.F.4

3. Determination of PBR Credit Rating

a. ~~Table K, referenced in Appendix 2 Section H, converts the ratings of NAIC approved ratings organizations (AROs) and NAIC designations to a numeric rating system from 1 through 20 that is to be used in the steps below~~Except for assets covered by Section 9.F.3.b through 9.F.3.d below, the PBR credit rating is based on the NAIC Designation Category, as described in the instructions to the annual statement for Schedule D, with 1.A – 1.G mapped to 1 – 7, 2.A – 2.C mapped to 8 – 10, 3.A – 3.C mapped to 11 – 13, 4.A – 4.C mapped to 14 – 16, 5.A – 5.C mapped to 17 – 19, and 6 mapped to 20. ~~A rating of 21 applies for any ratings of lower quality than those shown in the table.~~

~~b. For an asset with an NAIC designation that is derived solely by reference to underlying ARO ratings without adjustment, the company shall determine the PBR credit rating as the average of the numeric ratings corresponding to each available ARO rating, rounded to the nearest whole number.~~

~~c. For an asset that is not a commercial mortgage and that has an NAIC designation that is not derived solely by reference to underlying ARO ratings without adjustment, the company shall determine the PBR credit rating as the second least favorable numeric rating associated with that NAIC designation.~~

~~d.~~b. Except for assets covered by Section 9.F.3.d below, f~~F~~or a commercial or agricultural mortgage loan, the ~~company shall determine the~~ PBR credit rating ~~as the Table K lookup of the numeric rating corresponding to the loan's NAIC commercial mortgages (CM) category, where the latter is assigned by the company in accordance with NAIC life RBC instructions~~is based on the NAIC Commercial Mortgage Designation, with 1 mapped to 7, 2 mapped to 10, 3 mapped to 11, 4 mapped to 12, 5 mapped to 13, and 6 – 7 mapped to [20].

c. Except for assets covered by Section 9.F.3.d below, f~~F~~or a residential mortgage loan, the PBR credit rating is based upon the description found in the Annual Statement, Asset Valuation Reserve Default Component Page, with Line 41 mapped to 7, Line 50 mapped to 10, and line 55 mapped to 11.

~~e.~~d. For a commercial or residential loan that is ~~I~~insured or ~~G~~guaranteed, the PBR credit rating is mapped to 5.

~~**Guidance Note:** The 1 through 21 PBR credit rating system attempts to provide a more granular assessment of credit risk than has been used for establishing NAIC designations for RBC and asset valuation reserve (AVR) purposes. The reason is that unlike for RBC and AVR, the VM-20 reserve cash flow models start with the gross yield of each asset and make deductions for asset default costs. The portion of the yield represented by the purchase spread over Treasuries is often commensurate with the more granular rating assigned, such as A+ or A-. Thus, use of the PBR credit rating system may provide a better match of risk and return for an overall portfolio in the calculation of VM-20 reserves. However, for assets that have an NAIC designation that does not rely directly on ARO ratings, a more granular assessment consistent with the designation approach is not currently available.~~

~~**Guidance Note:** The Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), which establishes the rules for setting NAIC designations, underwent significant change during 2009-2010, particularly in the area of assessing the credit risk of structured securities. The NAIC Valuation of Securities (E) Task Force implemented an interim solution in 2009 to set designations for non-agency RMBS based on modeling~~

~~by a third-party firm. The Task Force is developing a long-term solution for these and other structured securities, such as commercial mortgage-backed securities (CMBS), that may involve a combination of modeling and other methods, such as "notching up" or "notching down" the result derived by reference to ARO ratings. In all such cases where the ARO rating basis is either not used at all or is adjusted in some way, the intent is that paragraph (c) be used to determine the PBR credit rating. Another common example where (c) is to be used would be securities that are not Securities Valuations Office (SVO) filing exempt (FE), such as many private placement bonds. For example, a private placement that was not FE and was rated by the SVO as NAIC 1 would be assigned a PBR credit rating of 6 (second least favorable), equivalent to A2.~~

4. Special Situations

For an asset handled under Section 9.F.3~~.c~~ and for which the NAIC designation varies depending on the company's carrying value of the asset, the company must avoid overstatement of the net return of the asset when projecting future payments of principal and interest together with the prescribed annual default costs.

Guidance Note: For example, if a non-agency RMBS is rated NAIC 2 if held at a particular company's carrying value but NAIC 4 if held at par, and that company's cash-flow model first projects the full recovery of scheduled principal and interest, it would be more appropriate to then deduct annual default costs consistent with NAIC 4 rather than NAIC 2. If the company's cashflow model has already incorporated a reduced return of principal and interest consistent with the company's carrying value, then it would be more appropriate to deduct annual default costs consistent with NAIC 2. Modeling of assets with impairments is an emerging topic, and methods for handling in vendor and company projection models vary.

VM-20 Appendix 2 second paragraph

It is important to note up front that the development of prescribed default costs is based entirely on analysis of corporate bonds. Default costs for other fixed income securities and commercial and agricultural mortgages are assumed to follow those of corporate bonds with similar NAIC ~~designations through a mapping tool called "PBR credit rating."~~Designation Categories. Examples of other fixed income securities are structured securities, private placements and preferred stocks. ~~Discussions at the NAIC during 2009-2010, particularly at the Valuation of Securities (E) Task Force, focused on the observation that similarly rated assets of different types may have similar likelihood of default or loss of principal but may have a significantly different distribution of the severity of that loss. Discussions have particularly focused on the different drivers of severity between structured securities and corporate bonds. As a result, the Valuation of Securities (E) Task Force has been developing updated methods to assign NAIC designations for C-1 RBC purposes for structured securities in order to better take into account these differences. The VM-20 procedure to assign a PBR credit rating has been structured so that in the cases where the Task Force decides to go away from directly using the ratings of approved ratings organizations, the PBR credit rating will be based on the NAIC designation rather than underlying ratings. Where the Task Force continues to authorize use of underlying ratings, the PBR credit rating also will be based on those ratings. However, VM-20 uses the underlying ratings to assign the PBR credit rating in a somewhat different manner.~~

VM-20 Appendix 2, end of section A.4

Among tables ~~published on~~produced by the NAIC ~~website~~ and published on the NAIC website or available upon request (See Section H):

a. Table A shows baseline default costs using Moody's data.
b. Table B shows the baseline default cost margin (Table A rates minus the historical mean rates).

VM-20 Appendix 2, end of section B.8

Among tables ~~published on~~produced by the NAIC ~~website~~ and available upon request (See Section H):

a. Table C shows empirical CTE 70 default rates from Moody's.
b. Table D shows prescribed cumulative default rates derived from Moody's data.

VM-20 Appendix 2, end of section C.3

Among tables ~~published on~~produced by the NAIC ~~website~~ and available upon request (See Section H):

a. Table E1 shows a sorted version of "Exhibit 22 – Annual Average Defaulted Bond and Loan Recovery Rates, 1982–2007," and develops the CTE 70 recovery rates and the implied margin.
   Table E1 develops mean and CTE 70 recovery rates for all bonds, as well as for senior bank loans and five bond lien position categories that make up the All Bonds statistics. Implementation will be facilitated if VM-20 uses one recovery rate based on All Bonds rather than using all six lien position categories. Using the more detailed data would require either companies or the SVO to assign each asset to one of the categories.
   Table E1 also illustrates that bonds that are more senior in the issuer's capital structure tend to have higher recovery rates than bonds that are subordinated.
b. Table E2 shows the final recovery rates that vary by PBR credit rating. This table was determined by assuming CTE 70 applies for Ba3/BB- and below, mean applies for Baa1/BBB+ and above, and interpolated recovery rates apply for ratings that are between Ba3/BB- and Baa1/BBB+. This approach recognizes that investment grade bonds are more likely to be senior in the issuer's capital structure, and below investment-grade bonds are more likely to be subordinated. Differentiating by actual seniority position of each bond was not considered practical. In addition, because recovery rates and default rates are not 100% correlated and the cumulative default rates were set at CTE 70, use of the mean recovery rate, at least for the higher-quality bonds, helps to avoid overly conservative prescribed default costs for those bonds.

VM-20 Appendix 2, Section H

Current and historical versions of Tables A, F, G, H, I, and J ~~through K~~ used for calculating asset default costs and asset spreads are available on the NAIC website home page (www.naic.org) under the Industry tab of the website in the Principle-Based Reserving Overview section. Tables B through E which document interim steps calculating these factors are available upon request.

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

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

   VM-22 (A) Subgroup
   Addressing LATF referral for the VM-22 Standard Projection Amount (SPA): Disclosures & Credibility

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

   June 18, 2025
   APF 2025-12~~XX~~
   NAIC Valuation Manual, VM-22 Section 3.C and VM-31 Section 3.F.14.k

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

   See attachment

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

   On April 3, 2025, the NAIC Life Actuarial (A) Task Force voted to make a referral to the NAIC VM-22 Subgroup to address regulator concerns raised during the Subgroup discussion regarding the VM-22 Standard Projection Amount. These concerns were primarily focused on inserting the SPA as a floor mechanism upon no or limited credibility supporting actuarial assumptions, as well as enhanced disclosures if the SPA serves only as a disclosure item.

   In the referral, LATF directed the VM-22 Subgroup to:
   1. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA whenever an ASPA is indicated.
   2. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA for all companies at least every 3 years.
   3. Clarify that if an ASPA is indicated and the company is not strengthening their reserves in response to the SPA result, they need to provide support that the material drivers of the difference are due to company assumptions that can be supported based on reliable, relevant, and credible company data.
   4. Reiterate that the SPA is not a safe harbor.

   The edits outlined in this amendment proposal are intended to provide wording to address the four items above.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
6/17/25	S.O./A.F.		
Notes: 2025-12 Exposed 6/20/25 by Ben Slutsker, Chair of VM-22 Subgroup for a 60-day comment period ending 8/19/25. Adopted by VM-22 Subgroup 9/17/25.			

VM-22 Section 3.C

C. The Additional Standard Projection Amount

The additional standard projection amount is determined by applying the standard projection method defined in Section 6.

Where an Additional Standard Projection Amount is indicated, the company should strengthen the assumptions and/or margins used for the SR until an ASPA would no longer be indicated, unless the Company can show that the difference between the SR and the SPA can be attributed to differences between the assumptions prescribed for the SPA and the company assumptions, for assumptions where the company assumption is based on company experience data that is reliable, relevant, and credible.

However, the SPA disclosure is not a safe harbor. An ASPA not being indicated does not automatically imply that ~~the company does not need to strengthen~~ the assumptions and/or margins used for the SR or DR are appropriate. The Company should have robust support for the development of all company assumptions and margins.

If an ASPA is not indicated, subject to the requirements in this subjection, ~~T~~the additional standard projection amount is only required for disclosure purposes pursuant to VM-31.

~~**Guidance Note:** To further expand upon use of the Standard Projection Amount (SPA), the NAIC Life Actuarial (A) Task Force adopted a referral to the VM-22 (A) Subgroup on April 3, 2025 that states the following:~~

~~"*LATF directs the VM-22 Subgroup to:*~~

~~*1. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA whenever an ASPA is indicated.*~~

~~*2. Require an attribution analysis, individually covering all material drivers and a residual impact, between the SR and SPA for all companies at least every 3 years.*~~

~~*3. Clarify that if an ASPA is indicated and the company is not strengthening their reserves in response to the SPA result, they need to provide support that the material drivers of the difference are due to company assumptions that can be supported based on reliable, relevant, and credible company data.*~~

~~*4. Reiterate that the SPA is not a safe harbor.*"~~

~~Therefore, although not included in the NAIC Valuation Manual effective for 1/1/2026 due to time constraints, the VM-22 (A) Subgroup will develop language to address the above directive for the 1/1/2027 Valuation Manual. Upon such adoption by the Life Actuarial (A) Task Force, as feasible, companies are encouraged to incorporate such changes for 2026 reporting. The enhanced disclosures will ensure an effective SPA and enable the VM-22 (A) Subgroup and LATF to evaluate the SPA framework as adopted within three years.~~

VM-31 Section 3.F.14

k. Attribution Analysis for VM-22

i. For groups of contracts that calculate a SR or DR under VM-22 requirements, where an ASPA is indicated and the Company can support not strengthening the assumptions and/or margins used for the SR or DR until an ASPA would no longer be indicated, the Company should provide an attribution analysis between the SR and the SPA, individually covering all material drivers and a residual impact. For any material drivers, support should be provided that the Company assumption is based on Company experience data that is reliable, relevant, and credible.

ii. For groups of contracts that calculate a SR or DR under VM-22 requirements, where an ASPA is not indicated, the Company should provide an attribution analysis between the SR or DR and the SPA, individually covering all material drivers and a residual impact, at least every three years. For any material drivers, support should be provided that the Company assumption is based on Company experience data that is reliable, relevant, and credible.

Guidance Note: The VM-22 Subgroup and LATF will be reevaluating the decision to make the SPA a disclosure within three years. The strength and reliability of the SPA disclosures, including the attribution analysis, in initial years will be a key consideration for that reevaluation.

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

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

   Rachel Hemphill, TDI, Update reinvestment guardrail for VM-20, VM-21, and VM-22.

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

   VM-20 Section 7.E.1.g, VM-21 Section 4. D.4.b, VM-22 Section 4.D.3.b

   Valuation Manual, January 1, 2026 Edition

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

VM-20 Section 7.E.1.g

g. Notwithstanding the above requirements, the modeled reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs and investment expenses by projection year that are consistent with a credit quality blend of at least:
i. 5% Treasury
ii. 15% PBR credit rating 3 (Aa2/AA)
iii. 40% PBR credit rating 6 (A2/A)
iv. 40% PBR credit rating 9 (Baa2/BBB)

~~a minimum credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).~~

VM-21 Section 4.D.4.b

b. Notwithstanding the above requirements, the SR shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of at least:
i. 5% Treasury
ii. 15% PBR credit rating 3 (Aa2/AA)
iii. 40% PBR credit rating 6 (A2/A)
iv. 40% PBR credit rating 9 (Baa2/BBB)

~~a minimum credit quality blend of 50% PBR credit rating 6 (A2/A) and 50% PBR credit rating 3 (Aa2/AA).~~

VM-22 Section 4.D.3.b

Notwithstanding the above requirements, the aggregate reserve shall be the higher of that produced by the modeled company investment strategy and that produced by substituting an alternative investment strategy in which the fixed income reinvestment assets have the same weighted average life (WAL) as the reinvestment assets in the modeled company investment strategy and are all public non-callable corporate bonds with gross asset spreads, asset default costs, and investment expenses by projection year that are consistent with a credit quality blend of at least:
i. 5% Treasury
ii. 15% PBR credit rating 3 (Aa2/AA)

iii. ~~80~~40% PBR credit rating 6 (A2/A)
iv. 40% PBR credit rating 9 (Baa2/BBB)

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

After adoption of a guardrail for VM-22 that was intended to be a compromise between the existing VM-20 and VM-21 guardrails and the Academy proposed guardrail of 5% Treasury, 15% PBR credit rating 3 (AA), 40% PBR credit rating 6 (A), and 40% PBR credit rating 9 (BBB), LATF planned to consider updating the guardrails for VM-20 and VM-21 to be consistent with the VM-22 guardrail. LATF members noted that they would not want to consider such a change without first reviewing impact testing. ACLI agreed to provide this impact testing. Since then, additional review has made clear that the compromise guardrail will not always give the intended compromise effect. As a result, I propose that LATF instead consider adopting the Academy guardrail for all of VM-20, VM-21, and VM-22. To address prior regulator concerns, I recommend that LATF not consider adoption of this proposal without reviewing impact testing of the updated proposal provided by ACLI. So, I am requesting the ACLI update the agreed-upon testing to now reflect the Academy guardrail for VM-20, VM-21, and VM-22. The initial exposure should be set to allow sufficient time for this testing to be completed.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
11/13/25	JR		
Notes:2025-16			

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

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

   Rachel Hemphill, TDI, Update VM-20 stochastic reserve calculation to reflect aggregation.

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

   VM-20 Section 5.G

   Valuation Manual, January 1, 2026 Edition

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

   VM-20 Section 5.G

   The SR equals the amount determined in Section 5.F. If the company includes policies from two or more VM-20 reserving ~~category~~ categories in a subgroup for aggregation purposes as described in Section 5.A, the company shall calculate the SR for policies from each VM-20 reserving category on a stand-alone basis by following the process of A through F above. Then, the final SR for the group of policies from a given VM-20 reserving category is determined by:

   $I_A = I_S*(T_A/ T_S)$, if $T_S \neq 0$
   $I_A = 0$, if $T_S = 0$

   Where:

   I_A = the SR for the policies from an individual VM-20 reserving category reflecting aggregation.
   I_S = the SR for the policies from an individual VM-20 reserving category on a stand-alone basis.
   T_A = the SR for the group of policies in aggregate.
   T_S = the sum of I_S for the group of policies for the Term, ULSG, and All Other reserving categories.

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

   Allow reflection of the aggregation benefit in the VM-20 stochastic reserve.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
11/14/25	JR		
Notes: 2025-17			

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

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

   Seong-min Eom, NJ Division of Insurance
   Pat Allison and Angela McNabb, NAIC

   NAIC Collection of Group Annuity Mortality Experience

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

   VM-50
   Section 2.B
   Section 4.B

   VM-51
   Section 2 title
   Section 2.C
   Section 2.D
   New Section 3: Statistical Plan for Group Annuity Mortality
   Appendices 1-4
   New Appendix 5: Group Annuity Mortality Data Elements and Format

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

   See attachment.

   Note:
   The NAIC relied on the following SOA work product, parts of which were reproduced with permission and used to draft this amendment to the *Valuation Manual* for group annuitant mortality experience:
   - 2015 – 2018 Group Annuity Mortality Experience Report. Copyright 2022, The Society of Actuaries and Society of Actuaries Research Institute, Chicago, Illinois.

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

   This amendment establishes a Statistical Plan for Group Annuity Mortality and designates the NAIC as the Experience Reporting Agent.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
10/25/24	SO		
Notes: APF 2024-12: Draft for 4th exposure			

VM-50: Experience Reporting Requirements

Table of Contents

Section 1: Overview

A. Purpose of the Experience Reporting Requirements

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

B. PBR and the Need for Experience Data

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

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

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

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

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

5. The collection of experience data will provide a basis for establishing and updating the

assumptions and margins prescribed by regulators in the *Valuation Manual*.

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

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

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

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

Section 2: Statutory Authority and Experience Reporting Agent

A. Statutory Authority

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

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

3. Section 14A(5) of Model #820 defines the data to be collected to be confidential.

B. Experience Reporting Agent

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

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

2. The NAIC is designated as Experience Reporting Agent for the following Statistical Plans:
   a. Life Insurance Mortality, beginning Jan. 1, 2020
   b. Group Annuity Mortality, beginning Jan. 1, 2027.

3. The designation of the NAIC as Experience Reporting Agent does not preclude state insurance regulators from independently engaging other entities for similar data required under this *Valuation Manual* or other data purposes.

4. The NAIC shall collect an annual fee from companies participating in the data collections.

Section 3: Experience Reporting Requirements

A. Statistical Plans

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

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

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

B. Role and Responsibilities of the Experience Reporting Agent

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

the data submission.

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

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

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

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

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

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

6. The Experience Reporting Agent will obtain and undergo at least annual external audits to validate that controls with respect to data security and related topics are consistent with industry standards and best practices. The Experience Reporting Agent will provide a copy of any report prepared in connection with such an audit, upon a company's request. In the event of a material deficiency identified in the external audit or in the event of an identified

security breach affecting the Experience Reporting Data, the Experience Reporting Agent shall notify the NAIC, and the states that have directed the Experience Reporting Agent to collect this information, of the nature and extent of such an issue. In the event of an identified security breach affecting Experience Reporting Data, the Experience Reporting Agent shall also notify any insurer whose data was affected. Upon good cause shown, the Experience Reporting Agent will take reasonable actions to protect the data under its control, including that the data submission process may be suspended until the security issue has been remediated. If data submission is suspended under this section, the Experience Reporting Agent will work with the states that have directed collection to issue appropriate guidance modifying the requirements of VM 51, Section 2.D and/or Section 3.D. The term "good cause" shall mean that there is the chance of irreparable harm upon continuing the transmission of the data to the Experience Reporting Agent. Once the security issue has been remediated, the Experience Reporting Agent shall notify the NAIC and the states that have directed the Experience Reporting Agent to collect this information. The Experience Reporting Agent shall work in conjunction with the NAIC and the states that have directed the Experience Reporting Agent to collect this information to develop a revised data submission schedule for any deferred submissions. The revised schedule shall provide for reasonable timing for companies to provide such data.

C. Role of Other Organizations

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

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

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

3. Analyze data, including any summarized or aggregated data produced by the Experience Reporting Agent;

4. Create initial experience tables and any revised tables;

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

6. Create statutory valuation tables as appropriate and necessary;

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

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

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

Section 4: Data Quality and Ownership

A. General Requirements

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

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

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

B. Specific Requirements

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

2. Each submission of data filed by a company with the Experience Reporting Agent shall be balanced against a set of control totals provided by the company with the data submission. ~~At a minimum, these control totals shall include applicable record counts, claim counts,~~

~~amounts insured and claim amounts.~~ Any submission that does not balance to the control totals shall be referred to the company for review and resolution.

a. Control totals for the Statistical Plan for Life Insurance Mortality shall include applicable record counts, claim counts, amounts insured, and claim amounts.
b. Control totals for the Statistical Plan for Group Annuity Mortality shall include applicable certificate counts and annual income inforce.

3. Each company submitting experience data and each company on whose behalf data is being submitted as required in VM-51 will perform a reconciliation between its submitted experience data with its statistical and financial data, and provide an explanation of differences, to the Experience Reporting Agent.
    a. For the Statistical Plan for Life Insurance Mortality, ~~T~~the reconciliation must include policy count and insurance amount.
    b. For the Statistical Plan for Group Annuity Mortality, the reconciliation must include certificate counts, annual income inforce, and statutory reserves.

4. Third-Party Administration Reporting
    a. If a third-party administrator (TPA) that is not an insurance company or an insurance company not required to submit its direct data is submitting data on behalf of an insurance company, the reconciliation will consist of separate lines identifying each insurance company for whom this entity is submitting data.
    b. If the TPA is an insurance company that is required to submit its direct data, the reconciliation must include separate lines identifying each additional company whose data is being submitted.
    c. The reconciliation to company statistical and financial data for both the direct writer and the reinsurer or TPA must include lines indicating the amount of business that is being reported by the reinsurer or TPA. The NAIC will use this information to confirm that all in-scope business is reported and that there is no double counting of policies.

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

6. Where quality would not appear to be significantly compromised, the Experience Reporting Agent may use records with missing or invalid data if such invalid or missing data do not involve a field that is relevant or would affect the credibility of the report. For companies with a body of data for a state, line of business, product type or observation period that fails to meet these standards, the Experience Reporting Agent will use its discretion, with regulatory disclosure of key decisions made, regarding the omission of the entire body of data or only including records with valid data. Completeness of reports is

desirable, but not at the risk of including a body of data that appears to have an unreasonably high chance of significant errors.

7. Errors of a consistent nature are referred to as "systematic." Incorrect coding instructions can introduce errors of a consistent nature. Programming errors within the data processing system of ~~insurer~~ the insurance company can also produce systematic miscoding as the system converts data to the required formats for experience reporting. Most systematic errors will produce data that, when reviewed using tests designed to reveal various types of systematic errors, will appear unreasonable and likely to be in error. In addition, some individual coding errors may produce erroneous results that show up when exposures and losses are compared in a systematic fashion. Such checking often cannot, however, provide a conclusive indication that data with unusual patterns is incorrect. The Experience Reporting Agent will perform tests and look at trends using previously reported data to determine if systematic errors or unusual patterns are occurring.

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

9. At a minimum, reasonability checks by the Experience Reporting Agent will include:

   a. An unusually large percentage of company data reported under a single or very limited number of categories;

   b. Unusual or unlikely reporting patterns in a company's data;

   c. Claim amounts that appear unusually high or low for the corresponding exposures;

   d. Reported claims without corresponding policy values and exposures;

   e. Unreasonable loss frequencies or amounts in comparison to ranges of expectation that recognize statistical fluctuation;

   f. Unusual shifts in the distribution of business from one reporting period to the next.

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

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

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

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

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

15. The Experience Reporting Agent will calculate Actual to Expected (A/E) ratios for each company based on the records deemed acceptable after the data review process has been completed. An accredited actuary is required to review and sign off on the reasonableness of the A/E ratios. The company shall correct and resubmit their data if A/E ratios are found to be unreasonable.

C. Ownership of Data

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

2. The Experience Reporting Agent will be responsible for maintaining data, error reports, logs and other intermediate work products, and reports for use in processing, documentation, production and reproduction of reports provided to state insurance regulators in accordance with the *Valuation Manual*. The Experience Reporting Agent will

be responsible for demonstrating such reproducibility at the request of state insurance regulators or an auditor designated by state insurance regulators.

Section 5: Experience Data

A. Introduction

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

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

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

B. Design of Reports Linked to Purpose

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

C. Basic Report Designs

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

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

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

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

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

D. Supplemental Reports

1. For specific lines of business and types of experience data, state insurance regulators may request additional reports from the Experience Reporting Agent. State insurance regulators also may request custom reports, which may contain specific data or experience not regularly produced in other reports.

2. The regulator and the Experience Reporting Agent must negotiate time schedules for producing supplemental reports. The information in these reports is limited by the amount of data actually available and the manner in which it has been reported.

E. Reports to State Insurance Departments

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

1. A list of companies whose data is included in the compilation.

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

Section 6: Confidentiality of Data

A. Confidentiality of Experience Data

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

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

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

B. Treatment of Confidential Information

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

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

3. Consistent with state laws based on Section 14B(3) of the Model #820 and any agreements between a state insurance department and the Experience Reporting Agent, access to the confidential information will be limited to:

   a. State, federal or international regulatory agencies;

b. The company with respect to confidential information it has submitted, and any reports prepared by the Experience Reporting Agent based on such confidential information;

c. The NAIC, and its affiliates and subsidiaries;

d. Auditor(s) of the Experience Reporting Agent for purposes of the experience reporting function outlined in this VM-50; and

e. Other individuals or entities, including contractors or subcontractors of the Experience Reporting Agent, otherwise assisting the Experience Reporting Agent or state insurance regulators in fulfilling the purposes of VM-50. These other individuals or entities may provide services related to a variety of areas of expertise, such as assisting with performing industry experience studies, developing valuation mortality tables, data editing and data quality review. These other individuals and entities shall be subject to the same standards as the Experience Reporting Agent with respect to the maintenance of confidential information.

VM-51: Experience Reporting Formats

Table of Contents

Section 1: Introduction

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

B. Each statistical plan shall contain the following information:

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

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

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

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

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

6. The experience data reports to be produced.

Section 2: Statistical Plan for Life Insurance Mortality

A. Type of Experience Collected Under This Statistical Plan

The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

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

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

   a. As defined in VM-50 Section 4.B.~~43~~, the reconciliation to company statistical and financial data for both the direct writing company and all reinsurers and/or TPAs must include lines indicating the amount of business that is being reported by the reinsurers and/or TPAs. The Experience Reporting Agent will compare the reconciliations for all business submitted by the direct writer and any reinsurers and/or TPAs to ensure that all business is included and that there is no double counting of policies.

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

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

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

The Experience Reporting Agent, under the direction of the Life Actuarial (A) Task Force, will select companies that are required to submit experience data. The selection of companies will be based on achieving a target level of approximately 85% of industry mortality experience in scope. Companies selected to submit mortality experience data are expected to continue reporting their experience in future years, barring circumstances justifying an exemption. The list of companies selected is subject to change. Additional companies may be selected to maintain the target level of industry experience. Any additional companies selected will be given sufficient notice to prepare for the data submission.

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

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

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2024 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2023, which is the observation calendar year.~~For the 2024 reporting calendar year, companies who are required to submit data for this statistical plan for mortality will be required to submit two observation calendar years of data, namely observation calendar year 2022 and observation calendar year 2023. For reporting calendar years after 2024, companies who are required to submit data for this statistical plan for mortality will be required to submit one observation calendar year of data.~~

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

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

ii. Report terminations that were incurred in calendar year 20XX and reported before April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so. However, exclude rescinded policies (e.g., 10-day free look exercises) from the data submission.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

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

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.

Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by March 31 of the year after the observation year.

Plans of insurance should be carefully matched with the three-digit codes in item 20, Plan. These plans of insurance are important because they will be used not only for mortality experience data collection, but also for policyholder behavior experience data collection. It is expected that most policies will be matched to three-digit codes that specify a particular policy type rather than select a code that indicates a general plan type.

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

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

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

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

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

F. Experience Data Reports Required by This Statistical Plan

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

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

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

Section 3: Statistical Plan for Group Annuity Mortality

A. Type of Experience Collected Under This Statistical Plan

The type of experience to be collected under this statistical plan is mortality experience.

B. Scope of Business Collected Under This Statistical Plan

1. The data for this statistical plan includes direct written group annuity business issued by a company in the U.S. for lives in any country as well as reinsurance assumed written by a company in the U.S. for business written by non-US companies. ~~outside the U.S~~. Product types include:
   a. Group Pension Risk Transfer (PRT, as defined in VM-01) annuities originating from ongoing and terminated private and public defined benefit pension plans, including both participating and nonparticipating contracts where the insurance company bears mortality risk.
   b. Purchased group annuities with mortality risk originating from defined contribution plans.
   c. Immediate Participation Guarantee contracts for which the insurance company bears the mortality risk.
   d. Longevity Reinsurance, as defined in VM-01.
   e. Group Variable Payout Annuities, defined as group annuities that include a provision for benefit payments which vary in accordance with the rate of return of the underlying investment portfolio.

2. The intent is to align the scope of business collected under this statistical plan with the scope of VM-22. Therefore, the following types of business defined in VM-01 are excluded from data collection:
   a. Guaranteed Investment Contracts
   b. Synthetic Guaranteed Investment Contracts

c. Funding Agreements
d. Stable Value contracts
e. Pre-Need Annuities

3. All values should be prior to any reinsurance ceded except for the situation defined in VM-51 Section 3.B.4. Assumption reinsurance of a line of business, where the assuming company is legally responsible for all benefits and claims paid, shall be included within the scope of this statistical plan.

4. In the event a reinsurer or TPA is responsible for administering a block of business, the reinsurer or TPA may submit that block of business on behalf of the direct writer. In this case, the reinsurer or TPA must be identified in Appendix 5 Item 1 - Submitting Company ID, and the direct writer must be identified in Appendix 5 Item 2 - NAIC Company Code of Direct Writer.

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

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

5. The direct writing company is ultimately responsible for all the data submitted for its company.

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

The Experience Reporting Agent, under the direction of the Life Actuarial (A) Task Force, will select companies that are required to submit experience data. The selection of companies will be based on achieving a minimum target level of approximately 90% of industry statutory reserves in scope. Companies selected to submit mortality experience data are expected to continue reporting their experience in future years, barring circumstances justifying an exemption. The list of companies selected is subject to change. Additional companies may be selected to maintain the target level of industry experience, or at the discretion of the Life Actuarial (A) Task Force. Any additional companies selected will be given sufficient notice to prepare for the data submission.

Companies with less than $250 million of statutory reserves for in-scope group annuity business shall be exempted from reporting experience data required under this statistical plan. This threshold for exemption shall be reviewed annually and be subject to change by the Experience Reporting Agent.

Exemptions may be granted by the Experience Reporting Agent where appropriate, following consultation with the domestic insurance regulator.

D. Process for Submitting Experience Data Under This Statistical Plan

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

Data for this statistical plan for mortality will be compiled using a calendar year method. The reporting calendar year is the calendar year that the company submits the experience data. The observation calendar year is the calendar year of the experience data that is reported. The observation calendar year will be one year prior to the reporting calendar year. For example, if the current calendar year is 2027 and that is the reporting calendar year, the company is to report the experience data that was in-force or issued in calendar year 2026, which is the observation calendar year.

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

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

ii. Report terminations that were incurred in calendar year 20XX and reported before April 1, 20XX+1. Companies may report terminations reported after April 1, 20XX+1 if they choose to do so.

For any reporting calendar year, the data call will occur during the second quarter, and data is to be submitted according to the requirements of the *Valuation Manual* in effect during that calendar year. Data submissions must be made by Sept. 30 of the reporting calendar year. Corrections of data submissions must be completed by Feb. 28 of the year following the reporting calendar year. The NAIC may extend either of these deadlines if it is deemed necessary.

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

Companies subject to reporting pursuant to Section 3.C are required to complete the Experience Data Elements and Formats as defined in Appendix 5.

F. Experience Data Reports Required by This Statistical Plan

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

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

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

Appendix 1: Life Insurance Preferred Class Structure Questionnaire

Appendix 2: Life Insurance Mortality Claims Questionnaire

MORTALITY CLAIMS QUESTIONNAIRE

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

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

Company	NAIC Company Code
Name	Date

MORTALITY CLAIMS

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

2. The death claim amounts are to be for the total face amount and on a gross basis (before reinsurance). The data is based on:

   a. Total face amount (for policies that include the cash value in addition to the face amount as a death benefit, use only the face amount) as specified OR

      Other (describe):

      If not as specified, indicate time period for which this occurred _____ - _____

   b. Gross basis (before reinsurance) as specified OR Other (describe):

      If not as specified, indicate time period for which this occurred: _____ - _____

      Is this the same basis used for face amounts included in the study data? Yes No

3. The date that the termination is reported is to be used for the termination reported date. The date that the termination actually occurred is to be used for the actual termination date. What dates are used for death claims in the study data with respect to?

a)	Termination reported date If not reported date, indicate basis for dates provided	Reported date	Other (describe):
b)	Actual termination date for death claims: If not date of death, indicate basis for dates provided	Date of death	Other (describe):

4. Death claims pending at the end of the observation period but paid during the subsequent six months following the observation year are to be included in the data submission. Claims that are still pending at the end of the six-month run out are to be included.

   Are such pending claims included in the study data? Yes No

   If no indicate time period for which this occurred: _____

5. The face amounts and death claim amounts are to be included without capping by amount. Are the face amounts and death claims/exposures included without capping by amount?

   Yes No

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

6. For death claims on policies issued before 1990:

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

   If no, indicate approach used:

7. Please briefly describe any other unique aspects of the death claims data that are not covered above.

Appendix 3: Life Insurance Additional Plan Code Form

Appendix 4: Life Insurance Mortality Data Elements and Format

The table below provides descriptions of the required data fields. Further details and coding examples are provided in a data dictionary located on the NAIC's website. The data dictionary is a living document and will be updated periodically as needed.

ITEM	LENGTH	DATA ELEMENT	DESCRIPTION
20	3	Plan	**Coverage purchased under a Guaranteed Insurability Option:** 110 = Exercised Guaranteed Insurability Option

Appendix 5: Group Annuity Mortality Data Elements and Format

The table below provides descriptions of the required data fields. Further details and coding examples are provided in a data dictionary located on the NAIC's website. The data dictionary is a living document and will be updated periodically as needed.

It is expected that companies may not have all the requested data elements, so certain data elements may be left blank or approximated, as noted in the Description column. If key fields necessary to perform an experience study are left blank (e.g. date of termination, date of death) or are inconsistent, the Experience Reporting Agent may make approximations as described in the data dictionary.

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
1	9	Submitting Company ID	ID number representing the company submitting this file. If the company has an NAIC Company Code, then that code must be used. If the company does not have an NAIC Company Code, the company's Federal Employer Identification Number (FEIN) must be used. If the direct writer is the company submitting the data, Items 1 and 2 must contain the same value.
2	5	NAIC Company Code of the Direct Writer of Business	The NAIC Company Code of the company that wrote the business being reported. In the case of assumption reinsurance where the assuming company is legally responsible for all benefits and claims paid, the assuming company is considered to be the direct writer. If the direct writer is the company submitting the data file, Items 1 and 2 must contain the same value.
3	4	Observation Year	Enter Calendar Year of Observation
4	20	Contract Number	Enter the Group Annuity Contract number. This must be carried through consistently for all observation years.
5	8	Contract Issue Date	Enter the numeric Group Annuity Contract issue date in YYYYMMDD format.
6	1	Plan Type	1 = PRT originating from Private Defined Benefit Plans 2 = PRT originating from Public Defined Benefit Plans 3 = Purchased Annuities with Mortality Risk Originating from Defined Contribution Plans 4 = Longevity Reinsurance 5 = Immediate Participation Guarantee contracts for which the insurance company bears the mortality risk 6 = Group Variable Payout Annuities

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			7 = Other Group Annuities with Mortality Risk Note that COLAs do not qualify as variable payout annuities.
7	1	Country Code	1 = United States 2 = Canada 3 = United Kingdom 4 = Other
8	20	Certificate Number	Enter a unique identifying number for the annuitant. This must be carried through consistently for all observation years. Certificate numbers must be encrypted. Actual certificate numbers cannot be used.
9	8	Certificate Issue Date	Enter the numeric Certificate issue date in YYYYMMDD format.
10	2	Issue Age	Enter the annuitant's issue age.
11	1	Beneficiary Indicator	1 = Primary 2 = Beneficiary 3 = Contingent (not yet in pay status) 4 = Unknown
12	1	Gender	1 = Male 2 = Female 3 = Unisex – Unknown Gender 4 = Unisex – Male 5 = Unisex – Female 6 = Unknown
13	8	Date of Birth	Enter the numeric date of birth in YYYYMMDD format.
14	8	Date of Entry	Enter the numeric date of entry in YYYYMMDD format. See the data dictionary for details.
15	1	Status Code when the Group Annuity Contract Was Purchased	1 = Retired (in payout status) 2 = Deferred (either terminated or active)
16	1	Status Code as of the Observation Year	1 = Retired (in payout status) 2 = Deferred (either terminated or active)
17	8	Date of Termination	Enter the numeric date of termination in YYYYMMDD format. Leave this field blank if there was no termination.
18	1	Mode of Termination	1 = Death 2 = Retirement 3 = Other 4 = No Termination

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
19	12	Amount of Annual Income	Provide the annual income amount to the nearest dollar as of the end of the observation year. Convert to US dollars if benefits are in any other currency.
20	1	Joint and Survivor	1 = 0% (Single Life) 2 = >0% - <=50% 3 = >50% - <=67% 4 = >67% - <=75% 5 = >75% - <=100% 6 = Joint percent unknown 7 = Joint indicator unknown
21	1	Benefit Class	1 = Life only 2 = Life only, plus Temporary life annuity 3 = Life with period certain 4 = Life with period certain, plus Temporary life annuity 5 = Cash refund 6 = Cash refund, plus Temporary life annuity 7 = Unknown or Not Applicable
22	2	Certain Period	Enter the Certain Period in years if Benefit Class = 3 or 4. For all other Benefit Classes, leave this field blank.
23	1	Job Classification	1 = Hourly 2 = Salaried 3 = Not Applicable 4 = Unknown
24	1	Union Classification	1 = Union 2 = Nonunion 3 = Not Applicable 4 = Unknown
25	6	NAICS Code	Enter the applicable North American Industry Classification System (NAICS) Code. Leave blank if unknown or not applicable.
26	4	SIC Code	Enter the applicable Standard Industrial Classification (SIC) Code. Leave blank if unknown or not applicable.
27	1	Separate Account/General Account	1=Separate Account, where assets are legally insulated from General Account claims 2=General Account
28	2	PRT Options	Was the participant exposed to any of the following immediately prior to, coincident with, or after the purchase of the annuity contract? Please consider offers that may have been made by either the insurer or by the pension plan that purchased the contract (to

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			the extent such plan actions are known by the insurer and were considered when underwriting the contract). 11 = A one-time voluntary full lump sum window 12 = A one-time voluntary partial lump sum window 13 = A one-time involuntary full lump sum window 14= A one-time benefit enhancement 15 = A one-time option to convert the form of benefit to another form of benefit 16 = A one-time option to add or remove spousal benefits 17 = Any other one-time actions that the carrier considered potentially anti-selective to mortality when underwriting the contract 18 = More than one of the above codes apply 19 = Not applicable (use for non-PRT business) 20 = Unknown
29	1	Availability of Full and/or Partial Lump Sums at Retirement	1=No lump sums are available 2=Full and partial lump sums are available 3=Only full lump sums are available 4=Only partial lump sums are available 5=Full lump sums are available; Unknown whether partial lump sums are available 6=Unknown whether full lump sums are available; partial lump sums are available 7=Unknown whether full or partial lump sums are available 8 = Not applicable (use for non-PRT business)
30	1	Cost of Living Increases	Is there a cost of living or inflation increase feature? 1 = Yes 2 = No 3 = Not Applicable (use for non-PRT business) 4 = Unknown
31	1	Other Income Increases	Is there a feature (other than a cost-of-living increase) that causes the benefit not to be level (e.g. Social Security integration, or level benefit option that would cause the benefit amount to change)? 1 = Yes 2 = No 3 = Not Applicable (use for non-PRT business)

ITEM	MAXIMUM LENGTH	DATA ELEMENT	DESCRIPTION
			4 = Unknown
32	1	Collar Type	1 = White Collar 2 = Blue Collar 3 = Unknown Collar Type 4 = Not Applicable (use for non-PRT business) Enter the collar type as determined by the company. See the data dictionary for coding details.
33	2	State of Residence	Use standard, two-letter state abbreviation codes (e.g. FL for Florida) for the state of the annuitant's domicile.
34	5	U.S. Zip Code	For business issued in the U.S., provide the annuitant's 5-digit zip code. For non-U.S. business, leave this blank.
35	6	Canadian Postal Code	For business issued in Canada, provide the annuitant's 6-digit postal code. For non-Canadian business, leave this blank.
36	2	UK Postcode Area	For business issued in the UK, enter the 2-digit postcode area. For non-UK business, leave this blank. If Unknown, leave this blank.

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

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

   Identification:
   Rachel Hemphill, Texas Department of Insurance

   Title of the Issue:
   Update VM-21 and VM-22 references to reflect IMR being attributed to a group of policies or contracts, not a group of assets.

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

   2026 Valuation Manual, VM-21 Sections 4.A.7 and 4.D.1.iii and VM-22 Sections 4.A.7 and 4.D.1.iii

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

   See attached.

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

   VM-21 and VM-22 refer to the IMR to be reflected as "attributable to the assets selected".

   VM-20, in contrast, refers to the IMR as being allocated to the model segment (e.g., see VM-20 Sections 4.A.1, 5.F, 7.D.7) with references such as "less the positive or negative PIMR balance at the valuation date allocated to the group of one or more policies being modeled".

   VM-20 also contains guidance on the allocation of IMR, while VM-21 and VM-22 do not.

   This APF is to make VM-21 and VM-22 consistent with VM-20, and to add the guidance existing in VM-20 to VM-21 and VM-22. This will make it clear that the allocation of IMR is to the model segment, reflecting the policies or contracts.

Dates: Received	Reviewed by Staff	Distributed	Considered
3/6/26	SO		
Notes: 2026-02			

VM-21 Section 4.A.7

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company's cash-flow testing, and the amounts should be adjusted to a pre-tax basis. The determination of the PIMR allocation is subject to the following:

a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.

b. In performing the allocation to each model segment, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion. Any negative IMR that is admitted must be fully allocated by line of business and cannot be allocated to surplus. In the case of negative PIMR, since a negative amount is being added when determining the starting asset amount, the amount of starting assets is reduced by the absolute value of the allocated amount of negative PIMR and the absolute value of the allocated amount of negative PIMR is then added in as the final step in calculating the scenario reserves.

c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-21, Section 4.D.1

D. Projection of Assets

1. Starting Asset Amount

a. For the projections of accumulated deficiencies, the value of assets at the start of the projection shall be set equal to the approximate value of statutory reserves at the start of the projection plus the allocated amount of PIMR attributable to the assets selected. Assets shall be valued consistently with their annual statement values. The amount of such asset values shall equal the sum of the following items, all as of the start of the projection:

i. All of the separate account assets supporting the contracts;
ii. Any hedge instruments held in support of the contracts being valued; and
iii. An amount of assets held in the general account equal to the approximate value of statutory reserves as of the start of the projections plus the allocated amount of PIMR attributable to the contracts being valued~~assets selected~~ less the amount in (i) and (ii).

VM-22 Section 4.A.7

7. Interest Maintenance Reserve (IMR)

The IMR shall be handled consistently with the treatment in the company's cash flow testing, and the amounts should be adjusted to a pre-tax basis. The determination of the PIMR allocation is subject to the following:

a. The amount of PIMR allocable to each model segment is the approximate statutory interest maintenance reserve liability that would have developed for the model segment, assuming applicable capital gains taxes are excluded. The allocable PIMR may be either positive or negative.

b. In performing the allocation to each model segment, any portion of the total company IMR balance that is not admitted under statutory accounting procedures shall first be removed. The company shall use a reasonable approach to allocate the total company balance, after removing any non-admitted portion thereof, between PBR and non-PBR business and then allocate the PBR portion among model segments in an equitable fashion. Any negative IMR that is admitted must be fully allocated by line of business and cannot be allocated to surplus. In the case of negative PIMR, since a negative amount is being added when determining the starting asset amount, the amount of starting assets is reduced by the absolute value of the allocated amount of negative PIMR and the absolute value of the allocated amount of negative PIMR is then added in as the final step in calculating the aggregate scenario reserves.

~~a.~~c. The company may use a simplified approach to allocate the PIMR, if the impact of the PIMR on the minimum reserve is minimal.

VM-22, Section 4.D.1.iii

iii. The allocated amount of PIMR attributable to the contracts being valued~~assets selected~~.

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

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

   Elaine Lam, California Department of Insurance
   Ben Slutsker, Minnesota Department of Commerce

   Clarify calculation mechanics in the VM-22 SPA dynamic lapse formula, specifically in the Market Factor and Rate Factor formulas.

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

   January 1, 2026 Edition of the *Valuation Manual* – VM-22 Section 6.C.5 Full Surrenders

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

   See attached.

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

   In the current VM-22 SPA dynamic lapse formula, in order to get the intended result, the Market Factor accepted percentage inputs (for CR, MR, BF) as whole numbers rather than decimals. For example, 5% was expected to be input as 5, instead of 0.05. This input format caused confusion due to inconsistency with mathematical convention where percentages are typically expressed as decimals (e.g., 5% is 0.05, not 5).

   This APF updates the formula for Market Factor to accept decimal inputs for percentages rather than whole number inputs, which follows mathematical convention. The formula for Rate Factor also requires updating, to output a decimal percentage rather than a whole number percentage (which again follows mathematical convention), to be correctly input into the Total Lapse formula. In the end, the Total Lapse result will be unchanged.

   Mechanically, to end up with the same result, the changes being proposed are to:
   - multiply the decimal percentage inputs of the Market Factor by 100
   - divide the Rate Factor by 100 to turn it into a decimal percentage output

   (Footnote: CR = Crediting Rate; MR = Market Rate; BF = Buffer Factor)

   A subsequent update to the APF puts "~~÷~~ 100" into the Market Factor rather than the Rate Factor. This has the advantage of both the Market Factor and Rate Factor to consistently be decimals.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
3/10/26	S.O.		
Notes: 2026-03			

W:\National Meetings\2010\...\TF\LHA\

VM-22 Section 6.C.5 – Full Surrenders
(proposed changes in red)

…

Total Lapse = (Base Lapse x GMIR Factor + Rate Factor x MVA Factor) × ITM Factor

…

Rate Factor
Rate Factor = Market Factor × Max(0, 1 – 5 × (1-CSV/AV))

…

Market Factor

$Market\ Factor = -1.25 \times [100 \times (CR - MR)]^{X} \div 100$ if CR ≥ MR

$Market\ Factor = 0$ if MR > CR ≥ (MR − BF)

$Market\ Factor = 1.25 \times [100 \times (MR - BF - CR)]^{X} \div 100$ if CR < (MR − BF)

X = 2.0 during Surrender Charge Period, 2.5 at Shock, and 2.5 thereafter

Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force

Amendment Proposal Form*

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

   Identification:
   Matt Cheung, Illinois Department of Insurance

   Title of the Issue:
   Clarify that variable annuities in payout phase, either after annuitization or account value depletion, can be reserved for as a variable annuity under VM-21 with domiciliary commissioner approval. If reserved for under VM-21, the Standard Projection Amount requirements apply to these contracts. This also clarifies the discount rates to use for VA's in payout phase that are reserved for as payout annuities under VM-V.

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

   - 2026 Valuation Manual, Section II Reserve Requirements Subsection 2: Annuity Products
   - 2026 Valuation Manual, VM-21 Requirements Section 6.C.9
   - 2026 Valuation Manual, VM-V Section 1.B

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

   See attached.

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

   There is a diversity of practice currently of how variable annuities in payout are reserved for, and this APF serves to clarify that they can either be treated as variable annuities (which is the same treatment they had prior to annuitization/account value depletion, with domiciliary commissioner approval), or as fixed annuities.

Dates: Received	Reviewed by Staff	Distributed	Considered
2/11/26	SO		

Notes: APF 2025-14
5/7/26 changes highlighted in green

Subsection 2: Annuity Products

A. This subsection establishes reserve requirements for all contracts classified as annuity contracts as defined in SSAP No. 50 in the AP&P Manual.

B. Minimum reserve requirements for variable annuity (VA) contracts and similar business, specified in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, shall be those provided by VM-21. The minimum reserve requirements of VM-21 are considered PBR requirements for purposes of the Valuation Manual, and therefore are applicable to VM-G.

C. Minimum reserve requirements for non-variable annuity contracts issued prior to 1/1/2026 are those requirements as found in VM-A, VM-C, and VM-V as applicable, with the exception of the minimum requirements for the valuation interest rate for single premium immediate annuity contracts, and other similar contracts, issued after Dec. 31, 2017, including those fixed payout annuities emanating from host contracts issued on or after Jan. 1, 2017, and on or before Dec. 31, 2017. The maximum valuation interest rate requirements for those contracts and fixed payout annuities are defined in VM-V, Statutory Maximum Valuation Interest Rates for Formulaic Reserves.

Minimum reserve requirements for non-variable annuity contracts issued on 1/1/2026 and later are those requirements as found in VM-22, with the exception of Preneed Annuities, Guaranteed Investment Contracts, Synthetic Guaranteed Investment Contracts, Funding Agreements, and other Stable Value Contracts which shall follow the requirements found in VM-A, VM-C, and VM-V. Minimum reserve requirements for fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts, as well as fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts with guaranteed living benefits once the contract funds are exhausted, are those requirements as found in VM-22, with the exception that, with the permission of the domiciliary commissioner, the company may use the same maximum valuation interest rate used to value payment streams in accordance with the guidance applicable to the host contract. The minimum reserve requirements of VM-22 are considered PBR requirements for purposes of the Valuation Manual, and therefore are applicable to VM-G.

~~VA contracts in payout phase, regardless of how they are administered, can be reserved for under VM-21 with domiciliary commissioner approval.~~
VA contracts in payout phase administered as fixed payout contracts can be reserved for under VM-21 with domiciliary commissioner ~~approval~~notification, if not rejected by the domiciliary commissioner.

VM-21: Requirements for Principles-Based Reserves for Variable Annuities

Section 6: Requirements for the Additional Standard Projection Amount

C. Prescribed Assumptions

9. Mortality

The mortality rate for a contract holder with age x in year (2012 + n) shall be calculated using the following formula, where q_x denotes mortality from the 2012 IAM Basic Mortality Table multiplied by the appropriate factor (F_x) from Table 6.9 and $G2_x$ denotes mortality improvement from Projection Scale G2:

$$q \quad = q \quad (1-G2) * F$$

Table 6.9

Attained Age (x)	F_x for VA with GLB and VA in payout phase		F_x for VA without GLB and with roll-up GDB		F_x for All Other	
	Male	Female	Male	Female	Male	Female
<=52	100%	95%	160%	150%	110%	105%
53	99%	95%	160%	152%	110%	106%
54	98%	95%	160%	154%	110%	107%
55	97%	95%	160%	156%	110%	108%
56	96%	95%	160%	158%	110%	109%
57	95%	95%	160%	160%	110%	110%
58	93.5%	93.5%	160%	160%	109%	109%
59	92%	92%	160%	160%	108%	108%
60	90.5%	90.5%	160%	160%	107%	107%
61	89%	89%	160%	160%	106%	106%
62	88%	88%	160%	160%	105%	105%
63	89%	88%	160%	159%	105%	104%
64	90%	88%	160%	158%	105%	103%
65	91%	88%	160%	157%	105%	102%
66	92%	88%	160%	156%	105%	101%
67	93%	88%	160%	155%	105%	100%
68	95%	90%	160%	154%	107%	101.5%
69	97%	92%	160%	153%	109%	103%
70	99%	94%	160%	152%	111%	104.5%
71	101%	96%	160%	151%	113%	106%
72	103%	98%	160%	150%	115%	108%
73	103.5%	99.5%	158%	149%	115%	109%
74	104%	101%	156%	148%	115%	110%
75	104.5%	102.5%	154%	147%	115%	111%
76	104.5%	103.5%	152%	146%	115%	112%
77	105%	105%	150%	145%	115%	113%
78	106.5%	106.5%	147%	143%	115%	113.5%

79	108%	108%	144%	141%	115%	114%
80	109.5%	109.5%	141%	139%	115%	114.5%
81	111%	111%	138%	137%	115%	114.5%
82	113%	113%	135%	135%	115%	115%
83	113%	113%	132%	132%	114.5%	114.5%
84	113%	113%	129%	129%	114%	114%
85	113%	113%	126%	126%	113.5%	113.5%
86	113%	113%	123%	123%	113.5%	113.5%
87	113%	113%	120%	120%	113%	113%
88	113%	113%	119%	119%	113%	113%
89	113%	113%	118%	118%	113%	113%
90	113%	113%	117%	117%	113%	113%
91	113%	113%	113%	116%	113%	113%
92	113%	113%	115%	115%	113%	113%
93	112.5%	112.5%	114%	114%	112.5%	112.5%
94	112%	112%	113%	113%	112%	112%
95	111.5%	111.5%	112%	112%	111.5%	111.5%
96	111%	111%	111%	111%	111%	111%
97	110%	110%	110%	110%	110%	110%
98	109%	109%	109%	109%	109%	109%
99	108%	108%	108%	108%	108%	108%
100	107%	107%	107%	107%	107%	107%
101	106%	106%	106%	106%	106%	106%
102	105%	105%	105%	105%	105%	105%
103	103.0%	103.0%	103.0%	103.0%	103.0%	103.0%
104	101.0%	101.0%	101.0%	101.0%	101.0%	101.0%
>=105	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

VM-V

A. Purpose and Scope

1. These requirements define for single premium immediate annuity contracts and other similar contracts, certificates and contract features the statutory maximum valuation interest rate that complies with Model #820. These are the maximum interest rate assumption requirements to be used in the CARVM and for certain contracts, the CRVM. These requirements do not preclude the use of a lower valuation interest rate assumption by the company if such assumption produces statutory reserves at least as great as those calculated using the maximum rate defined herein.

2. The following categories of contracts, certificates and contract features, whether group or individual, including both life contingent and term certain only contracts, directly written or assumed through reinsurance, with the exception of benefits arising from variable annuities valued under VM-21 and all contracts not passing the SET covered by Sections 1 through 13 of VM-22, are covered by VM-V:

   a. Immediate annuity contracts issued after Dec. 31, 2017;
   b. Deferred income annuity contracts issued after Dec. 31, 2017;
   c. Structured settlements in payout or deferred status issued after Dec. 31, 2017;
   d. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued after Dec. 31, 2017;
   e. Fixed payout annuities resulting from the exercise of settlement options or annuitizations of host contracts issued during 2017, for fixed payouts commencing after Dec. 31, 2018, or, at the option of the company, for fixed payouts commencing after Dec. 31, 2017;
   f. Supplementary contracts, excluding contracts with no scheduled payments (such as retained asset accounts and settlements at interest), issued after Dec. 31, 2017;
   g. Fixed income payment streams, attributable to contingent deferred annuities (CDAs) issued after Dec. 31, 2017, once the underlying contract funds are exhausted;
   h. Fixed income payment streams attributable to guaranteed living benefits associated with deferred annuity contracts issued after Dec. 31, 2017, once the contract funds are exhausted; and
   i. Certificates with premium determination dates after Dec. 31, 2017, emanating from non-variable group annuity contracts specified in Model #820, Section 5.C.2, purchased for the purpose of providing certificate holders benefits upon their retirement.

Guidance Note: For Section 2d, Section 2e, Section 2f and Section 2h above, there is no restriction on the type of contract that may give rise to the benefit.

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

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

   Rachel Hemphill, TDI

   Clarify 2017 CSO refers to the Loaded version of the tables unless Unloaded tables are specifically referenced.

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

   January 1, 2026 Edition of the *Valuation Manual* – VM-M Section 1.H.1

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

   See attached.

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

   Clarity, as the SOA posts both loaded and unloaded versions of the 2017 CSO to their website.

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

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
4/27/26	S.O.		
Notes: 2026-04			

VM-M Section 1.H.1

"2017 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the CSO Subgroup of the Joint Academy Life Experience Committee and SOA Preferred Mortality Oversight Group from the 2015 Valuation Basic Mortality Table developed by the joint group's Valuation Basic Mortality Subgroup, and adopted by the NAIC in April 2016. The 2017 CSO Mortality Table is ~~included in the Proceedings of the NAIC (1st Quarter 2016)~~available at https://mort.soa.org. Unless the context indicates otherwise, the "2017 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Unless specified otherwise, the "2017 CSO Mortality Table" refers to the loaded version of the table.

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

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

   Scott O'Neal and McKayla Doyle, NAIC

   Editorial corrections to address reference errors and formatting inconsistencies.

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

   January 1, 2026 Edition of the *Valuation Manual* – VM-20 Section 7.F.3.b, VM-21 Section 7.C.9.b*, VM-21 Section 7.D.3.b, VM-21 Section 13, VM-22 Section 10.H.2, VM-31 Section 3.E.3, VM-31 Section 3.F.3.i, VM-50 Section 2.A*, VM-51 Section 2.E.*

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

   See attached.

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

   The APF corrects editorial inconsistencies across multiple sections of the *Valuation Manual*, including reference errors and formatting discrepancies, to ensure clarity, consistency, and technical accuracy.

*** These editorial corrections were made to the 2025 version of the *Valuation Manual* and carried forward in the 2026 version of the *Valuation Manual*.**

NAIC Staff Comments:

Dates: Received	Reviewed by Staff	Distributed	Considered
5/19/26	SO		
Notes: 2026-05			

VM-20 Section 7.F.3.b

b. If the company models policy loans explicitly, the company shall:

i. Treat policy loan activity as an aspect of policyholder behavior and subject to the requirements of Section 9.D.

ii. For both the DR and the SR, assign loan balances either to exactly match each policy's utilization or to reflect average utilization over a model segment or sub-segments.

iii. Model policy loan interest in a manner consistent with policy provisions and with the scenario. In calculating the DR and SR, include interest paid in cash as a positive policy loan cash flow in that projection interval, per Section 74.BA.14.j, but do not include interest added to the loan balance as a policy loan cash flow. (The increased balance will require increased repayment cash flows in future projection intervals.)

iv. Model policy loan principal repayments, including those that occur automatically upon death or surrender. In calculating the DR and the SR, include policy loan principal repayments as a positive policy loan cash flow, per Section 74.BA.14.j.

v. Model additional policy loan principal. In calculating the DR~~deterministic~~ and SR, include additional policy loan principal as a negative policy loan cash flow, per Section 74.BA.1.j4 (but do not include interest added to the loan balance as a negative policy loan cash flow).

vi. Model any investment expenses allocated to policy loans and include them either with policy loan cash flows or insurance expense cash flows.

VM-21 Section 7.C.9.b*

b. Calculate two sets of NSPs at each attained age:

i. One using 100% of the 1994 Variable Annuity MGDB Age Last Birthday (ALB) Mortality Table (with the aforementioned five-year age setback for females); and

ii. A second using either:

(a) The prudent estimate mortality if that has been established by the company.

(b) For companies that have not established a prudent estimate mortality assumption, the appropriate percentage of the 2012 IAM Basic Table with Projection Scale G2 ALB (as described in Section 1112.B.3).

VM-21 Section 7.D.3.b

b. Combine the mapped exposure to determine the expected long-term "volatility of current fund holdings." This will require a calculation based on the expected long-term volatility for each fund and the correlations between the prescribed asset classes as given in the table "*Correlation Matrix for Prescribed Asset Classes*" in Section 7~~6~~.D.4.

VM-21 Section 13

Section 13: Allocation of the Aggregate Reserve to the Contract Level

Section 3~~2~~.F states that the aggregate reserve shall be allocated to the contracts falling within the scope of these requirements. That allocation should be done for both the pre- and post-reinsurance ceded reserves.

VM-22 Section 10.H.2

c. Model contract loan interest in a manner consistent with contract provisions and with the scenario. Include interest paid in cash as a positive contract loan cash flow in that projection interval, per Section 4.A.1.i, but do not include interest added to the loan balance as a contract loan cash flow. (The increased balance will require increased repayment cash flows in future projection intervals.)

d. Model contract loan principal repayments, including those that occur automatically upon death or surrender. Include contract loan principal repayments as a positive policy loan cash flow, per Section 4.A.1.i~~h~~.

e. Model contract loan principal. Include additional contract loan principal as a negative contract loan cash flow, per Section 4.A.1.i~~h~~ (but do not include interest added to the loan balance as a negative policy loan cash flow).

VM-31 Section 3.E.3

	Post-Reinsurance-Ceded		Pre-Reinsurance-Ceded	
	Current Year (YYYY)	Prior Year (YYYY-1)	Current Year (YYYY)	Prior Year (YYYY-1)
Total VM-21 Reserve				
Stochastic Reserve (SR)				
- SR Amount				
- CTE 70 (best efforts)				
- CTE 70 (adjusted)				

- E Factor			N/A	N/A
Standard Projections				
- Additional Standard Projection Amount				
- Prescribed Projections Amount				
- Unbuffered Additional Standard Projection Amount				
- Unfloored CTE 70 (adjusted)				
- Unfloored CTE 65 (adjusted)				
Alternative Methodology (AM)				
- AM Reserve				
- AM Reserve (without floor)				
- Cash Surrender Value Floor				
- Reserve Floor under AG 33				
Phase-In Components				
Amortization Approach				
R1			N/A	N/A
R2			N/A	N/A
A			N/A	N/A
B			N/A	N/A
C = R1 – R2			N/A	N/A
D				
			N/A	N/A
Summary Statistics				
- Separate Account Value			~~N/A~~	~~N/A~~
- General Account Value			~~N/A~~	~~N/A~~
- Total Account Value			~~N/A~~	~~N/A~~
- Cash Surrender Value			~~N/A~~	~~N/A~~
- Contract Count			~~N/A~~	~~N/A~~
RBC Amount				
- CTE level used for C-3 RBC in LR027 (pre-tax)			N/A	N/A
- CTE level used for C-3 RBC under LR027 (post-tax)			N/A	N/A
- Effect of Phase-In			N/A	N/A
- Effect of Smoothing			N/A	N/A

	Post-Reinsurance-Ceded		Pre-Reinsurance-Ceded	
	Current Year (YYYY)	Prior Year (YYYY-1)	Current Year (YYYY)	Prior Year (YYYY-1)
Total VM-22 Reserve				
Modeled Reserve				
- DR Amount				
- SR Amount				
- CTE 70 (best efforts) for SR				
- CTE 70 (adjusted) for SR				

- E Factor for SR			N/A	N/A
Standard Projections				
- Additional Standard Projection Amount				
- Prescribed Projections Amount				
- Unbuffered Additional Standard Projection Amount				
- Unfloored CTE 70 (adjusted)				
- Unfloored CTE 65 (adjusted)				
Summary Statistics				
- Separate Account Value			~~N/A~~	~~N/A~~
- General Account Value			~~N/A~~	~~N/A~~
- Total Account Value				
- Cash Surrender Value				
- Contract Count				

VM-31 Section 3.F.3.i

i. Actual to Expected Analysis – Disclosure of the results of the most recently available actual to expected (without margins) analysis for the assumptions including Section 3.F.3.cd ~~c~~ Expenses Other than Commissions, Section 3.F.3.de ~~d~~ Partial Withdrawals, Section 3.F.3.fg ~~e~~ Annuitization Benefits and Section 3.F.3.gh ~~f~~ GMIB and GMWB Utilizations, including:

i. Definitions of the expected basis used in all actual-to-expected ratios shown.

ii. Comments addressing the conclusions drawn from the analysis.

VM-50 Section 2.A*

A. Statutory Authority

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

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

3. Section 14A(5) of Model #820 defines the data to be collected to be confidential.

VM-51 Section 2.E*

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

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

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

Generally, each policy number represents a policy issued as a result of ordinary underwriting. If a single life policy, the base policy on a single life has the policy number and a segment number of 1. On a joint life policy, each life has separate records with the same policy number. The base policy on the first life has a segment number of 1, and the base policy on the second life has a segment number of 2. Policies that cover more than two lives are not to be submitted.

Term/paid up riders or additional amounts of insurance purchased through dividend options on a policy issued as a result of ordinary underwriting are to be submitted. Each rider is on a separate record with the same policy number as the base policy and has a unique segment number. The details on the rider record may differ from the corresponding details on the base policy record. If underwriting in addition to the base policy underwriting is done, the coverage is given its own policy number.

Terminations (both death and non-death) are to be submitted. Terminations are to include those that occurred in the observation year and were reported by March 31~~June 30~~ of the year after the observation year.

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

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

Identification:
NAIC VM-22 (A) Subgroup

Title of the Issue:
Clarify VM-22 applicability to deposit-type contracts based on Academy proposed edits

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

2026 Valuation Manual, VM-22 Sections 1.A and 2.A

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

VM-22, Section 1.A

Purpose

These requirements establish the minimum reserve valuation standard for non-variable annuity contracts as defined in Section II of the Valuation Manual, Subsection 2.C and for Deposit-Type Contracts falling under the scope of VM-22 Section 2.A. For all contracts encompassed by the Scope, these requirements constitute the Commissioners Annuity Reserve Valuation Method (CARVM) and, for some contracts and certificates, the Commissioners Reserve Valuation Method (CRVM).

VM-22, Section 2.A:

Scope

Applicable non-variable annuity contracts specified in VM Section II, Subsection 2 "Annuity Products", Paragraphs C and D and ~~applicable contracts in VM Section II, Subsection 3~~ "Deposit-Type Contracts" not otherwise excluded by VM Section II, Subsection 2.C are subject to VM-22 requirements.

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

Clarify that there are some deposit-type contracts that fall in scope of VM-22 requirements, though not all deposit-type contracts are in scope.

Dates: Received	Reviewed by Staff	Distributed	Considered
12/15/25	A.F.	12/17/25	
Notes: 2025-18. Exposed by VM-22 SG for a 90-day comment period ending 3/17/26.			

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

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

   Identification:
   NAIC VM-22 (A) Subgroup

   Title of the Issue:
   Remove criteria requirements of VM-22 Aggregation

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

   2026 Valuation Manual, VM-22 Section 3.F and VM-31 Section 3.F.14.j

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

   See following page

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

   Remove criteria for aggregate payout and deferred annuities in VM-22 and add a disclosure in VM-31 for the aggregation benefit.

Dates: Received	Reviewed by Staff	Distributed	Considered
12/15/25	A.F.	12/17/25	
Notes: 2025-20 Exposed by VM-22 SG for 90-day comment period ending 3/17/26.			

VM-22, Section 3.F.2:

2. The Payout Annuity Reserving Category and Accumulation Reserving Category may be aggregated. ~~only if they meet the following criteria:~~

~~a. The company manages the risks of the contracts within both categories in an integrated risk management process.~~

~~b. The contracts within both categories are managed within a single portfolio, or portfolios with the same ALM strategy.~~

~~**Guidance Note:** For the purposes of aggregating payout and accumulation reserving categories, the Subgroup plans to revisit whether to include prerequisites to permit aggregation, as well as which criteria and disclosures to focus on for such aggregation.~~

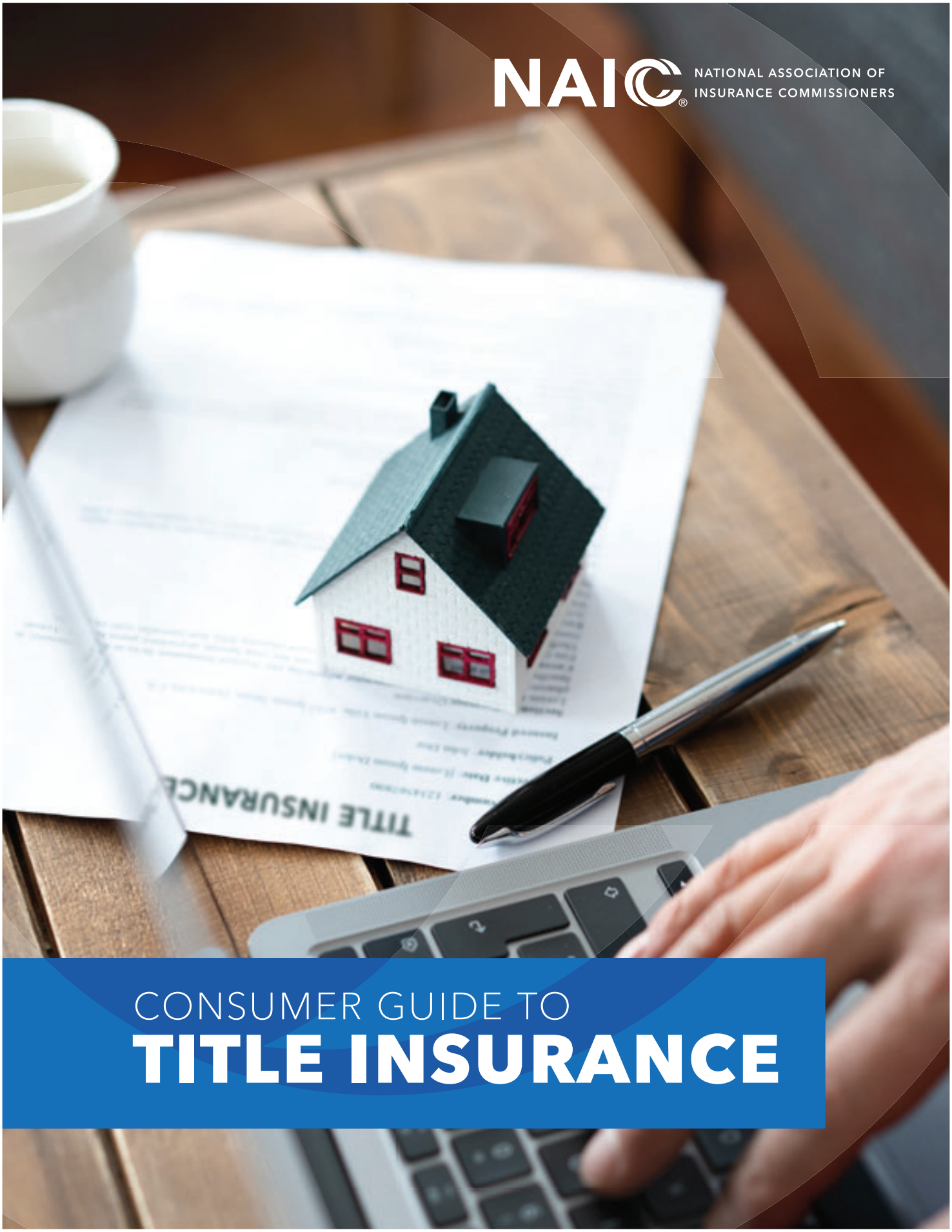
VM-31, Section 3.F.14.j:

j. Aggregation – The following information on aggregation:

i. Disclosure of the impact of aggregation, that is, a comparison of seriatim calculations compared to aggregation permitted under VM-21 or VM-22, and discussion of the method used to determine the impact, pursuant to Section 6.A.1.a in VM-21 or VM-22.

ii. For VM-22, ~~support that the criteria in~~ to the extent the Payout Annuity Reserving Category and Accumulation Reserving Category are aggregated pursuant to VM-22 Section 3.F.2, provide a breakdown of reserve results (SR and CSV) for each Reserving Category, both pre- and post-reinsurance, along with case counts and face amounts.~~is met.~~

iii. To the extent that aggregation is done across multiple model segments, whether across reserving categories or within a reserving category, the methodology used to allocate the aggregation benefit across model segments shall be documented.



CONSUMER GUIDE TO
TITLE INSURANCE

CONSUMER GUIDE TO **TITLE INSURANCE**

THIS GUIDE PROVIDES:

- The basics of title insurance.
- The importance of title insurance.
- Shopping tips for title insurance and closing services.
- Questions to ask before you buy title insurance.

Drafting Note: This template is designed for state insurance departments interested in creating a consumer education publication about title insurance. It serves as a comprehensive guide that can be customized to suit the specific needs of each state.

CONSUMER GUIDE TO **TITLE INSURANCE**

TABLE OF CONTENTS

DISCLAIMER:
The information included in this publication is meant to serve as a guide and is not a substitute for legal or professional advice. Please contact a professional if you have any questions.

CONSUMER GUIDE TO **TITLE INSURANCE**

INTRODUCTION

Buying or refinancing a property is a significant financial decision that involves many steps. One critical but sometimes overlooked step is choosing title insurance. Title insurance protects property owners and/or lenders from financial losses caused by past issues, such as unpaid liens, forged documents, or claims from missing heirs that weren't discovered during a title search. This protection typically lasts for the entire time you own the property.

When you buy title insurance, be sure it is from a title insurance agent or company licensed to do business in { State }.[1]

[1] *[**Drafting note:** If your state has an agent locating/verification tool, this is a great place to reference the website specific to the agent verification tool and/or contact number for the state's licensing office.]*

This shopping tool focuses on title insurance—what it is, when it's required, why it's important, and information to help you choose the right policy.

KEY STEPS IN THE HOMEBUYING PROCESS


Prepare finances and credit


Secure financing pre-approval....if needed


Find a real estate professional


Identify the right property


Make an offer


Sign the purchase agreement and get an inspection


Determine your insurance coverage needs


Close and enjoy your new home

CONSUMER GUIDE TO **TITLE INSURANCE**

WHAT IS TITLE INSURANCE AND WHAT DOES IT COVER?

A deed is a legal document that conveys the legal ownership of a property.
A deed is a legal document that conveys the legal ownership of a property.

Title insurance is an insurance policy that covers past title problems that come up *after* you buy or refinance a property.

Lost, forged, or incorrectly filed deeds, property access issues, and liens on a property are just a few of the title problems that could come up after you buy or refinance a property.

For example, if you get a letter telling you there is an unpaid mortgage on a home you just bought, you could submit a claim to your title insurance company. The title insurance company would cover the legal costs and other expenses to investigate, defend against the claim to the title, and settle the dispute and/or resolve the issue.

Without title insurance, you might have to pay all of the legal costs to settle the dispute. And if you lose the dispute, you could lose money, the equity you have in your home, and possibly your home.

WHAT ARE THE TWO MAIN TYPES OF TITLE INSURANCE?

There are two types of title insurance policies:

1. An Owner's Title Insurance Policy

An *owner's policy* protects you for the full price you paid for the property, plus legal costs if a past covered title problem comes up after you buy your property. The coverage in an owner's policy is often for the amount you paid to buy your property. The policy will cover you as long as you have a legal right to own the property. The buyer most often pays the premiums for an owner's policy.

If you aren't required to buy an owner's policy, you may want to anyway, so you don't risk losing the money you've paid for your property if there's a problem with the title.[2]

[2] *[**Drafting note:** If your state requires an owner's policy, use this sentence: "In {State}, you must buy an owner's policy." If your state does NOT require an owner's policy, use this sentence: "While some states require you to buy an owner's policy, {State} does not."*

An *enhanced owner's policy*, which has more coverage than a standard owner's policy, may also be available in your area. Enhanced owner's policies cost about 20% more than a standard owner's policy, but they cover extra risks. An enhanced owner's policy may also continue to cover you after you no longer own a property.

2. A Lender's Title Insurance Policy

If you borrow money to buy your property, your lender is likely to require you to buy a *lender's policy*. A lender's policy only protects *the lender* if a title problem comes up after you buy the property. The coverage in a lender's policy is for the amount of the mortgage and goes down as you pay down your loan. Unlike an owner's policy, the lender's policy ends when you pay off your mortgage. You may have to pay the premium for a lender's policy.

Because a lender's policy only protects the lender from title problems, you'll also need an owner's policy if you want to protect yourself and the equity you have in your property.

CONSUMER GUIDE TO **TITLE INSURANCE**

WHAT DOESN'T TITLE INSURANCE COVER?

Title insurance policies *do not* cover ownership issues that come about *after* you've bought a property. For example, if your neighbor builds a fence on your property line or a contractor files a lien after you've bought your property, your title insurance policy will **not** cover the costs to settle the dispute.

Also, your title insurance policy might not cover certain existing issues with the property. For instance, the property may have an ongoing boundary dispute or an undisclosed easement (for example, someone else has the legal right to use part of your property, like a driveway or utility line, for a specific purpose). Your title insurance typically will **not** cover the costs of resolving these types of issues.

A title insurance policy primarily covers past title defects, such as forged documents and improperly filed titles, but does not address issues that come up after the closing.

Ask for a list of what will and won't be covered and ask questions to be sure you understand the differences.

WHAT SHOULD I KNOW ABOUT CHOOSING A TITLE COMPANY AND BUYING TITLE INSURANCE: RIGHTS, COSTS, AND REFERRALS?

YOU HAVE THE RIGHT TO SHOP FOR AND CHOOSE WHO PROVIDES YOUR TITLE INSURANCE AND CONDUCTS THE CLOSING!

When you buy a property, two important steps are choosing the right title company and understanding your title insurance. Both are important to protect your investment and make sure your closing goes smoothly. Before, or more likely, at the time you make an offer to buy a property, you'll be asked to name a licensed title company, agent/producer, or attorney to handle your real estate closing. The closing is also known as a settlement.

The licensed professional you choose will be responsible for several crucial steps in the process to buy a property, including buying title insurance. At all times during the process, you have the right to choose the title company for your transaction. At no point should you be pressured, coerced, or required to sign an agreement with a company you didn't choose.

AFFILIATED BUSINESS ARRANGEMENTS IN THE LAW

The Federal Real Estate Settlement Procedures Act (RESPA) defines and regulates affiliated business arrangements (ABAs). This law requires a written disclosure that names a specific title company and explains that the agent has a financial interest and will make money if you use this title company. RESPA prohibits kickbacks and referral fees for parties involved in real estate settlements.

For more information, access the full text here.

CONSUMER GUIDE TO **TITLE INSURANCE**

WHO SELLS TITLE INSURANCE AND WHO PAYS FOR IT?

You can start to research title insurance when you begin your search for a property to buy. Only licensed companies, agencies, or agents are allowed to sell title insurance policies. You can ask friends, family, or your real estate agent for advice to help you with your choice. Online reviews may also be helpful.

Who pays for title insurance depends on local rules and traditions, but buyers and sellers can also negotiate this. Often, the seller pays for the owner's policy, and the buyer pays for the lender's policy. Ask your real estate agent who usually pays for title insurance in your area.

You pay for title insurance once—at closing.

If you're refinancing, you, as the property owner, must buy and pay for the new lender's title insurance policy. Generally, you won't need a new owner's policy when you refinance if you bought one when you bought the property.

BE AWARE

Your agent or broker may have an affiliated business arrangement (ABA) with the title insurance agent or company they recommended. There may be a financial arrangement in place that gives the agent an incentive to make this recommendation.

If there's an affiliated arrangement, the agent must tell the buyer in a written notice before the closing. Often, the title company is pre-selected, and the name is pre-filled on the offer paperwork. The disclosure is a separate document.

The established relationship in an ABA could mean a smoother transaction and more coordinated services. But it also could mean higher costs, a conflict of interest, and poorer service if the focus is on financial gain. You are never required to use a company that has an affiliated business relationship.

HOW DO I CHOOSE A TITLE INSURANCE COMPANY?

Regardless of who refers you to a title insurance company, it's essential to compare the estimated costs and fees and to ask questions. While the cost of a title policy is fixed based on the purchase price of the property, fees and some costs can vary widely between title companies.

The cost comparison chart on page 17 lists several costs and fees. Ask for an estimate of these fees and costs based on the expected purchase price of the property. You may be able to negotiate some of them. If you don't understand what a fee or cost is, ask questions. Do not accept statements like:

"Everyone charges the same price."

"We'll give you a discount on something else if you use our title agent."

"If you choose another title agent, your purchase may be delayed."

A title company should be willing and able to answer all your questions before you make a decision. Even if the process feels rushed, federal law gives you the right to receive and review a closing disclosure at least three business days before closing.

Shopping around and asking questions allows you to make an informed decision, find a company you feel confident in, and potentially save you money.

CONSUMER GUIDE TO **TITLE INSURANCE**

WHAT ARE ALTERNATIVES TO TITLE INSURANCE?

WHAT IS AN ATTORNEY OPINION LETTER?

If you are offered an attorney opinion letter (AOL) instead of title insurance, here's what you should know. An AOL is essentially a letter from a lawyer that states who owns the property and shares their opinion about any issues they find in the public records after reviewing the title.

The letter is the lawyer's opinion on the condition and ownership of a property's title. The letter may include information on the legal status, validity, and risks of a real estate transaction. It may address issues such as title disputes, enforceability of loan terms, or compliance with local laws. This opinion is based on facts and information available as of the day the AOL is written.

The letters do not typically cover fraud, forgery, or liens that aren't in public records. If there is a problem with the title, the attorney who drafted the letter does not pay your legal costs and expenses to fix the problem. You will pay the costs to research and resolve the issue. The attorney who drafts the letter determines the price of the AOL.

State insurance departments do not regulate the contents, form, or pricing of AOLs. Title insurance is primarily regulated at the state level, and state insurance agencies may license title insurance companies and review and approve forms and rates

Whether you can use an AOL depends on the type of transaction, the location of the property, and the type of property. Currently, AOLs are mainly used by lenders and usually only protect the lender.

WHAT EMERGING PRODUCTS SHOULD I KNOW ABOUT IN THE AOL MARKET?

Insurance companies have begun to offer an insurance policy that protects an attorney if they made an error or mistake when providing their opinion in the AOL.

The liability insurance is purchased at the same time as the AOL and serves as a safety net for attorney mistakes. Usually, it protects only the lender and the attorney who issued the AOL, not you as the property owner.

Some newer liability coverage offerings may extend protection for you and your lender. If you are offered an AOL with an insurance policy that states it covers you as the property owner, be sure to review the terms carefully and ask questions to understand what's included.[3]

[3] *[**Drafting note:** If your state has issued guidance regarding AOLs or other products being offered as an alternative to title insurance, reference the bulletin or guidance issued by your state here.]*

If you're considering an AOL, check the "What Does a Title Insurance Policy Cost?" section for costs and discounts, and use the cost chart to compare options.

CONSUMER GUIDE TO **TITLE INSURANCE**

HOW DOES TITLE INSURANCE FIT INTO THE CLOSING PROCESS?

WHAT HAPPENS AT CLOSING?

The closing is the final step to buy or refinance a property. The closing can be in person, remote, or by mail. An in-person closing usually takes an hour or two. Several individuals may attend, including the buyer, seller, real estate agents, attorneys, title agents, and lenders. If you can't be there in person or remotely, you can appoint someone to sign documents on your behalf.

A closing agent is responsible for managing the closing and coordinating the steps to finalize the transaction. Closing agents can be title agents or attorneys. After the seller accepts your offer or the lender approves your refinancing, you'll work together to choose a closing date. On that day, you and the seller must settle any outstanding debts and sign the necessary legal paperwork to finalize the transaction.

You pay the title insurance premium only once—at closing.

Remember that your policy protects you and your heirs with a legal right to the property from title issues for as long as you own it.

WHAT DOCUMENTS WILL I SEE AT CLOSING?

The closing disclosure is an important document. The disclosure details all payments required to complete the transaction, including title insurance premiums and closing protection letter premiums/ fees.

Federal law lets you review your closing disclosure at least three business days before closing. Reviewing the disclosure as soon as possible gives you more time to ask questions and avoid delays in your closing date.

You'll sign many documents at closing. Be sure you understand what you're signing.

After closing, you'll receive copies of all signed documents. The figure below illustrates what you can expect during the closing process.

CONSUMER GUIDE TO **TITLE INSURANCE**

WHAT STEPS TO EXPECT IN A REAL ESTATE TRANSACTION

SIGN CONTRACT AND PROVIDE EARNEST MONEY	You will sign the purchase contract and provide an earnest money deposit to show you are serious about buying the property.
TITLE SEARCH COMPLETED	The title agent or title company will review the property's history to check for issues like liens, disputes, or outstanding mortgages. You'll be notified if anything needs to be resolved before closing.
RECEIVE TITLE INSURANCE COMMITMENT	You'll get a report from your title agent or title company outlining the title insurance premium, requirements, and any exceptions (such as easements).
REVIEW CLOSING DISCLOSURE	If you are borrowing money to buy real estate, you will receive your Closing Disclosure at least three days before closing, outlining how the funds will be disbursed and the mortgage terms. Review this carefully and ask questions if anything is unclear.
ATTEND CLOSING	On closing day, you'll sign all required documents, pay any remaining costs, and the funds will be distributed (such as paying off liens, disbursing proceeds, paying premiums, etc.).
DOCUMENTS RECORDED	After closing, the closing agent or title company files paperwork with the county where the property is located to update public records with your ownership and lender information. This isn't always done correctly, and mistakes can happen, so you should always follow up with the county to confirm.
RECEIVE YOUR TITLE POLICY AND DEED	You'll receive your owner's title policy and the recorded deed as proof of ownership. The lender will receive a lender's title policy. (You should keep your title policy as proof of title insurance.)

WHAT IS A CLOSING PROTECTION LETTER?

Title insurance doesn't protect the lender or buyer against mistakes made during the closing, or if money is stolen or paid to the wrong parties. For an added fee, title insurance companies offer closing protection letters. In some cases, the lender may require a closing protection letter.

If you buy a closing protection letter, the title insurance company will reimburse you for any money you lose from negligence, fraud, theft of funds, or errors the closing agent made.

Without this protection, you'd have to sue the agent to get back any money lost.

If you buy closing protection coverage, be sure to ask for a copy of the closing protection letter for your records.[4]

[4] ***Drafting note:*** *States that do not require closing protection, have modified coverage requirements, or have determined a closing protection letter to be insurance should delete or edit this section accordingly.*

CONSUMER GUIDE TO **TITLE INSURANCE**

WHAT'S THE DIFFERENCE BETWEEN TITLE INSURANCE AND HOMEOWNERS INSURANCE?

Title insurance is different from homeowners insurance (sometimes called hazard insurance).

Title insurance protects you against past title problems. Homeowners insurance protects you against future issues that cause damage to your home or personal property. Homeowners insurance also limits your personal legal responsibility (or liability) if someone is injured while they are on your property.

Licensed title insurance agents and companies sell title insurance. Insurance agents licensed to sell property/casualty insurance sell homeowners insurance.

You pay for title insurance just once when you buy or refinance your property. For homeowners insurance, you make your first payment at closing and then keep paying regularly (such as every month or year) to keep your coverage active. Homeowners insurance needs to be renewed each year, and a premium is paid at each renewal.

Homeowners insurance does not protect your ownership of the property and does not replace the need for title insurance. The table below summarizes the differences between title insurance and homeowners insurance. Remember to always review your insurance policy for terms and conditions regarding your coverage.

FEATURES	TITLE INSURANCE*	HOMEOWNERS INSURANCE*
PROTECTION	Covers defects in the property's legal history or title.	Covers physical damage to the home and personal property from future events, as well as liability risks.
TIMELINE	Covers specified past and existing issues with a property.	Covers future damage and liability.
COMMON ISSUES COVERED	Prior liens, errors in public records or past deeds, heirs and claims, and forged documents.	Damage from fires and storms, theft and vandalism, personal liability, and additional living expenses.
PAYMENT	One-time premium paid at closing.	Recurring monthly or annual premium payments.
POLICY DURATION	Lasts as long as you or your heirs own the property.	Lasts for the policy term and must be renewed.
*Always review your policy for terms and conditions		

For more information about homeowners insurance, refer to the NAIC's A Consumer's Guide to Home Insurance and the NAIC's A Shopping Tool for Homeowners Insurance.

CONSUMER GUIDE TO **TITLE INSURANCE**

HOW CAN I PROTECT MYSELF FROM REAL ESTATE FRAUD?

Scammers often target real estate transactions. They use fake documents, hacked emails, and even artificial intelligence (AI) technology to steal money or property. While title insurance protects against past ownership issues, it may not cover scams that happen during the closing process.

The good news is that there are simple steps you can take to recognize fraud and keep your transactions secure.

WHAT ARE THE MOST COMMON TYPES OF SCAMS?

Seller Impersonation Fraud: Scammers use fake IDs or paperwork to pretend to own a vacant or rental property. They quickly list the property for sale and try to close the deal fast to steal the money.

Wire Transfer Fraud: Hackers break into email accounts and send fake wiring instructions that look like they came from your title company, agent, or attorney. If you send money to these accounts, it may be lost forever.

Mortgage Payoff Fraud: Criminals claim to be your lender or closing agent and trick you into wiring your mortgage payoff to the wrong place.

AI-Powered Voice Scams: Scammers use AI to mimic the voices of people you trust, convincing you to change payment or closing details.

Deed Theft: Criminals illegally transfer property ownership to themselves by forging documents, such as deeds. They then use this fake ownership to sell the property, secure loans against it, or rent it out to unaware tenants.

WHAT ARE THE SIGNS OF A SCAM?

- Requests to change payment or wire instructions via email or text.
- Unwillingness to speak by phone or meet in person.
- Pressure to close quickly or remotely.
- Properties priced well below market value or in poor condition.
- Closings scheduled for weekends or holidays.

CONSUMER GUIDE TO **TITLE INSURANCE**

HOW CAN I STAY SAFE?

- **Get a verified contact list:** Collect phone numbers and email addresses for all closing professionals from trusted sources.
- **Use secure platforms:** Choose title insurance companies that offer fraud prevention tools.
- **Review documents carefully:** Read your title commitment and closing disclosure in advance. Watch for unusual terms or instructions.
- **Double-check wire transfers:** Before and after sending money, speak directly with your title insurance or closing agent to confirm that it was received.
- **Verify all changes:** If you're asked to update any part of the closing process, call your contacts using known numbers to confirm.
- **Stay vigilant after closing:** Monitor your property for ongoing changes to your deed and title. You can use public land records or pay for a title monitoring service. *[Insert jurisdiction-specific information.]*

WHAT SHOULD I DO IF I SUSPECT FRAUD?

- Contact your bank immediately to attempt a wire recall.
- Notify your title insurance company and all parties involved in the transaction.
- Alert your credit bureau.
- Call your local Federal Bureau of Investigation (FBI) office and report the crime.
- File a report with the FBI's Internet Crime Complaint Center: www.ic3.gov.

CONSUMER GUIDE TO **TITLE INSURANCE**

HOW DO I FILE A TITLE INSURANCE CLAIM?

If there is an issue about your property's title, contact your title insurance company as soon as possible. If you don't know the name of your title insurance company, check the paperwork you signed when you bought or refinanced your property.

You can contact your title insurance agent or closing company for help. They will look into the issue and help determine if a valid claim exists. If there is one, they will explain the process to resolve the issue.

The
Is Here to Help.

For more information about buying insurance, please visit

or call

As a consumer protection agency, the

can also help if you think an insurance agent or company has misled you or acted improperly.

To file a complaint, please visit our website at

or send a written complaint and any supporting documents to:

CONSUMER GUIDE TO **TITLE INSURANCE**

OTHER RESOURCES

To verify that professionals who will help you with your real estate transaction are licensed, please contact:

Real Estate Agent

Bank/Mortgage Lender

Real Estate Appraiser

Insurance Agent

Insurance Company

Title Agent

Title Insurance Company

Attorney

To find other useful information about the home buying process, please contact:

U.S. Department of Housing and Urban Development
451 7th Street S.W.
Washington, DC 20410
202-708-1112
www.hud.gov

Consumer Financial Protection Bureau
P.O. Box 4503
Iowa City, Iowa 52244
855-411-2372
855-237-2392 (Fax)
http://www.consumerfinance.gov

National Flood Insurance Program
500 C Street SW
Washington, DC 20472
800-621-FEMA
www.floodsmart.gov

FBI Internet Crime Complaint Center
www.ic3.gov

FTC Identity Theft Help
www.identitytheft.gov

CONSUMER GUIDE TO **TITLE INSURANCE**

TITLE INSURANCE SHOPPING TOOLKIT

These pages are designed to be a practical toolkit. You're encouraged to download or print and use these materials during your decision-making process. Have the downloaded toolkit or a printed copy with you during meetings with title insurance agents, real estate agents, or when you review documents. Each section offers key questions to protect your interests.

WHEN YOU SHOP FOR TITLE INSURANCE, BE SURE TO ASK THE TITLE INSURANCE AGENT OR COMPANY THE FOLLOWING QUESTIONS:

- How long have you been licensed to sell title insurance in
- What title insurance companies' policies do you sell?
- Are title insurance premiums regulated in
- Are any discounts available?
- Are you related or affiliated in any way with my real estate agent, mortgage lender, builder, or attorney?
- Will anyone be paid a referral fee or commission, or be compensated if I buy title insurance from you or a company you represent?
- In addition to title insurance premiums, what other fees and charges will I pay?
- What policy endorsements are available?
- Do you charge a cancellation fee if I don't buy title insurance from you after you do a title search?
- Will I need to pay for a survey (a professional drawing of the property's boundaries and property location) before you can sell me title insurance?

IF YOU'RE CONSIDERING AN ATTORNEY OPINION LETTER (AOL), BE SURE TO ASK THE FOLLOWING QUESTIONS:

- How is an AOL different from title insurance?
- How does the cost of an AOL compare to the cost of title insurance?
- Will my lender accept an AOL instead of title insurance?
- Is there any extra insurance with the AOL? If yes, who is it from, and what does it cover?
- If there's a problem, do I have to go to court to get help?
- What problems won't the AOL cover?

CONSUMER GUIDE TO **TITLE INSURANCE**

When choosing a closing agent, be sure to ask the following questions:

- Can you give me a list of all the fees and charges I would pay if you were my closing agent?
- What fees and charges are negotiable?
- Are your closing staff licensed title insurance agents?
- How and when do you conduct closings?
- Who will handle my closing?
- When will you give me a copy of the closing document?
- Do you have references or testimonials from former clients?
- Do you offer closing protection coverage?
- How much does closing protection cost?

Shop around for title insurance and closing services

You should shop for title insurance and closing services, as premiums and fees can vary. Use the chart below to see how much you'll be charged for specific premiums, fees, and services.

TITLE INSURANCE SHOPPING TOOL

COST COMPARISON CHART

	Company Name	Company Name	Company Name
Title Insurance			
Premium Price (Lender's Title Policy)	$	$	$
Premium Price (Owner's Title Policy)	$	$	$
Endorsement Price	$	$	$
Title Search Fee	$	$	$
Closing Protection Letter	$	$	$
Deed Preparation Fee	$	$	$
Other	$	$	$
Other	$	$	$
Total:	**$**	**$**	**$**

	Company Name	Company Name	Company Name
Closing Costs			
Government Recording Charge	$	$	$
Tax & Other Certifications	$	$	$
Overnight Mail	$	$	$
Wire Fee	$	$	$
Transfer Tax	$	$	$
Notary Fee	$	$	$
Settlement Fee	$	$	$
Document Preparation Fee	$	$	$
Email/Electronic Doc Fee	$	$	$
Other	$	$	$
Other	$	$	$
Total:	**$**	**$**	**$**

CONSUMER GUIDE TO **TITLE INSURANCE**

GLOSSARY OF TERMS AND DEFINITIONS

Affiliated Business Arrangement: An arrangement in which a person who can refer business, such as a real estate agent, has an ownership interest in a settlement service provider (e.g., title insurance, mortgage company) and refers business to them.

Attorney Opinion Letter: A legal opinion from an attorney on a property's title status.

Closing: The process of completing a real estate transaction during which deeds, mortgages, leases, and other required instruments are signed and/or delivered, parties settle and balance their accounts, and money is paid. Closing can also be referred to as a settlement.

Closing protection letters: A document issued by a title insurance company. The letter protects a lender if a title insurance company's agent or attorney fails to follow closing instructions or steals funds.

Commitment: The preliminary report or binder that the title insurance company creates before it issues a title insurance policy. The commitment includes the policy's terms, conditions, and exceptions.

Deed: A legal document that conveys legal ownership.

Defect: A problem or missing information related to the title that affects your ownership rights to the property.

Earnest money deposit: A good-faith payment from the potential buyer to show serious intent to buy the property.

Exception: Specific items or issues listed in a title insurance policy that the insurance doesn't cover.

Insurance: A contract where you pay for financial protection against specific risks.

Lien: A legal claim on a property for money owed to a creditor or lienholder. Property with a lien usually cannot be sold.

Lender's policy: Protects the lender against problems with the title for as long as they have an interest in the property (typically until the mortgage is paid off).

Owner's policy: Protects the owner against problems with the title for as long as they have an interest in the property. Covers the full purchase price of the property and legal costs if a past title issue comes up.

Policy: A written legal agreement (i.e., contract) between an insurance company and the owner of the policy (i.e., policyholder) that provides financial coverage for specific losses in return for fees (i.e., premium payments).

Premium rates: Price for a unit of insurance.

Real Estate Settlement Procedures Act (RESPA): A federal law that offers guidance for certain real estate settlement procedures. For more information about RESPA, visit: https://www.consumerfinance.gov/compliance/compliance-resources/mortgage-resources/real-estate-settlement-procedures-act/

Recording: Officially entering a real estate or property transaction document into the public record.

Simultaneous issue: When an owner's and lender's title insurance policies are issued at the same time. The premium could be lower if policies are issued at the same time.

Title: A legal right to own, possess, use, control, enjoy, and dispose of real estate or a right or interest therein.

CONSUMER GUIDE TO **TITLE INSURANCE**

GLOSSARY OF TERMS AND DEFINITIONS CONTINUED

Title agent: A person licensed to issue title insurance. This person reviews property histories, determines if the property can be insured, and issues title insurance reports or policies. They also handle money, such as premiums or escrow funds, manage escrow accounts and closings, negotiate title insurance deals, and take care of closing paperwork.[5]

[5] ***Drafting Note:*** *If a jurisdiction uses different terminology, such as "producer" instead of "agent," this definition can be modified accordingly.*

Title insurance: A contract that provides financial protection for past title problems that come up after you buy or refinance a property.

Title insurance report: A preliminary report, statement, or agreement issued before a title insurance policy that outlines the terms, conditions, exceptions, and other relevant details the title insurer is willing to accept for issuing the policy.

Title insurer: An insurance company that underwrites and provides title insurance policies to protect against financial loss due to issues with a property's title.

Title Report: The results of the title examination. These results include what, if anything, needs to be fixed to make sure the property can be sold without problems. Note that a title report does not say whether a property can be sold or insured.

Title search and examination: The process of reviewing recorded documents about a property to see if the seller has the legal right to sell it and whether there are any problems, like debts or legal claims, that could affect the sale.

PROJECT HISTORY

TITLE INSURANCE CONSUMER SHOPPING TOOL TEMPLATE

1. Purpose, Description of the Project, Date Adopted

- The *Title Insurance Consumer Shopping Tool Template* educates consumers about title insurance, assists with shopping, explains closing, and can be customized by each state. The tool, last revised in 2021, required a complete overhaul to incorporate new products, market developments, and changes in how consumers access and use information.

- The *Title Insurance Consumer Shopping Tool Template* was adopted by the Title Insurance (C) Working Group at the 2025 Fall National Meeting and by the Property and Casualty Insurance (C) Committee at the 2026 Spring National Meeting.

2. Relationship to Federal Legislation, If Any

N/A

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

Title Insurance (C) Working Group

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

Title Insurance (C) Working Group ongoing charge:

- D. Update the survey of state laws regarding title data and title matters report and the *Title Insurance Consumer Shopping Tool Template* as needed.

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

Drafted by a drafting group consisting of the following Working Group members: Chuck Myers (LA), Connie Van Slyke (NE), Jim Easton (IN), Angela Crooker (VA), and Pratima Lele and Angela King (DC). Input was sought from NAIC Consumer Advocate Brenda J. Cude on readability. Modest revisions were incorporated based on industry feedback following the exposure period.

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

- The drafting group began revising the shopping tool in May, initially focusing on content updates. This included:
  - Clarifying attorney opinion letters so consumers understand their purpose and differences from traditional title insurance.
  - Updating the fraud section for emerging artificial intelligence (AI) schemes, title protection options, and mortgage monitoring services.

- Expanding the affiliated business arrangements section to include kickback settlements and consumer rights under the Real Estate Settlement Procedures Act (RESPA).
- Noting different state coverage requirements in the closing protection section.
- Replacing details on home buying and homeowners insurance with a link to the NAIC Homeowners Insurance Buyer Guide.

- The drafting group then made extensive revisions to improve readability, scanability, and usefulness. This included:
  - Using plain language, consolidating and reorganizing sections, restructuring into two columns, and creating a toolkit with a fillable cost-comparison chart and resources page.
  - Adding graphic elements, pull-outs, a glossary, and a chart showing the steps in the closing process.
  - It should be noted that the chart was updated after adoption by the NAIC's Internal Editing department to present the steps from a consumer perspective rather than the closing agent's perspective.

- The NAIC Title Insurance Working Group exposed the *Title Insurance Consumer Shopping Tool Template* on Nov. 12, 2025, and adopted it at the 2025 Fall National Meeting.

- The Property and Casualty Insurance (C) Committee adopted it at the 2026 Spring National Meeting.

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

N/A

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

N/A

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

N/A

Draft: 3/17/2026

Adopted by the Market Regulation and Consumer Affairs (D) Committee March 25, 2026

PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION GUIDANCE FOR REGULATORS

Maintained by the Pharmacy Benefit Management (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee

The NAIC has prepared this publication to assist state insurance regulators that are considering licensure or regulation of pharmacy benefit managers (PBMs). It is not a model law and, as such, is not intended to represent a uniform standard for all state insurance regulators.

A regulator using these guidelines should refer to the laws adopted by their state when determining its requirements for licensure, registration, or regulation of pharmacy benefit managers.

Table of Contents

SECTION 1: INTRODUCTION

The purpose of this document is to serve as a guide for state insurance regulators that are considering pharmacy benefit manager licensure or regulation. It includes sample standards and criteria for the licensure of pharmacy benefit managers and their operations as defined in state law.

State insurance regulators may wish to license PBMs to:

(1) Promote, preserve, and protect the public health, safety and welfare; and

(2) Promote the solvency of the commercial health insurance industry, the regulation of which is reserved to the states by the McCarran-Ferguson Act (15 U.S.C. §§ 1011 – 1015), as well as to ensure access and affordability in prescription drug benefits.

PBM licensing best practices include:

(1) Providing for powers and duties of the commissioner; and

(2) Prescribing enforcement standards and appeals processes for violations of state law.

The document includes the following sections:

1. Core licensing guidelines for PBMs – This section provides core licensing standards for licensing PBMs.
2. Illustrative operational requirements under license – This section goes beyond core licensing standards and addresses additional PBM operational requirements under the license for consideration. Some states have enacted or proposed laws establishing these operational standards. The examples provided here reflect standards that certain legislatures have adopted or considered as part of broader regulation tied to a PBM's license to operate in the state.
3. Additional policy resources - This section details additional NAIC resources for states that wish to consider further regulation of a PBM's operations or the pharmacy benefit, and a brief illustrative list of additional PBM regulations some states have proposed or enacted into law.

SECTION 2: CORE LICENSING GUIDELINES FOR PBMS

The following section reflects core licensing standards for states that wish to begin licensing pharmacy benefit managers (PBMs).

Definitions

States should ensure that key terms are clearly defined in state law when establishing licensing standards for PBMs. Definitions of terms such as covered person, health plan, health carrier, pharmacist, and pharmacy used in the licensure of PBMs should be consistent with their existing state laws or regulations to maintain uniformity and avoid introducing new interpretations of currently defined terms.

For new licensure standards, the only essential term to define is "pharmacy benefit manager," as all other terms necessary for licensing should already be addressed in a state's insurance or pharmacy statutes and regulations.

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

A. (1) "Pharmacy benefit manager" means a person or entity that administers or processes prescription drug benefits on behalf of a health plan that is issued, delivered, or renewed in this state, is subject to state insurance regulation, and provides coverage to residents of this state, unless defined differently in state law.

(2) Pharmacy benefit manager does not include:

(a) A health care facility, pharmacist, or pharmacy licensed in this state;

(b) A health care professional licensed in this state;

(c) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or

(d) A health carrier to the extent that it administers or processes prescription drug benefits exclusively for its enrollees.

Applicability & Scope

When establishing new standards, a state's statutes should clarify the applicability to PBMs currently operating in the state and to in-scope PBM-health plan contracts, as defined in state law, that are currently in-force.

For example, a state may determine that new rules apply to a PBM's in-scope operations for a contract with a health plan that is issued, renewed, recredentialed, amended or extended on or after the effective date of any regulatory changes as prescribed by the commissioner and provide that the commissioner will establish a timeline for compliance.

States should also clarify the applicability of licensing standards upon the date of license. For example, a state may consider, as a condition of licensure, any in-scope contract must comply with the state's licensing standards that relate to that contract upon issuance, renewal, recredentialing, or amendment, on or after the effective date of the PBM's license.

States should take care to provide that their licensing standards are not intended and should not be construed to conflict with existing relevant federal law.

Note: States should refer to state and federal law and consult the NAIC'S ERISA Handbook for additional, general guidelines.

Licensing Requirements

States should provide for the licensing process, including addressing the following items:

- License required – States should provide that a person may not establish or operate as a pharmacy benefit manager in this state for health plans subject to state insurance regulation without first obtaining a license from the commissioner.

- Commissioner authority to establish key requirements – States should permit the commissioner to adopt regulations establishing the licensing application and financial reporting requirements for pharmacy benefit managers.

- Key application materials – States should require a person applying for a pharmacy benefit manager license to submit an application for licensure in the form and manner prescribed by the commissioner. The state should specify key documents and forms to include in the application, such as:

  (1) Articles of Incorporation or other entity formation documents which contain stamps or certification of filing with the Secretary of State of the domicile state;

  (2) Organizational Chart detailing entity structure of officers;

(3) Provide names, business and mailing address, email addresses and phone number for individuals responsible for regulatory compliance and complaints;

(4) Certificate of Good Standing or other documentation verifying registration in the applying state;

(5) Completed Biographical Affidavit UCAA Form 11 or state form as prescribed by the commissioner for all officers and managing owners with more than 10% ownership in the entity;

(6) Surety Bond in the amount prescribed by the commissioner and all applicable state laws and regulations;

(7) Errors & Omissions Coverage in the amount prescribed by the commissioner and all applicable state laws and regulations;

(8) Audited Financials or other approved financial statement form approved by the commissioner showing financial viability;

(9) List of all affiliations of a health insurer, health care center, hospital service corporation, medical service corporation, sub-contractors with noted duties pursuant to agreements between parties, or fraternal benefit society licensed in the state of application attested to by an officer of the applying pharmacy benefit manager entity; and

(10) Any other state specific documents deemed necessary by the commissioner.

- Non-refundable application fee – States should specify that a person submitting an application for a pharmacy benefit manager license shall include with the application a non-refundable application fee as prescribed by the commissioner and applicable state laws and regulations.

  Note: States should consider setting the licensing fee to reflect the median PBM licensing fee across states when adjusted to exclude outliers. States may wish to consider the most updated information reflecting the median fee, including an NAIC compilation of state licensing fees, if available.

- Authority to deny a license – States should authorize the commissioner to refuse to issue or renew a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation or has been found to have violated the insurance laws of this state or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction. States should specify written advance notice requirements should the commissioner elect to refuse to issue or renew a license.

- Renewal requirements – States should provide for renewal requirements, including:

  (1) Validity – States should specify that, unless surrendered, suspended or revoked by the commissioner, a license issued under this section shall remain valid as long as the pharmacy benefit manager continues to do business in the state and remains in compliance with the provisions of the state's statutes and any applicable rules and regulations, including the payment of an annual/biennial/triennial license renewal fee as prescribed by applicable state laws and regulations and completion of a renewal application on a form prescribed by the commissioner.

(2) Timing for renewal – States should specify when such renewal fee and application must be received. For example, a state may specify that they must be received by the commissioner on or before the designated renewal date or the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license as prescribed by the commissioner and applicable state laws and regulations.

(3) Key application materials – The state should specify what materials should be included in the renewal application. For example, states may wish to specify that the renewal application must include:

(a) Audited financials or other financial statement form approved by the commissioner showing financial solvency as determined by the commissioner; and

(b) Proof of continuation of previously submitted bonds or newly executed surety and error and omissions bonds.

- Requirements After Inactivation of License – States should clarify the requirements that apply to a PBM after its license becomes inactive, including whether the PBM must maintain surety and E&O bonds for a defined period of time and what, if any, reporting requirements may continue to apply for a limited time. For example, states may use language such as the following:

(1) The pharmacy benefit manager shall maintain surety and errors and omissions bonds for a period of at least one year immediately following the surrender, non-renewal or revocation of the license.

(2) All data calls and reporting may be required for the months the pharmacy benefit manager was actively licensed and conducting business in the state.

Proof of Network Adequacy Requirements and Reporting.

Note: States should consider their existing network adequacy laws when establishing PBM network adequacy or other standards.

While many states impose network adequacy standards on health insurance issuers contracting with PBMs to ensure prescription drug access, states may also wish to establish standards for a PBM's own pharmacy networks that are in-scope to promote reasonable patient access. If a state elects to apply network adequacy requirements directly to PBMs, it may consider language such as the following:

(a) A pharmacy benefit manager's network shall be reasonably adequate, shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence and shall not be comprised only of mail order pharmacy benefits but have a mix of mail order and physical stores in this state.

(b) A pharmacy benefit manager shall provide a network report describing the pharmacy benefit manager's network and the mix of mail-order to physical stores in this state in a time and manner required as prescribed by the commissioner. A pharmacy benefit manager's network shall include a detailed description of any separate, sub-networks for specialty drugs.

(c) Failure to provide a timely report or meet the network adequacy standards provided in subparagraph (a) of this paragraph may result in the suspension, revocation, or denial of a pharmacy benefit manager's license by the commissioner.

Note: States may also consider adding a waiver provision for applicants and licensees unable to meet the network adequacy requirements under this subsection.

Enforcement

States should provide for enforcement of licensing requirements, including addressing the following items:

- Commissioner enforcement authority – States should specify that the commissioner must enforce compliance with all applicable laws and regulations of the state, unless this is already addressed generally in state insurance law.

- Regulatory Examinations – If state statutes do not already provide general authority, states should provide for the commissioner's authority to examine a licensed PBM's relevant books and records to determine compliance with state law and clearly specify when such information or data is not subject to public disclosure. For example, states may use language such as the following:

  (1) The commissioner may examine or audit the relevant books and records of a licensed pharmacy benefit manager for a health plan subject to state insurance regulation to determine compliance with all state laws and regulations.

  (2) All pharmacy benefit managers licensed in this state shall provide to the commissioner or their designee convenient and free access, at all reasonable office hours, to all books and records directly relating to compliance with the PBM laws and regulations of the state.

  (3) The cost of the examination shall be the responsibility of the pharmacy benefit manager. It can be considered that if the examination was the result of a complaint filed and it is determined that the complaint was not justified, the commissioner can consider not requiring payment from the pharmacy benefit manager.

  (4) The information or data acquired during an examination under paragraph (1) is:

    (a) Considered proprietary and confidential;

    (b) Not subject to the [Freedom of Information Act] of this state;

    (c) Not subject to subpoena; and

    (d) Not subject to discovery or admissible in evidence in any private civil action.

- Use of examination materials – States should specify that the commissioner may use any document or information provided during the regulatory examination to determine compliance with all applicable state laws and regulations.

- Enforcement of additional operational standards – If a state imposes additional operational standards on PBMs, the state may grant the commissioner authority to impose a penalty on a pharmacy benefit manager or the health plan with which it is contracted, or both, for any violation of those operational standards enumerated in state laws and regulations.

- Appeals – Unless addressed in a general statute, states should provide for an appeals process for any administrative action or fine imposed upon a pharmacy benefit manager in accordance with state laws and regulations.

Effective and Compliance Dates

When establishing new licensing standards, a state's statutes should clarify the transition period for a person doing business in the state as a pharmacy benefit manager on or before the effective date of any changes in state laws or regulations. Depending on the complexity of the standards, PBMs should be given at least six (6) months to one (1) year to come into compliance following the effective date of the change.

Note: States' laws or regulations may vary on when a change in state law or regulation is effective and when compliance is required. As such, states should review their laws and regulations and ensure the effective and compliance dates are drafted accordingly, ensuring there is clarification on the application to existing PBM-health plan contracts that are in-force on the effective date, compliance date, or date of licensure, whichever is applicable.

SECTION 3: ILLUSTRATIVE OPERATIONAL REQUIREMENTS UNDER LICENSE

The following section moves beyond core licensure standards. These include additional PBM operational standards that some states have enacted or proposed that are tied to a PBM's license to operate in the state.

Gag Clauses and Other Pharmacy Benefit Manager Prohibited Practices

Some states have adopted or considered restrictions to prohibit specified practices to address concerns about transparency and patient access to information. These standards go beyond core licensure requirements but may be enforced as part of the PBM's authority to operate in the state. The following language illustrates approaches states may consider when addressing related prohibited practices tied to a PBM's license.

- Gag clause prohibition – While gag clauses are generally not permitted, states may wish to specify that in any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription services for health plans subject to state insurance regulation, no pharmacy or pharmacist may be prohibited, restricted or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

  (1) The nature of treatment, risks or alternative thereto;

  (2) The availability of alternate therapies, consultations, or tests;

  (3) The decision of utilization reviewers or similar persons to authorize or deny services;

  (4) The process that is used to authorize or deny healthcare services or benefits; or

  (5) Information on financial incentives and structures used by the health plan.

- Total cost transparency – States may consider providing that a pharmacy benefit manager may not prohibit a participating pharmacy or pharmacist providing prescription services for health plans subject to state insurance regulation from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available.

- Permissible disclosure to regulators – States may consider providing that a pharmacy benefit manager contract with a participating pharmacist or pharmacy providing prescription services for health plans subject to state insurance regulation may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials, provided that:

  (1) The recipient of the information represents it has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and

  (2) Prior to disclosure of information designated as confidential the pharmacist or pharmacy:

    (a) Marks as confidential any document in which the information appears; or

    (b) Requests confidential treatment for any oral communication of the information.

- Limits on contract termination – States may wish to prohibit a pharmacy benefit manager from terminating the contract of or penalizing a participating pharmacist or pharmacy providing prescription services for health plans subject to state insurance regulation for:

  (1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by law or the commissioner; or

  (2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with state law or regulation.

Submission of Key Service Contracts and Arm's Length Agreements

Some states have adopted or considered requiring applicants for PBM licenses to submit representative copies of key service contracts or arm's length agreements to confirm compliance with prohibited practices or other non-core licensing requirements, such as network adequacy and reporting. These standards go beyond core licensure requirements but may provide the regulator with additional information to confirm the PBM's compliance with state law prior to license issuance. The following language illustrates approaches states may consider when requiring additional materials prior to license issuance.

- Representative service contracts – States may wish to specify that a person submitting an application for a pharmacy benefit manager license must file representative copies of its standard pharmacy network/provider participation agreement, standard health carrier/client services agreement, and any material subcontracting or delegation agreements as part of the license application.

- Arm's length agreements – States may wish to specify that if any facilities, personnel, services, or networks are provided or held by an entity other than the person submitting the application, including a parent company, subsidiary, or affiliate, the person submitting the application must maintain and submit an arm's length agreement establishing the person's legal right of access to and use of those resources in accordance with good corporate governance.

Digital Infrastructure and Information Security

Some states have adopted or considered requiring applicants for PBM licenses to provide information relating to their digital infrastructure and information security. These standards go beyond core licensure requirements but may provide the regulator with additional information to confirm the PBM's compliance with state law prior to license issuance. The following language illustrates approaches states may consider when requiring additional materials prior to license issuance.

- Digital infrastructure – States may wish to specify that a person submitting an application for a pharmacy benefit manager license must demonstrate, as part of the license application, that it has adequate digital infrastructure, personnel, systems, and processes to securely process claims, safeguard records, and implement reasonable cybersecurity and breach-reporting measures.

- Information security – States may wish to specify the documentation applicants must provide to demonstrate operational readiness and information security controls, including:

  (a) A written attestation from a responsible officer confirming the existence of policies, personnel, and systems designed to protect data and ensure secure claim processing;

  (b) A summary description of digital infrastructure and cybersecurity measures, including data encryption, access control, and backup protocols;

  (c) Copies or summaries of the applicant's cybersecurity and incident response policies; and

  (d) Representative copies of any third-party or affiliate service agreements governing digital systems, data access, or hosting arrangements, which must include provisions ensuring confidentiality, breach notification, and legal right of access.

- Maintenance – States may wish to, further, specify that licensees must maintain such infrastructure, controls, and documentation on an ongoing basis throughout the term of licensure and make them available to the commissioner upon request.

SECTION 4: ADDITIONAL POLICY RESOURCES

States may choose to explore policy options that go beyond core and non-core PBM licensure requirements. These considerations often involve regulating aspects of PBM operations or the pharmacy benefit itself. For additional detail on these policy approaches, states should consult the following resources:

- The *Health Carrier Prescription Drug Benefit Management Model Act* (#22), which provides standards for the establishment, maintenance and management of prescription drug formularies and other procedures used by health insurance issuers that provide prescription drug benefits.
- The *Health Benefit Plan Network Access and Adequacy Model Act* (#74), which establishes standards for the creation and maintenance of networks by health carriers to ensure the adequacy, accessibility and quality of health care services offered under a managed care plan.
- Chapter XX, Conducting the Pharmacy Benefit Manager Examination, of the *Market Regulation Handbook*
- *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* and *Guidance Document – ERISA Preemption and State PBM Laws* (NAIC Guidance Documents)

- *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (NAIC White Paper)
- *Compilation of State Pharmacy Benefit Manager Business Practice Laws*

The following sample requirements reflect policy standards that some states have explored or implemented as part of broader PBM regulation. These examples illustrate obligations linked to pharmacy benefits and PBM business practices. For more information, consult the *Compilation of State Pharmacy Benefit Manager Business Practice Laws*.

Sample Requirements Beyond Licensure Include:

- Parity in treatment of affiliated and non-affiliated pharmacies
- Retroactive or point of sale fees limits
- Reporting or transparency requirements relating to pharmacy reimbursements and/or rebates
- Pharmacy credentialing or network participation requirements

Risk-Based Capital
Preamble

History of Risk-Based Capital by the NAIC

A. Background

1. The NAIC, through its committees and working groups, facilitated many projects of importance to state insurance regulators, the industry, and users of statutory financial information in the early 1990s. That was evidenced by the original mission statement and charges given to the Capital Adequacy (E) Task Force (~~CADTF~~Task Force) of the Financial Condition (E) Committee.

2. From the inception of insurance regulation in the mid-1800s, the limitation of insurance company insolvency risk has been a major goal of the regulatory process. The requirement of adequate capital has been a major tool in limiting insolvency costs throughout the history of insurance regulation. Initially, the states enacted statutes requiring a specified minimum amount of capital and surplus for an insurance company to enter the business or to remain in business.

3. Fixed minimum capital requirements were largely based on the judgment of the drafters of the statutes and varied widely among the states. Those fixed minimum capital and surplus requirements have served to protect the public reasonably well for more than a century. However, they fail to recognize variations in risk between broad categories of key elements of insurance, nor do they recognize differences in the amount of capital appropriate for the size of various insurers.

4. In 1992, the NAIC adopted the life risk-based capital (RBC) formula with an implementation date of year-end 1993. The formula was developed for specific regulatory needs. Four major risk categories were identified for the life formula, which took into consideration their diversification properties through a covariance adjustment that recognizes that problems in all risk categories are unlikely to occur simultaneously: asset risk; insurance risk; interest rate risk; and all other business risk. The property/casualty and health formulas were implemented in 1994 and 1998, respectively. The focus of these two formulas is: asset risk; underwriting risk; credit risk; and business risks (health).

5. Since then, RBC requirements have evolved, utilizing data beyond what is reported in annual statements, enabling a more accurate identification of solvency risk. The life RBC formula, for example, now assesses the risk of differentiated segments of commercial real estate mortgage investments, which has become a material asset class. The property/casualty RBC formula now recognizes that catastrophe risks are significant for some companies and reflects how exposure to region-specific events, such as natural weather events, can have on solvency. The health RBC formula now removes federal pass-through premium payments, which, by their nature, do not exhibit underwriting risk.

6. The use of RBC requirements has also expanded. It is now used by regulators to assess the solvency risk of insurance groups in Group Capital Calculations and the U.S. Aggregation Method~~, addressing International Capital Standards under the International Association of Insurance Supervisors~~. It is also used by other stakeholders who are assessing potential regulatory action.

~~The total RBC needed by an insurer to avoid being taken into conservatorship is the Authorized Control Level RBC, which is 50% of the sum of the RBC for the categories, adjusted for covariance. The covariance adjustment is meant to take into account that problems in all risk categories are not likely to occur at the same time.~~

B. The Mission of the Task Force

7~~6~~. The mission of the ~~CADTF~~Task Force was to determine the amount of capital an insurer should be required to hold to avoid triggering various specific regulatory actions. It pursued that objective through the RBC formula, which ~~The RBC formula~~ largely consist~~ed~~s of a series of risk factors that are applied to selected assets, liabilities, or other specific company financial data to establish the threshold levels generally needed to bear the risk arising from that item.

8~~7~~. To carry out its mission, the ~~CADTF~~ Task Force was charged with carrying out the following initiatives:

- Evaluate emerging "risk" issues for referral to the RBC working groups/subgroups for certain issues involving more than one RBC formula.
- Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
- Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
- Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the *Accounting Practices and Procedures Manual*, *Annual Statement Blanks*, and the *Valuation Manual* to ensure that model laws, publications, formulas, analysis tools, etc., supported by the ~~CADTF~~Task Force continue to meet regulatory objectives.
- Monitor and evaluate changes to the *Purposes and Procedure Manual* of the NAIC Investment Analysis Office to determine if assets or, specifically, investments evaluated by the NAIC Securities Valuation Office are relevant to the RBC formula in determining the threshold capital and surplus for all insurance companies or whether reporting available to the regulator is a more appropriate means to address the risk.
- ~~-~~Evaluating refinements to the existing NAIC RBC formula and considering improvements and revisions to the various RBC Blanks to (1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity (when it is determined to be necessary); and (2) oversee the development of additional reporting formats within the existing RBC Blanks as needs are identified.

9. The Task Force will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the risk to the industry, identifiable segments of companies, as well as the very specific purpose of the RBC formulas to develop regulatory threshold capital levels.

10~~8~~. The RBC forecasting, and instructions, as well as RBC reports were developed and are now maintained in accordance with the Task Force mission and charges.~~mission of the CADTF as a method of measuring the threshold amount of capital appropriate for an insurance company to avoid capital specific regulatory requirements based on its size and risk profile.~~

C~~B~~. Purpose of Risk-Based Capital Requirements

11~~9~~. The purpose of RBC requirements is to ~~help~~ identify potentially weakly capitalized companies. RBC requirements ~~in order to~~ facilitate regulatory actions designed to, in most cases, ensure policyholders will receive the benefits promised without relying on a guaranty association or taxpayer funds. Consequently, the RBC formula calculates ~~capital level trigger points~~ thresholds that enable regulatory intervention in the operations of such companies.

12~~0~~. ~~RBC instructions,~~ RBC reports and adjusted report(s) are intended solely for use by the commissioner/state in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and are considered confidential. All domestic insurers are required to file an RBC report unless exempted by the commissioner. There are no state permitted practices to modify the RBC formula, and all insurers are required to abide by the RBC instructions.

13~~1~~. Comparison of an insurer's TAC to any RBC ~~l~~Level is a regulatory tool that may indicate the need for **possible** corrective action with respect to the insurer and is **not intended or appropriate as a means to rank insurers generally**. Therefore~~—except as otherwise required under the provisions of~~ *Risk-Based Capital (RBC) for Insurers Model Act* (#312) ~~or~~ and the *Risk-Based Capital (RBC) for Health Organizations Model Act* (#315) ~~—~~strictly restrict insurers and their regulators from making assertions or disclosures regarding comparisons of insurers' TAC or derived component with limited exceptions as referenced in the Model Law. ~~the making, publishing, disseminating, circulation or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or place before the public, in a newspaper, magazine or other publication, or in a form of a notice, or in any other way, an advertisement, announcement or statement (including but not limited to press releases, earnings releases, webcast materials, or any other earnings presentations or webcasts) containing an assertion, representation or statement with regard to the RBC levels of any insurer or of any component derived in the calculation by any insurer is prohibited.~~ The RBC framework has been developed with certain regulatory needs in mind. While methodologies are transparent, state regulators keep company-specific calculations confidential, as well as any workout plans for companies that have triggered a regulatory action.

14. ~~C~~RBC requirements are a regulatory tool and are not intended or appropriate as a means to rank insurers. Therefore, state laws generally prohibit insurers and their regulators from making assertions or disclosures regarding comparisons of RBC information with limited exceptions. Insurers may make assertions or disclosures of certain RBC information, consistent with applicable state law, to accommodate the interests of other stakeholders, including policyholders, investors, ratings agencies, lenders, and other regulatory authorities. Any insurer's assertion or disclosure of RBC information must be consistent with applicable state laws. While this Preamble does not establish independent disclosure requirements or prohibitions, when RBC-related information is disclosed outside its stated regulatory purpose and in the context of this paragraph, insurers should, as applicable, provide appropriate contextual information alongside it, describing RBC's purpose as a regulatory tool and its limitations for other uses. The nature and extent of any such contextual information should be

determined by the disclosing party based on the facts and circumstances and applicable legal requirements.

DC. Objectives of Risk-Based Capital Reports

15~~2~~. The primary responsibility of each state insurance department is to regulate insurance companies in accordance with state laws, with an emphasis on solvency for the protection of policyholders. The ultimate objective of solvency regulation is to ensure that policyholder, contract holder and other legal obligations are met when they come due and that companies maintain capital and surplus at all times and in such forms as required by statute.

16. To support this role, the RBC reports identify potentially weakly capitalized companies, in that each insurer must report situations where the actual TAC is below a threshold amount for any of the several RBC levels. This is known as an "RBC event" and reporting is mandatory. The state regulatory response is likely to be unique to each insurer, as each insurer's risk profile will have some differences from the average risk profile used to develop the RBC formula factors and calculations.

17. There are several RBC ~~levels~~ Levels with different ~~levels~~degrees of anticipated required additional regulatory oversight following the reporting of an RBC event. Company Action Level (CAL) has the least amount of additional regulatory oversight, as it envisions the company providing to its regulator a plan of action to increase capital or reduce risk or otherwise satisfy the regulator of the adequacy of its capital. Regulatory Action Level (RAL) is the next ~~higher level~~threshold, where the regulator is more directly involved in the development of the plan of action. Authorized Control Level (ACL) anticipates an even higher amount of regulatory action in implementing the plan of action. Mandatory Control Level (MCL) requires the insurance commissioner to place the reporting entity under regulatory control. -

ED. Critical Concepts of Risk-Based Capital

18~~3~~. Over the years, various financial models have been developed to try to measure the "right" amount of capital that an insurance company should hold.[1] "No single formula or ratio can give a complete picture of a company's operations, let alone the operation of an entire industry. However, a properly designed formula will help in the early identification of companies with inadequate capital levels and allow corrective action to begin sooner. This should ultimately lower the number of company failures and reduce the cost of any failures that may occur."

19~~4~~. Because the NAIC formula develops threshold levels of capitalization rather than a target level, it may not be meaningful ~~it is neither useful nor appropriate~~ to use the RBC formula to compare the RBC ratio developed by one insurance company to the RBC ratio developed by another. ~~Comparisons of amounts that exceed the threshold standards do not provide a reliable assessment of their relative financial strength. For example, a company with an RBC ratio of 600% is not necessarily financially stronger than a company with an RBC ratio of 400%.~~ While companies that maintain RBC ratios well above the threshold standards can be considered to have minimal solvency risk, the information content of those insurers' RBC ratios is limited. For this reason, Model #312 and Model #315 prohibit insurance

[1] Report of the Industry Advisory Committee to the Life Risk-Based Capital (E) Working Group, p. 6; Nov. 2~~1~~7, 1991.

companies, their agents, and others involved in the business of insurance from using the company's RBC results to compare competitors.

20. The principal focus of solvency measurement is the determination of financial condition through an analysis of the financial statements and RBC requirements, while appropriately accounting for differences in business models as reflected in each of the formulas. However, protection of the policyholders can only be maintained through continued monitoring of the financial condition of the insurance enterprise. Operating performance is another indicator of an enterprise's ability to maintain itself as a going concern.

~~16. The CADTF and its RBC working groups are charged with evaluating refinements to the existing NAIC RBC formula and considering improvements and revisions to the various RBC blanks to 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity (when it is determined to be necessary); and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified.~~

~~17. The CADTF and its RBC working groups will monitor and evaluate changes to the annual financial statement blanks and the *Purposes and Procedure Manual of the NAIC Investment Analysis Office* to determine if assets or, specifically, investments evaluated by the NAIC Securities Valuation Office are relevant to the RBC formula in determining the threshold capital and surplus for all insurance companies or whether reporting available to the regulator is a more appropriate means to addressing the risk. The CADTF will consider different methods of determining whether a particular risk should be added as a new risk to be studied and selected for a change to the applicable RBC formula, but due consideration will be given to the materiality of the risk to the industry, as well as the very specific purpose of the RBC formulas to develop regulatory threshold capital levels.~~

F. Limited use of Risk-Based Capital

21. ~~Use of~~ RBC ratios ~~is~~ are intended ~~limited~~ to help identify~~ing~~ potentially weakly capitalized companies to facilitate regulatory action and oversight, and do not provide a complete, clear, or meaningful ranking of insurers. Regulators consider the insurer's overall financial situation when interpreting them. They were not developed or intended for any other use. Nevertheless, to the extent RBC ratios are considered for purposes beyond identifying potentially weakly capitalized companies, their usefulness may ~~Any other application of RBC would be inappropriate to the detriment of policyholders, companies, and investors. While RBC may be used in other components of the regulatory framework, such uses should be in the context of identifying potentially weakly capitalized companies. For example, statutory accounting may leverage RBC in determining the admissibility of certain types of assets, when the benefits of those assets may not be readily available to the policyholders of a troubled company.~~ be limited for companies that are not at risk of triggering an action level. A spectrum of factors entering into RBC calculations should be considered when using RBC ratios beyond identifying weakly capitalized companies, including, but not limited to:
    - Insurers voluntarily strengthening or weakening assumptions used for reserving, resulting in a reduction or increase of an insurer's RBC ratio.
    - RBC requirements are often developed with data that extends over a substantial period of years, with actuarial modeling often extending over long horizons. As a result, RBC ratios often represent a relatively stable, durable measure of capital.

- While RBC requirements are designed to reflect differentiated risks across components, on their own, they may be insufficient for assessing differentiated risks for purposes other than identifying weakly capitalized companies. Limitations may result from RBC components not being sufficiently granular to differentiate risks, given the immateriality as it relates to solvency risk, or a single component not reflecting a comprehensive perspective of risk, as is the case, for example, with asset risk, which may not reflect liquidity, market, or duration risks, which are captured elsewhere in the framework when applicable.
- RBC requirements may fluctuate without indicating a corresponding change in the insurer's financial condition. Fluctuations may be driven by changes in the RBC formula, dividends, capital infusions, reinsurance transactions, the sale or acquisition of a block of business, and a significant change in new business written.

~~19. RBC does not provide a complete, clear, or meaningful ranking of insurers. For example, an insurer voluntarily strengthening assumptions used for reserving would generally reduce an insurer's RBC ratio but does not indicate a weaker position than a similarly situated insurer who did not elect to strengthen assumptions used for reserving. Regulators are able to consider a complete picture of the insurer's financial situation to appropriately follow up on RBC action levels. Using RBC beyond its intended purpose could create perverse incentives for companies that are not at risk of triggering an action level.~~

~~20. Reviewing an individual insurer's RBC over time may not provide a complete, clear or meaningful picture of the insurer's change in financial condition. Items that may have an impact on RBC which make year-to-year comparisons problematic include changes in the RBC formula, dividends, capital infusions, reinsurance transactions, sale or acquisition of a block of business, and a significant change in new business written.~~

~~20. RBC requirements for particular risk categories were developed based on specific regulatory guidelines and following agreed upon procedures and methodologies. The RBC requirements were developed with regulatory needs in mind. They were not developed or intended for any other use. As such, except where prescribed, RBC requirements would not be appropriate to rely on in other contexts such as reserve setting or risk management or evaluating the risk of investments. While the development of RBC requirements often rely on historical data points, the data used extends over a substantial period of years and the actuarial modeling extends out over a long time horizon. They do not reflect risk at any one point in time. Moreover, the granularity of an analysis for RBC purposes likely differs from the granularity appropriate for other applications. Therefore, RBC requirements are not appropriate to evaluate the relative or absolute level of risk outside of the context of a regulatory framework for identifying potentially weakly capitalized companies.~~

~~21. Because RBC is a broad tool to facilitate regulatory oversight, an insurer's RBC can fluctuate without indicating a corresponding change in the insurer's financial strength. Reviewing an individual insurer's RBC over time may not provide a complete, clear, or meaningful picture of the insurer's change in financial condition. Items that may limit the information content include changes to the RBC formula, dividends, capital infusions, reinsurance transactions, the sale or acquisition of a block of business, or a significant change in new business written.~~

G. Principles for RBC Requirements

Acknowledging the complex and varied insurance business activities and their associated risks, RBC requirements are established to capture risks using a wide range of data, methodologies, and regulatory judgment. These Principles of RBC Requirements govern the purpose and use of, as well as maintaining and prioritizing updates to, RBC requirements.

1. **Purpose**. The purpose of RBC requirements is to identify potentially weakly capitalized companies.
2. **Use**. RBC requirements are primarily used to facilitate regulatory action with respect to weakly capitalized companies. RBC requirements may be used for other purposes, but these uses must not distort or redefine the purpose of RBC requirements.
3. **Materiality**. RBC requirements should be updated when a change is material. Materiality for purposes of RBC means a level at which a decision whether to update RBC could meaningfully impact the regulator's assessment of the solvency risk for all or an identifiable segment of companies.
4. **Equal capital for equal risk**. RBC requirements should be guided by the principle of equal capital for equal risk, consistent in their statistical safety levels and time horizons, appropriate for the underlying risk, unless there are substantial differences in the nature of the risk in the context of the business model (e.g., life vs property & casualty) to warrant alternative treatments. RBC requirements should reflect measurable risks that can impact solvency, including the mitigating effects of risk management.
5. **Objectivity**. Appropriately consider only the factors that impact solvency risk, including but not limited to concentration, diversification, and tail risks, thereby avoiding the promotion or inhibition of objectives that are unrelated to assessing solvency risk.
6. **Accuracy**. Sufficiently precise to assess solvency risk, while avoiding unnecessary complexity.
7. **Grounded in Statutory Accounting and reserving**. Derived from values reported in the statutory annual statement and calibrated to align with Statutory Accounting and reserving practices, to the extent practical.
8. **Emerging risks.** Updated to incorporate emerging risks (including macroprudential risk) by the time they become material to the industry or an identifiable segment of companies.
9. **Transparency.** The process to maintain and update RBC requirements must adhere to the *NAIC Policy Statement on Open Meetings* and follow standards that provide for clear, complete, and transparent communication and documentation of proposed and adopted updates, methodologies, and supporting rationale.
10. **Process.** Maintaining and updating RBC requirements must adhere to model risk management standards, relying on data-driven methodologies with assessments of model performance and model validation when possible, acknowledging the need to rely on expert judgment and proxies, significantly so in some cases, and the use of interim solutions.
11. **Prioritization**. Recognizing the vast number of potential refinements that could be made to RBC requirements at any given time, the groups tasked with updating and maintaining the RBC model should use regulatory judgment to prioritize changes, considering their necessity, materiality, time and resource intensity, and other relevant considerations.

Notes from Task Force Deliberations (not to be included in the Preamble): These meeting notes provide non-authoritative background and context for the proposed edits to the Preamble; they are not binding interpretations of the Principles or the Preamble. References to discussions or regulators do not reflect those of the entire Task Force since the Principles were developed over many sessions, often with different members of Task Force present.

Notes on the Preamble:

- **The Scope of the Preamble**.
  - Regulators felt the Preamble should provide a narrative on the purpose and use of RBC. The scope should not be expanded to include references to the Principles for Maintaining and Prioritizing Updates to RBC, which would be redundant.
  - The language within the Preamble should be consistent with the Principles for the Purpose and Use of RBC.
  - The language must be consistent with Model Laws 312 and 315, since they are codified in state laws.
- **Paragraph 5**. Regulators felt that it was desirable to include historical context for RBC, as well as to provide context for how RBC requirements have evolved in terms of precision and application since their initial development.
- **Paragraph 7 (now Paragraph 8).** Consolidates text from Paragraphs 16 and 17, which describe CADTF's charges.
- **Paragraph 11~~.~~ (now Paragraph 14).**
  - There was an acknowledged nuance that Model Laws 312 and 315 restrict insurers from making assertions or disclosures regarding comparisons of insurers' TAC or derived components, such as RBC ratios, to rank insurers. Regulators pointed out the potential for the Model Laws to be interpreted more restrictively, limiting any assertions or disclosures of insurers' TAC or derived statistics, and that some states adopted language that is more restrictive than the Model Law. For example, Washington D.C. §31–3451.08, is relatively clear in that any assertions or disclosures of insurers' TAC or derived statistics are prohibited, with limited exceptions. To address this issue, the paragraph was framed in the context of state laws.
  - The question of whether guidelines should be provided on the level of disclosure and language was explored. Cases that were discussed that may warrant different levels of disclosure:
    - Responding to a question about RBC on an earnings call, which narrowly referenced only the RBC ratio in the context of its stated purpose of regulatory intervention, with information that is not subjective and public (e.g., the RBC ratio is 440%, which is 140 pp above the threshold that triggers potential regulatory intervention).
    - Statements that include subjective assessments (e.g., RBC ratio is 440%, which is significantly above our 400% target, and 140pp above the threshold that triggers potential regulatory intervention). The 400% target is subjective and suggestive, especially when reinforced with the word significant.
    - When RBC ratios are reported in written material alongside, say, Financial Strength Ratings, or is reported outside the context of potential regulatory intervention, such as reporting of GCC.
  - Regulators opted to remain silent on the matter for now, agreeing that further discussion is needed, particularly in light of the potential conflict with Model Laws and state statutes.
  - Concern was raised over whether the Preamble is the best place for added disclosure requirements, and the authority, in earnest, that it would provide state regulators to take action on companies violating the disclosure requirements. Regulators felt that the Model Law is a more appropriate

location, but that the change would be unnecessarily cumbersome and would not ensure that state laws would be modified accordingly. To avoid the possible conflict, regulators considered replacing the word 'must' with 'should'.

- Other edits included simplifying the language in Paragraph 11, which referred to and paraphrased the Model Law, which has been adopted into state law in various forms. Given the length and detail in the Model Law, the regulators felt that a reference to the Model Law streamlines the flow.
- The question of whether regulators have the right to refute any RBC ratios that they view as not representative of potential regulatory action outside of the regulatory trigger points was explored.

- **Paragraph 14 (now Paragraph 19)**. Regulators pointed out that the concept of financial strength was not defined. To avoid potential confusion, the chosen language generalizes the concepts and avoids the introduction of new terminology.
- **Paragraphs 18-21 (now Paragraph 21)**.
  - Regulators consolidated paragraphs 18-21, attempting to retain key concepts and streamline the articulation of the various considerations.
  - Regulators agreed that the following sentence, in its current form, is overly restrictive given its acknowledged broader use (e.g., AM): *Any other application of RBC would be inappropriate to the detriment of policyholders, companies, and investors*.

Capital Adequacy (E) Task Force
RBC Proposal Form

☐ Capital Adequacy (E) Task Force
☐ Catastrophe Risk (E) Subgroup
☐ Variable Annuities Capital. & Reserve (E/A) Subgroup
☐ Health RBC (E) Working Group
☐ P/C RBC (E) Working Group
☐ Economic Scenarios (E/A) Subgroup
☐ Life RBC (E) Working Group
☐ Longevity Risk (A/E) Subgroup
☒ RBC Investment Risk & Evaluation (E) Working Group

DATE:	**5/1/2026**
CONTACT PERSON:	**Maggie Chang**
TELEPHONE:	**816-783-8976**
EMAIL ADDRESS:	**mchang@naic.org**
ON BEHALF OF:	**Risk-Based Capital Investment Risk and Evaluation (E) Working Group**
NAME:	**Philip Barlow, Chair**
TITLE:	**Associate Commissioner of Insurance**
AFFILIATION:	**District of Columbia**
ADDRESS:	**1050 First Street, NE Suite 801**
	Washington, DC 20002

FOR NAIC USE ONLY

Agenda Item # 2026-12-IRE MOD
Year 2026

DISPOSITION

ADOPTED:
☐ TASK FORCE (TF) _____
☒ WORKING GROUP (WG) 6/23/2026
☐ SUBGROUP (SG) _____

EXPOSED:
☐ TASK FORCE (TF) _____
☒ WORKING GROUP (WG) 5/6/2026
☐ SUBGROUP (SG) _____

REJECTED:
☐ TF ☐ WG ☐ SG _____

OTHER:
☐ DEFERRED TO _____
☐ REFERRED TO OTHER NAIC GROUP
☐ (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

☐ Health RBC Blanks
☐ Health RBC Instructions
☐ Health RBC Formula
☐ Property/Casualty RBC Blanks
☐ Property/Casualty RBC Instructions
☐ Property/Casualty RBC Formula
☒ Life and Fraternal RBC Blanks
☒ Life and Fraternal RBC Instructions
☒ Life and Fraternal RBC Formula
☐ OTHER _____

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

This proposal incorporates CLOs' Modeled C-1 factors initially presented by the American Academy of Actuaries (Academy) on March 2, 2026 and subsequently adjusted for tax effect, presented on June 23, 2026.

The Academy did not propose C-1 factor for NAIC 6 CLOs due to limited sample for modelling. Based on Working Group's discussion, NAIC staff has taken an arithmetic mean of 1 and NAIC 5.C. factor, arriving at 92.56% pre-tax factor for NAIC 6.

Additional Staff Comments:

5/6/26 – building on Proposal 2025-22-IRE (CLO RBC Structure) MOD V.3, NAIC staff has identified further refinements in LR002 in order to effectuate Portfolio Adjustment Factor (PAF) methodology proposed by the Academy. Exposed on May 6 for 30-day public comment period ending June 5. Six comment letters were received.(mkc)

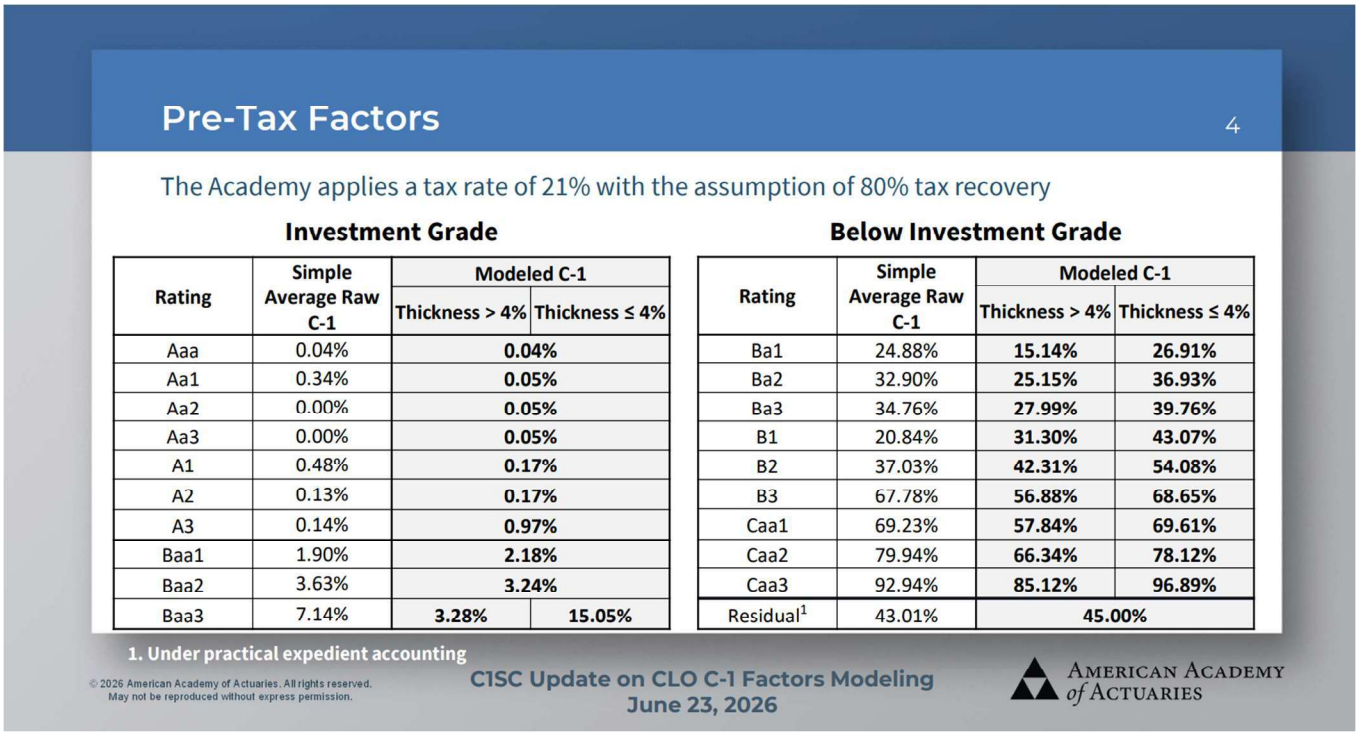
© 2026 National Association of Insurance Commissioners

6/23/26 – RBCIRE Working Group met and adopted a motion to modify the Proposal. During the adoption process, the Working Group agreed to the opportunities for some of these decisions to be looked at again if there were new information presented or new guidance from a higher Task Force.

Key customizations adopted are summarized as below:

- Academy's proposed C-1 factors (pre-tax, Chart 1) are adopted for all CLOs/CBOs/CDOs reported in AVR Default Component Table lines A9.1-A14. Note that the Academy revised its proposed factor for A3/NAIC 1.G. tranche resulted from the Working Group discussions.
- BSL CLOs with NAIC Designation 2.C. or below AND with tranche thickness equal to or below 4% will be assessed surcharge of 11.77%.
- To set CLO PAF = 1.0 (Option 1 of Academy's recommendation, Chart 2), amended to incorporate ACLI's request to include unique CLO Issuer count in the non-CLO PAF Calculation. Note that this represents an interim solution and the PAF methodology will be reviewed for 2027 and forward.
- CLO residual tranches continue to be afforded 45% pre-tax factor.
- Modifications are highlighted in yellow.

Chart 1



Pre-Tax Factors

4

The Academy applies a tax rate of 21% with the assumption of 80% tax recovery

Investment Grade

Rating	Simple Average Raw C-1	Modeled C-1	
		Thickness > 4%	Thickness ≤ 4%
Aaa	0.04%	0.04%	
Aa1	0.34%	0.05%	
Aa2	0.00%	0.05%	
Aa3	0.00%	0.05%	
A1	0.48%	0.17%	
A2	0.13%	0.17%	
A3	0.14%	0.97%	
Baa1	1.90%	2.18%	
Baa2	3.63%	3.24%	
Baa3	7.14%	3.28%	15.05%

Below Investment Grade

Rating	Simple Average Raw C-1	Modeled C-1	
		Thickness > 4%	Thickness ≤ 4%
Ba1	24.88%	15.14%	26.91%
Ba2	32.90%	25.15%	36.93%
Ba3	34.76%	27.99%	39.76%
B1	20.84%	31.30%	43.07%
B2	37.03%	42.31%	54.08%
B3	67.78%	56.88%	68.65%
Caa1	69.23%	57.84%	69.61%
Caa2	79.94%	66.34%	78.12%
Caa3	92.94%	85.12%	96.89%
Residual[1]	43.01%	45.00%	

1. Under practical expedient accounting

CISC Update on CLO C-1 Factors Modeling
June 23, 2026

American Academy of Actuaries

Chart 2

Summary of Findings—Portfolio Adjustment Factors

18

- The Academy models PAF consistent with the bond PAF methodology based on the number of unique loan *issuers* for a given portfolio of *N* CLO deals, deriving two metrics:
  - Absolute PAF = Portfolio of *N* CLO Deals PAF
  - Relative PAF = Absolute PAF ÷ Collateral Loan Universe PAF, assumes full diversification when holding a loan for every one of the 2,462 issuers in the collateral universe
- The Academy proposes two options:

Option 1	Option 2			
	N	CLO PAF	N	CLO PAF
CLO PAF of 1.00	1	1.38	7	1.08
	2	1.22	8	1.07
	3	1.16	9	1.07
	4	1.12	10	1.06
	5	1.10	11+	1.00
	6	1.09		
Based on Absolute PAF	Based on Relative PAF			

C1SC Update on CLO C-1 Factors Modeling
May 6, 2026

American Academy of Actuaries

****** **This section must be completed on all forms.** **Revised 2-2023**

BONDS

LR002

Basis of Factors

The bond factors are based on cash flow modeling using historically adjusted default rates for each bond category. For each of 2,000 trials, annual economic conditions were generated for the 10-year modeling period. Each bond of a 400-bond portfolio was annually tested for default (based on a "roll of the dice") where the default probability varies by designation category and that year's economic environment. When a default takes place, the actual loss considers the expected principal loss by category, the time until the sale actually occurs and the assumed tax consequences.

Actual surplus needs are reduced by incorporating anticipated annual contributions to the asset valuation reserve (AVR) as offsetting cash flow. Required surplus for a given trial is calculated as the amount of initial surplus funds needed so that the accumulation with interest of this initial amount and subsequent cash flows will not become negative at any point throughout the modeling period. The factors chosen for the proposed formula produce a level of surplus at least as much as needed in 92% of the trials by category and a 96% level for the entire bond portfolio.

The factor for NAIC 6 bonds recognizes that the book/adjusted carrying value of these bonds reflects a loss of value upon default by being marked to market.

Specific Instructions for Application of the Formula

Lines (1) through (7)
The book/adjusted carrying value of all bonds, excluding collateralized loan obligations (CLOs), Collateralized Bond Obligations (CBOs), and Collateralized Debt Obligations (CDOs) ~~and related fixed-income investments~~ should be reported in Column (1). The bonds are split into seven different risk classifications. For long-term bonds, these classifications are found on Lines A1 through A7 of the Asset Valuation Reserve Default Component~~, Page 30~~ of the annual statement.

The book/adjusted carrying value of all ~~collateralized loan obligations~~CLOs/CBOs/CDOs should be reported in Column 2. The ~~collateralized loan obligations~~ CLOs/CBOs/CDOs are split into six different risk classifications. These classifications are found on Lines A9.1 through A14 of the Asset Valuation Reserve Default Component~~, Page 30~~ of the annual statement.

Line (7.2)
Amounts reported in Column (2) line (7.2) should include book/adjusted carrying value of Broadly Syndicated Bank Loans (BSL) CLO tranches (as defined below) with current tranche thickness less than or equal to 4% (as defined below).

BSL are typically syndicated corporate loans distributed to a broad base of institutional investors and rated by credit rating agencies. BSL CLOs are primarily backed by syndicated corporate loans.

Current Tranche thickness is defined as the difference between the attachment point (AP) and the detachment point (DP) of a CLO tranche. AP refers to tranche's subordination percentage, and DP is the percentage of total par amount of the underlying portfolio including principal proceeds, that will completely write off the tranche. The current tranche thickness is to be measured using the most recent periodic report available, without being stale, as of the investment reporting date.

It was noted that the Academy's proposed surcharge on thin tranches range from 11.77% to 11.78% pre-tax, as such, to streamline the structure, NAIC staff incorporated a flat surcharge of 11.77% in Column (3).

Line (8)
The total, adjusted for amount reported in Column (2), Line (7.2) should equal long-term bonds ~~and other fixed-income instruments~~ reported on Page 2, Column 3, Line 1 plus Schedule DL Part 1, Column 6, Line 2009999999 of the annual statement.

Lines (9) through (15)
The book/adjusted carrying value of all short-term and cash equivalent bonds ~~and related fixed-income investments~~ should be reported in Column (1). The bonds are split into seven different risk classifications. For short-term bonds, these classifications are found on Lines ~~18~~ C1 through ~~24~~ C7 of the Asset Valuation Reserve Default Component, ~~Page 30~~ of the annual statement. For cash equivalent bonds, these classifications are found in Footnotes to Schedule E, Part 2.

Line (16)
The total should equal short-term bonds reported on Schedule DA, Part 1, Column 6 Line 0509999999 plus Schedule DL Part 1, Column 6, Line 9509999999 plus Schedule E, Part 2, Column 7, Line 0509999999.

Line (22)
Class 1 bonds (highest quality) issued by a U.S. government agency that are not backed by the full faith and credit of the U.S. government should be reported on this line. The loan-backed securities of the Federal National Mortgage Association (FNMA) and the Federal Home Loan Mortgage Corporation (FHLMC) would be examples of the securities reported on this line. Line (22) should not be larger than the sum of Lines (2) and (10). Exempt obligations should not be included on this line.

Line (23)
Column (1) and Column (2) require Company to bifurcate Line (21) Column (4) "Total RBC Requirement" into Non-CLO RBC Requirement (Column 1) and CLO RBC Requirement (Column 2) components. For Non-CLO (Column (1)), the amount needs to be further reduced by Column (4) Line(1), Column (4) Line(9) and Column (4) Line (22). The sum of Column (1) and Column (2) should agree to Column (4).

Line (24)

Column (1) - Bonds should be aggregated by issuer (the first six digits of the CUSIP number can be used). Exempt U.S. government bonds and bonds reported on Line (22) are not counted in determining the size factor. The RBC for those bonds will not be included in the base to which the size factor is applied. For 2026 filing, include unique CLO Issuer count (see Column (2) below) in this Column. If this field is left blank, the maximum size factor adjustment of 2.40 will be used.

Column (2) - CLOs/CBOs/CDOs should be aggregated by unique issuer (typically the special purpose vehicle that holds underlying collateral and issues CLO/CBO/CDO debt tranches, collectively the "CLO Issuers"). The first six digits of the CUSIP can be used. In the case of combo CLOs or other structures that hold multiple CLO issuers, the insurer should look through the underlying CLO issuers for purposes of determining the number of issuers. If this field is left blank, the maximum size factor adjustment of 1.00 will be used.

Line (25)

Column (1) - The size factor reflects the higher risk of a bond portfolio that contains relatively fewer bonds. The overall factor decreases as the portfolio size increases. The size factor is based on the weighted number of issuers. (The calculation shown below will not appear on the RBC filing software but will be calculated automatically.)

Line (25)	Source	(a) Number of Issuers* ~~(for bonds, excluding CLOs)~~				(b) Weighted Issuers* ~~(for bonds, excluding CLOs)~~
First 50	Company Records		X	2.40	=	
Next 50	Company Records		X	1.53	=	
Next 100	Company Records		X	0.85	=	

Next 300	Company Records		X	0.85	=	
Over 500	Company Records		X	0.82	=	
(i) Total Number of Issuers from Line (24) Column (1)						
(ii) Total Weighted Issuers ~~(for bonds, excluding CLOs/CBOs/CDOs)~~						
Size Factor = Total Weighted Issuers (ii) Divided by Total Number of Issuers (i)						

* For 2026 filing, include unique CLO Issuer count in Column (1) calculation.

Column (2) – The size factor for CLOs/CBOs/CDOs is defaulted to 1.0.

BONDS

Company Name

Cocode: 00000

BONDS

	SVO Bond Designation Category	Annual Statement Source	(1) Non-CLOs/CBOs/CDOs Book / Adjusted Carrying Value		Factor		(2) CLOs/CBOs/CDOs Book / Adjusted Carrying Value		(3) Factor		(4) Total RBC Requirement
	Long Term Bonds										
(1)	Exempt Obligations	C(1) AVR Default Component Column 1 Line A1	$0	X	0.00000		XXX		XXX	=	$0
(2.1)	NAIC Designation Category 1.A	C(1) AVR Default Component Column 1 Line A2.1 C(2) AVR Default Component Column 1 Line A9.1	$0	X	0.00158		$0	X	0.00040	=	$0
(2.2)	NAIC Designation Category 1.B	C(1) AVR Default Component Column 1 Line A2.2 C(2) AVR Default Component Column 1 Line A9.2	$0	X	0.00271		$0	X	0.00050	=	$0
(2.3)	NAIC Designation Category 1.C	C(1) AVR Default Component Column 1 Line A2.3 C(2) AVR Default Component Column 1 Line A9.3	$0	X	0.00419		$0	X	0.00050	=	$0
(2.4)	NAIC Designation Category 1.D	C(1) AVR Default Component Column 1 Line A2.4 C(2) AVR Default Component Column 1 Line A9.4	$0	X	0.00523		$0	X	0.00050	=	$0
(2.5)	NAIC Designation Category 1.E	C(1) AVR Default Component Column 1 Line A2.5 C(2) AVR Default Component Column 1 Line A9.5	$0	X	0.00657		$0	X	0.00170	=	$0
(2.6)	NAIC Designation Category 1.F	C(1) AVR Default Component Column 1 Line A2.6 C(2) AVR Default Component Column 1 Line A9.6	$0	X	0.00816		$0	X	0.00170	=	$0
(2.7)	NAIC Designation Category 1.G	C(1) AVR Default Component Column 1 Line A2.7 C(2) AVR Default Component Column 1 Line A9.7	$0	X	0.01016		$0	X	0.00970	=	$0
(2.8)	Subtotal NAIC 1	Sum of Lines (2.1) through (2.7)	$0				$0				$0
(3.1)	NAIC Designation Category 2.A	C(1) AVR Default Component Column 1 Line A3.1 C(2) AVR Default Component Column 1 Line A10.1	$0	X	0.01261		$0	X	0.02180	=	$0
(3.2)	NAIC Designation Category 2.B	C(1) AVR Default Component Column 1 Line A3.2 C(2) AVR Default Component Column 1 Line A10.2	$0	X	0.01523		$0	X	0.03240	=	$0
(3.3)	NAIC Designation Category 2.C	C(1) AVR Default Component Column 1 Line A3.3 C(2) AVR Default Component Column 1 Line A10.3	$0	X	0.02168		$0	X	0.03280	=	$0
(3.4)	Subtotal NAIC 2	Sum of Lines (3.1) through (3.3)	$0				$0				$0
(4.1)	NAIC Designation Category 3.A	C(1) AVR Default Component Column 1 Line A4.1 C(2) AVR Default Component Column 1 Line A11.1	$0	X	0.03151		$0	X	0.15140	=	$0
(4.2)	NAIC Designation Category 3.B	C(1) AVR Default Component Column 1 Line A4.2 C(2) AVR Default Component Column 1 Line A11.2	$0	X	0.04537		$0	X	0.25150	=	$0
(4.3)	NAIC Designation Category 3.C	C(1) AVR Default Component Column 1 Line A4.3 C(2) AVR Default Component Column 1 Line A11.3	$0	X	0.06017		$0	X	0.27990	=	$0
(4.4)	Subtotal NAIC 3	Sum of Lines (4.1) through (4.3)	$0				$0				$0
(5.1)	NAIC Designation Category 4.A	C(1) AVR Default Component Column 1 Line A5.1 C(2) AVR Default Component Column 1 Line A12.1	$0	X	0.07386		$0	X	0.31300	=	$0
(5.2)	NAIC Designation Category 4.B	C(1) AVR Default Component Column 1 Line A5.2 C(2) AVR Default Component Column 1 Line A12.2	$0	X	0.09535		$0	X	0.42310	=	$0
(5.3)	NAIC Designation Category 4.C	C(1) AVR Default Component Column 1 Line A5.3 C(2) AVR Default Component Column 1 Line A12.3	$0	X	0.12428		$0	X	0.56880	=	$0
(5.4)	Subtotal NAIC 4	Sum of Lines (5.1) through (5.3)	$0				$0				$0
(6.1)	NAIC Designation Category 5.A	C(1) AVR Default Component Column 1 Line A6.1 C(2) AVR Default Component Column 1 Line A13.1	$0	X	0.16942		$0	X	0.57840	=	$0
(6.2)	NAIC Designation Category 5.B	C(1) AVR Default Component Column 1 Line A6.2 C(2) AVR Default Component Column 1 Line A13.2	$0	X	0.23798		$0	X	0.66340	=	$0
(6.3)	NAIC Designation Category 5.C	C(1) AVR Default Component Column 1 Line A6.3 C(2) AVR Default Component Column 1 Line A13.3	$0	X	0.30000		$0	X	0.85120	=	$0
(6.4)	Subtotal NAIC 5	Sum of Lines (6.1) through (6.3)	$0				$0				$0
(7.1)	NAIC 6	C(1) AVR Default Component Column 1 Line A7 C(2) AVR Default Component Column 1 Line A14	$0	X	0.30000		$0	X	0.92560	=	$0
(7.2)	CLO in NAIC Designation Category 2.C or below, with thin tranches (See Instruction)	C(2) AVR Default Component Column 1 Line A10.3, in part + Line A11.1, in part + Line A11.2, in part + Line A11.3, in part + Line A12.1, in part + Line A12.2, in part + Line A12.3, in part + Line A13.1, in part + Line A13.2, in part + Line A13.3, in part	XXX		XXX		$0	X	0.11770	=	$0
(8)	Total Long-Term Bonds	Sum of Lines (1) + (2.8) + (3.4) + (4.4) + (5.4) + (6.4) + (7.1) + (7.2)	$0				$0				$0
	(Line (8) Column (1) + Line (8) Column (2) - Line (7.2) Column (2) should equal Page 2 Column 3 Line 1 + Schedule DL Part 1 Column 6 Line 2009999999)										
	Short Term and Cash Equivalent Bonds										
(9)	Exempt Obligations	AVR Default Component Column 1 Line C1 + Schedule E, Part 2, Column 7, Line 0019999999	$0	X	0.000		XXX		XXX	=	$0
(10.1)	NAIC Designation Category 1.A	AVR Default Component Column 1 Line C2.1 + Schedule E, Part 2, Footnote L000001A, Amount 1 - Schedule E, Part 2, Column 7, Line 0019999999	$0	X	0.00158		XXX		XXX	=	$0
(10.2)	NAIC Designation Category 1.B	AVR Default Component Column 1 Line C2.2 + Schedule E, Part 2, Footnote L000001A, Amount 2	$0	X	0.00271		XXX		XXX	=	$0
(10.3)	NAIC Designation Category 1.C	AVR Default Component Column 1 Line C2.3 + Schedule E, Part 2, Footnote L000001A, Amount 3	$0	X	0.00419		XXX		XXX	=	$0
(10.4)	NAIC Designation Category 1.D	AVR Default Component Column 1 Line C2.4 + Schedule E, Part 2, Footnote L000001A, Amount 4	$0	X	0.00523		XXX		XXX	=	$0
(10.5)	NAIC Designation Category 1.E	AVR Default Component Column 1 Line C2.5 + Schedule E, Part 2, Footnote L000001A, Amount 5	$0	X	0.00657		XXX		XXX	=	$0
(10.6)	NAIC Designation Category 1.F	AVR Default Component Column 1 Line C2.6 + Schedule E, Part 2, Footnote L000001A, Amount 6	$0	X	0.00816		XXX		XXX	=	$0
(10.7)	NAIC Designation Category 1.G	AVR Default Component Column 1 Line C2.7 + Schedule E, Part 2, Footnote L000001A, Amount 7	$0	X	0.01016		XXX		XXX	=	$0
(10.8)	Subtotal NAIC 1	Sum of Lines (10.1) through (10.7)	$0								$0

=ROUND(MAX(0,D10)*F10 + MAX(0,G10)*J10,0)

		AVR Default Component Column 1 Line C3.1 +							
(11.1)	NAIC Designation Category 2.A	Schedule E, Part 2, Footnote L000001B, Amount 1	$0	X	0.01261	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C3.2 +							
(11.2)	NAIC Designation Category 2.B	Schedule E, Part 2, Footnote L000001B, Amount 2	$0	X	0.01523	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C3.3 +							
(11.3)	NAIC Designation Category 2.C	Schedule E, Part 2, Footnote L000001B, Amount 3	$0	X	0.02168	XXX	XXX	=	$0
(11.4)	Subtotal NAIC 2	Sum of Lines (11.1) through (11.3)	$0						$0
		AVR Default Component Column 1 Line C4.1 +							
(12.1)	NAIC Designation Category 3.A	Schedule E, Part 2, Footnote L000001C, Amount 1	$0	X	0.03151	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C4.2 +							
(12.2)	NAIC Designation Category 3.B	Schedule E, Part 2, Footnote L000001C, Amount 2	$0	X	0.04537	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C4.3 +							
(12.3)	NAIC Designation Category 3.C	Schedule E, Part 2, Footnote L000001C, Amount 3	$0	X	0.06017	XXX	XXX	=	$0
(12.4)	Subtotal NAIC 3	Sum of Lines (12.1) through (12.3)	$0						$0
		AVR Default Component Column 1 Line C5.1 +							
(13.1)	NAIC Designation Category 4.A	Schedule E, Part 2, Footnote L000001D, Amount 1	$0	X	0.07386	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C5.2 +							
(13.2)	NAIC Designation Category 4.B	Schedule E, Part 2, Footnote L000001D, Amount 2	$0	X	0.09535	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C5.3 +							
(13.3)	NAIC Designation Category 4.C	Schedule E, Part 2, Footnote L000001D, Amount 3	$0	X	0.12428	XXX	XXX	=	$0
(13.4)	Subtotal NAIC 4	Sum of Lines (13.1) through (13.3)	$0						$0
		AVR Default Component Column 1 Line C6.1 +							
(14.1)	NAIC Designation Category 5.A	Schedule E, Part 2, Footnote L000001E, Amount 1	$0	X	0.16942	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C6.2 +							
(14.2)	NAIC Designation Category 5.B	Schedule E, Part 2, Footnote L000001E, Amount 2	$0	X	0.23798	XXX	XXX	=	$0
		AVR Default Component Column 1 Line C6.3 +							
(14.3)	NAIC Designation Category 5.C	Schedule E, Part 2, Footnote L000001E, Amount 3	$0	X	0.30000	XXX	XXX	=	$0
(14.4)	Subtotal NAIC 5	Sum of Lines (14.1) through (14.3)	$0						$0
		AVR Default Component Column 1 Line C7							
(15)	NAIC 6	Schedule E, Part 2, Footnote L000001F, Amount 1	$0	X	0.30000	XXX	XXX	=	$0
(16)	Total Short-Term and Cash Equivalent Bonds	Sum of Lines (9) + (10.8) + (11.4) + (12.4) + (13.4) + (14.4) + (15)	$0			$0			$0
	(Column (1) should equal Schedule DA Part 1 Column 6 Line 0509999999 + Schedule DL Part 1 Column 6 Line 9509999999 + Schedule E Part 2 Column 7 Line 0509999999)								
(17)	Total Long-Term and Short-Term Bonds (pre-MODCO/Funds Withheld)	Line (8) + (16)	$0			$0			$0
(18)	Credit for Hedging	LR014 Hedged Asset Bond Schedule Column (13) Line (0399999)							$0
(19)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	LR045 Modco or Funds Withheld Reinsurance Ceded - Bonds C-1o Column (4) Line (9999999)							$0
(20)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	LR046 Modco or Funds Withheld Reinsurance Assumed - Bonds C-1o Column (4) Line (9999999)							$0
(21)	Total Long-Term and Short-Term Bonds (including MODCO/FundsWithheld and Credit for Hedging adjustments.)	Lines (17) - (18) - (19) + (20)	$0			$0			$0
(22)	Non-exempt U.S. Government Agency Bonds	Schedule D Part 1 Section 1 and Section 2, Schedule DA Part 1 and Schedule E Part 2, in part†	$0	X	0.00158			=	$0

			Non-CLOs/CBOs/CDOs RBC Requirement	CLOs/CBOs/CDOs RBC Requirement		
(23)	**RBC Requirements** Subject to Size Factor	**Company Records (See Instruction)**	$0	$0		$0
(24)	Number of Issuers	Company Records **(See Instruction)**				
(25)	Size Factor for Bonds		2.4	1.0	XXX	**Column (1) =ROUND(IF(D85>0,(MIN(D85,50)*2.4+MIN(MAX(0,D85-50),50)*1.53+MIN(MAX(0,D85-100),100)*0.85+MIN(MAX(0,D85-200),300)*0.85+MAX(0,(D85-500))*0.82)/D85,2.4),3)**
(26)	Bonds Subject to Size Factor after the Size Factor is Applied	**Column (1)** Line (23) x **Column (1)** Line (25) + **Column (2) Line (23) X Column (2) Line (25)**			$0	**=ROUND(D84*D86+G84*G86,0)**
(27)	Total Bonds	Line (22) + Line (26)				$0

† Only investments in-U.S. Government agency bonds previously reported in Lines (2.8) and (10.8), net of those included on Line (19), plus the portion of Line (20) attributable to ceding companies' Lines (2.8) and (10.8) should be included on Line (22). No other bonds should be included on this line. Exempt U.S. Government bonds shown on Lines (1) and (9) should not be included on Line (22). Refer to the bond section of the risk-based capital instructions for more clarification.

Denotes items that must be manually entered on the filing software.

Capital Adequacy (E) Task Force

RBC Proposal Form

☐ Capital Adequacy (E) Task Force ☐ Health RBC (E) Working Group ☒ Life RBC (E) Working Group
☐ Catastrophe Risk (E) Subgroup ☐ P/C RBC (E) Working Group ☐ Longevity Risk (A/E) Subgroup
☐ Variable Annuities Capital. & Reserve Evaluation (E/A) Subgroup ☐ Economic Scenarios (E/A) Subgroup ☐ RBC Investment Risk & (E) Working Group

DATE:	**02/04/2026**
CONTACT PERSON:	**Kazeem Okosun**
TELEPHONE:	**816-783-8981**
EMAIL ADDRESS:	**kokosun@naic.org**
ON BEHALF OF:	**Life Risk-Based Capital (E) Working Group**
NAME:	**Ben Slutsker, Chair**
TITLE:	**Director of Life Actuarial Valuation**
AFFILIATION:	**Minnesota Department of Commerce**
ADDRESS:	**85 7th Place East, Suite 280**
	Saint Paul, MN 55101

FOR NAIC USE ONLY

Agenda Item # 2025-16-L MOD V.3 with editorial updates
Year 2027

DISPOSITION

ADOPTED:
☐ TASK FORCE (TF) _____
☒ WORKING GROUP (WG) **06-11-2026**
☐ SUBGROUP (SG) _____

EXPOSED:
☐ TASK FORCE (TF) _____
☒ WORKING GROUP (WG) **11/14/2025**
02-10-2026 (V.1)
03-22-2026 (V.2)
04-23-2026 (V.3)
☐ SUBGROUP (SG) _____

REJECTED:
☐ TF ☐ WG ☐ SG _____

OTHER:
☐ DEFERRED TO _____
☐ REFERRED TO OTHER NAIC GROUP
☐ (SPECIFY) _____

IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

☐ Health RBC Blanks ☐ Property/Casualty RBC Blanks ☒ Life and Fraternal RBC Blanks
☐ Health RBC Instructions ☐ Property/Casualty RBC Instructions ☒ Life and Fraternal RBC Instructions
☐ Health RBC Formula ☐ Property/Casualty RBC Formula ☒ Life and Fraternal RBC Formula
☐ OTHER _____

DESCRIPTION/REASON OR JUSTIFICATION OF CHANGE(S)

Life RBC (E) Working Group met June 18, 2025 and received a referral from Statutory Accounting Principles (E) Working Group regarding collateral loan schedule BA reporting changes (Attachment A). As a result of the referral, NAIC staff drafted the proposal with the following objectives:

(1) To make changes to Life RBC Blanks so as to reflect the adopted changes in Schedule BA and Asset Valuation Reserve (AVR) reporting effective 2026.
(2) To explore the potential need to revisit RBC and AVR factors based on the risk characteristics of the collaterals backing the collateral loans

The proposal 2025-16-L MOD was exposed at the Working Group on Feb 10 for a 24-day public comment period ending March 06, 2026. The modified proposal is in response to ACLI comment. Staff then layer in LR010 consideration.

Additional Staff Comments:

- 11-14-2025: Proposal was exposed with comments due 01-27-2026 - 4 comment letters received (KO)

- 02-10-2026: Proposal was modified (V.1) and re-exposed with comments due 03-06-2026 - 4 comment letters received (KO)
- 03-22-2026: The modified proposal (V.2) is in response to ACLI comment. Staff then layer in LR010 consideration.
- 04-30-2026: The proposal is further modified (V.3) to incorporate comments from ACLI, ACC and regulators. This modified proposal was exposed for 21-day public comment period ending 5/14/2026. Key changes from V.2 are highlighted in yellow within Blanks.
- 06-11-2026: The Working Group adopted OPTION 2. NAIC Staff incorporated the downstream impact of this adoption to LR010 Asset Concentration, LR030 Calculation of Tax Effect and LR031 Calculation of Authorized Control Level Risk-Based Capital pages. In addition, certain references in RBC Blanks and/or instructions are corrected in response to interested parties' informal feedback. Key changes from the proposal adopted by the Working Group on June 11 are highlighted in yellow in the BLANKS

Option 2 – Alternative Option to Consider. This option shifted tiering structure such that LTV 80% is in the mid-point of the tier. It also streamlined LTV Bands and provided a floor to address regulators' concerns

OCC	LTV Band	Midpoint	Haircut	RBC Charge for Collateral Loans backed by LP/LLC/JV interests	RBC Charge for Collateral Loans backed by residuals
OC < 111%	>90% or no independent verification	N/A	0%	30%	45%
OC ≥ 111% and < 143%	>70% - 90%	80%	20%	24%	36%
OC ≥ 143% and < 200%	>50%-70%	60%	40%	18%	27%
OC ≥ 200%	50% or below	25%[1]	50%[1]	15%	22.5%

[1] Haircut of 50% is chosen to ensure the minimum RBC charge is capped at 50% of the base charge.

** **This section must be completed on all forms.** **Revised 2-2023**

OTHER LONG-TERM ASSETS

LR008

Basis of Factors

Recognizing the diverse nature of Schedule BA assets, the RBC is calculated by assigning different risk factors according to the different type of assets. Assets with underlying characteristics of bonds and preferred stocks designated by the NAIC Capital Markets and Investment Analysis Office have different factors according to the NAIC assigned classification. Unrated fixed-income securities will be treated the same as Other Schedule BA Assets and assessed a 30% pre-tax charge. Rated surplus and capital notes have the same factors applied as Schedule BA assets with the characteristics of preferred stock. Where it is not possible to determine the RBC classification of an asset, a 30% pre-tax factor is applied.

Specific Instructions for Application of the Formula

Line (44)
Schedule BA affiliated common stock – all others should include all subs with an affiliate code 9 in the current life-based framework and "holding company in excess of indirect subsidiaries" or subsidiaries with affiliate code 3.

The Lines (43.2) – (43.5) and Line (45.2) – (45.5) series are assigned RBC charges based on overcollateralization (OC) / loan-to-value (LTV) levels.

In order to be afforded RBC charges based on overcollateralization (OC) / Loan-to-value (LTV), independent verification of fair value is required. Independent verification approaches may include, individually or in combination:

• Compliance certifications from unaffiliated third parties confirming adherence to stated valuation policies and investment guidelines;
• Independent third-party valuations of the underlying collateral; and/or
• Independent reasonableness checks designed to assess whether reported fair values fall within an appropriate and supportable range.

Data on OC/LTV as well as whether independent verification was obtained are disclosed on Annual Statement Schedule BA Other Long-Term Invested Assets.

Line (51)
Exclude: any collateral loan amounts which have been included elsewhere in the RBC formula, e.g., collateral loans backed by mortgage loans, ~~BA mortgages~~, collateral loans backed by Residual Tranches or Interest and collateral loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests.

Line (58)
Total Schedule BA assets [LR008 Other Long-Term Assets Column (1) Line (58) plus LR007 Real Estate Column (1) Line (14) plus Lines (17) through Line (20) plus LR009 Schedule BA Mortgages Column (1) Line (21)] should equal the total Schedule BA assets reported in the Annual Statement Page 2, Column 3, Line 8.

Company Name Cocode: 00000

OTHER LONG-TERM ASSETS

		Annual Statement Source	(1) Book / Adjusted Carrying Value	(2) Unrated Items ‡	(3) RBC Subtotal †		(4) Factor		(5) RBC Requirement
(43.1)	Schedule BA Unaffiliated Common Stock-Private	AVR Equity Component Column 1 Line F2	$0		$0	X	0.3000	=	$0
	Schedule BA Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests								
(43.2)	OC < 111% or No independent verification obtained	Company Records	$0		$0	X	0.3000	=	$0
(43.3)	OC Percentage ≥ 111% and < 143%	Company Records	$0		$0	X	0.2400	=	$0
(43.4)	OC Percentage ≥ 143% and < 200%	Company Records	$0		$0	X	0.1800	=	$0
(43.5)	OC Percentage ≥ 200%	Company Records	$0		$0	X	0.1500	=	$0
(43.6)	Total Schedule BA Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests (Column (1), line 43.6 should be equal to sum of AVR Equity Component lines K3 and K4)	Lines (43.2) + (43.3) + (43.4)+ (43.5)	$0		$0				$0
(44)	Schedule BA Affiliated Common Stock - All Other	AVR Equity Component Column 1 Line F5	$0		$0	X	0.3000	=	$0
(45.1)	Total Residual Tranches or Interests	AVR Equity Component Column 1 Line I13	$0		$0	X	0.4500	=	$0
	Schedule BA Collateral Loans backed by Residual Tranches or Interests								
(45.2)	OC < 111% or No independent verification obtained	Company Records	$0		$0	X	0.4500	=	
(45.3)	OC Percentage ≥ 111% and < 143%	Company Records	$0		$0	X	0.3600	=	$0
(45.4)	OC Percentage ≥ 143% and < 200%	Company Records	$0		$0	X	0.2700	=	$0
(45.5)	OC Percentage ≥ 200%	Company Records	$0		$0	X	0.2250	=	$0
(45.6)	Total Schedule BA Collateral Loans backed by Residual Tranches or Interests (Column (1), line 45.6 should be equal to sum of AVR Equity Component lines K5 and K6)	Lines (45.2) + (45.3) + (45.4)+ (45.5)	$0		$0				$0
(46)	Total Schedule BA Unaffiliated Common Stock/ Equity Interests and Affiliated Non-Insurance Stock (C1-cs) (pre-MODCO/Funds Withheld)	Line (42) + (43.1) + (43.6)+ (44) + (45.1) + (45.6)	$0		$0				$0
(47)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)							$0
(48)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)							$0
(49)	Total Schedule BA Unaffiliated Common Stock/ Equity Interests and Affiliated Non-Insurance Stock (C1-cs) (including MODCO/Funds Withheld.)	Lines (46) - (47) + (48)	$0						$0
	Schedule BA - All Other (C-1o)								
(50.1)	BA Affiliated Common Stock - Life with AVR	AVR Equity Component Column 1 Line F3	$0						
(50.2)	BA Affiliated Common Stock - Certain Other	AVR Equity Component Column 1 Line F4	$0						
(50.3)	Total Schedule BA Affiliated Common Stock - C-1o	Line (50.1) + (50.2)	$0		$0	X	0.3000	=	$0
(51)	**All Other Schedule BA Collateral Loans**	AVR Equity Component Column 1 Lines K7 + K8 + K9 + K10 + K11 + K12	$0		$0	X	0.0680	=	$0
(52.1)	NAIC 01 Working Capital Finance Notes	AVR Equity Component Column 1 Line L1	$0		$0	X	0.0050	=	$0
(52.2)	NAIC 02 Working Capital Finance Notes	AVR Equity Component Column 1 Line L2	$0		$0	X	0.0163	=	$0
(52.3)	Total Admitted Working Capital Finance Notes	Line (52.1) + (52.2)	$0		$0				$0
(53.1)	Other Schedule BA Assets, including Surplus Notes and Capital Notes	AVR Equity Component Column 1 Line J7 + L3	$0						
(53.2)	Less NAIC 1 thru 6 Rated/Designated Surplus	Column (1) Lines (22) through (27) + Column (1)	$0						

Company Name Cocode: 00000

OTHER LONG-TERM ASSETS

		Annual Statement Source	(1) Book / Adjusted Carrying Value	(2) Unrated Items ‡	(3) RBC Subtotal †		(4) Factor		(5) RBC Requirement
	Notes and Capital Notes	Lines (32) through (37)							
(53.3)	Net Other Schedule BA Assets	Line (53.1) less (53.2)	$0	$0	$0	X	0.3000	=	$0
(54)	Total Schedule BA Assets C-1o (pre-MODCO/Funds Withheld)	Lines (11) + (21) + (31) + (41) + (50.3) + (51) + (52.3) + (53.3)	$0						$0
(55)	Reduction in RBC for MODCO/Funds Withheld Reinsurance Ceded Agreements	Company Records (enter a pre-tax amount)							$0
(56)	Increase in RBC for MODCO/Funds Withheld Reinsurance Assumed Agreements	Company Records (enter a pre-tax amount)							$0
(57)	Total Schedule BA Assets C-1o (including MODCO/Funds Withheld.)	Lines (54) - (55) + (56)	$0						$0
(58)	Total Schedule BA Assets Excluding Mortgages and Real Estate	Line (49)+ (57)	$0						$0

† Fixed income instruments and surplus notes designated by the NAIC Capital Markets and Investment Analysis Office or considered exempt from filing as specified in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* should be reported in Column (3).

‡ Column (2) is calculated as Column (1) less Column (3) for Lines (1) through (17). Column (2) equals Column (3) - Column (1) for Line (53.3).

§ The factor for Schedule BA publicly traded common stock should equal 30 percent adjusted up or down by the weighted average beta for the Schedule BA publicly traded common stock portfolio subject to a minimum of 22.5 percent and a maximum of 45 percent in the same manner that the similar 15.8 percent factor for Schedule BA publicly traded common stock in the Asset Valuation Reserve (AVR) calculation is adjusted up or down. The rules for calculating the beta adjustment are set forth in the AVR section of the annual statement instructions.

Company Name | Cocode: 00000

ASSET CONCENTRATION FACTOR

Issuer		(1) Asset Type	(2) Book / Adjusted Carrying Value		(3) Factor		(4) Additional RBC	(5) Adjustment/ Subsidiary RBC	(6) RBC Requirement
#01		Issuer Name:							
#01	(1.1)	Bond NAIC Designation Category 2.A	$0	X	0.01261	=	$0	$0	$0
#01	(1.2)	Bond NAIC Designation Category 2.B	$0	X	0.01523	=	$0	$0	$0
#01	(1.3)	Bond NAIC Designation Category 2.C	$0	X	0.02168	=	$0	$0	$0
#01	(2.1)	Bond NAIC Designation Category 3.A	$0	X	0.03151	=	$0	$0	$0
#01	(2.2)	Bond NAIC Designation Category 3.B	$0	X	0.04537	=	$0	$0	$0
#01	(2.3)	Bond NAIC Designation Category 3.C	$0	X	0.06017	=	$0	$0	$0
#01	(3.1)	Bond NAIC Designation Category 4.A	$0	X	0.07386	=	$0	$0	$0
#01	(3.2)	Bond NAIC Designation Category 4.B	$0	X	0.09535	=	$0	$0	$0
#01	(3.3)	Bond NAIC Designation Category 4.C	$0	X	0.12428	=	$0	$0	$0
#01	(4.1)	Bond NAIC Designation Category 5.A	$0	X	0.16942	=	$0	$0	$0
#01	(4.2)	Bond NAIC Designation Category 5.B	$0	X	0.21202	=	$0	$0	$0
#01	(4.3)	Bond NAIC Designation Category 5.C	$0	X	0.15000	=	$0	$0	$0
#01	(5)	Bond Asset NAIC 6	$0	X	0.15000	=	$0	$0	$0
#01	(6.1)	Bond NAIC Designation Category 1.A †	$0	X	0.00158	=	$0	$0	$0
#01	(6.2)	Bond NAIC Designation Category 1.B †	$0	X	0.00271	=	$0	$0	$0
#01	(6.3)	Bond NAIC Designation Category 1.C †	$0	X	0.00419	=	$0	$0	$0
#01	(6.4)	Bond NAIC Designation Category 1.D †	$0	X	0.00523	=	$0	$0	$0
#01	(6.5)	Bond NAIC Designation Category 1.E †	$0	X	0.00657	=	$0	$0	$0
#01	(6.6)	Bond NAIC Designation Category 1.F †	$0	X	0.00816	=	$0	$0	$0
#01	(6.7)	Bond NAIC Designation Category 1.G †	$0	X	0.01016	=	$0	$0	$0
#01	(7)	Unaffiliated Preferred Stock NAIC 2	$0	X	0.01260	=	$0	$0	$0
#01	(8)	Unaffiliated Preferred Stock NAIC 3	$0	X	0.04460	=	$0	$0	$0
#01	(9)	Unaffiliated Preferred Stock NAIC 4	$0	X	0.09700	=	$0	$0	$0
#01	(10)	Unaffiliated Preferred Stock NAIC 5	$0	X	0.22310	=	$0	$0	$0
#01	(11)	Unaffiliated Preferred Stock NAIC 6	$0	X	0.15000	=	$0	$0	$0
#01	(12)	Unaffiliated Preferred Stock NAIC 1 †	$0	X	0.00390	=	$0	$0	$0
#01	(13.1)	**Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests (OC Percentage < 111% or no independent verification obtained)**	$0	X	**0.15000**	=	**$0**	$0	**$0**
#01	(13.2)	**Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests (OC Percentage ≥ 111% and < 143%)**	$0	X	**0.21000**	=	**$0**	$0	**$0**
#01	(13.3)	**Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests (OC Percentage ≥ 143% and < 200%)**	$0	X	**0.18000**	=	**$0**	$0	**$0**
#01	(13.4)	**Collateral Loans backed by Joint Ventures', Limited Partnerships' and Limited Liability Companies' Interests (OC Percentage ≥ 200%)**	$0	X	**0.15000**	=	**$0**	$0	**$0**
#01	(13.5)	**Collateral Loans backed by Residual Tranches or Interests (OC Percentage ≥ 111% and < 143%)**	$0	X	**0.09000**	=	**$0**	$0	**$0**
#01	(13.6)	**Collateral Loans backed by Residual Tranches or Interests (OC Percentage ≥ 143% and < 200%)**	$0	X	**0.18000**	=	**$0**	$0	**$0**
#01	(13.7)	**Collateral Loans backed by Residual Tranches or Interests (OC Percentage ≥ 200%)**	$0	X	**0.22500**	=	**$0**	$0	**$0**
#01	(13.8)	**All Other BA Collateral Loans**	$0	X	**0.06800**	=	**$0**	$0	**$0**
#01	(14)	Receivable for Securities	$0	X	0.01600	=	$0	$0	$0
#01	(15)	Write-ins for Invested Assets	$0	X	0.06800	=	$0	$0	$0
#01	(16)	Premium Notes	$0	X	0.06800	=	$0	$0	$0
#01	(17)	Real Estate - Foreclosed	$0						
#01	(18)	Real Estate - Foreclosed Encumbrances	$0	X	0.00000	‡	= $0	$0	$0
#01	(19)	Real Estate - Investments	$0						
#01	(20)	Real Estate - Investment Encumbrances	$0	X	0.00000	‡	= $0	$0	$0
#01	(21)	Real Estate - Schedule BA	$0						
#01	(22)	Real Estate - Schedule BA Encumbrances	$0	X	0.00000	‡	= $0	$0	$0
#01	(23)	Farm Mortgages - Category CM2	$0	X	0.01750	=	$0	$0	$0
#01	(24)	Farm Mortgages - Category CM3	$0	X	0.03000	=	$0	$0	$0
#01	(25)	Farm Mortgages - Category CM4	$0	X	0.05000	=	$0	$0	$0
#01	(26)	Farm Mortgages - Category CM5	$0	X	0.07500	=	$0	$0	$0
#01	(27)	Commercial Mortgages - Category CM2	$0	X	0.01750	=	$0	$0	$0
#01	(28)	Commercial Mortgages - Category CM3	$0	X	0.03000	=	$0	$0	$0

Details Eliminated to Conserve Space

Company Name Cocode: 00000

CALCULATION OF TAX EFFECT FOR LIFE AND FRATERNAL RISK-BASED CAPITAL

		Source	(1) RBC Amount		Tax Factor		(2) RBC Tax Effect	
	Common Stock	Details Eliminated to Conserve Space						
(123)	Unaffiliated Common Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (17) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)	$0	X	0.2100	=	$0	
(124)	Credit for Hedging - Common Stock	LR015 Hedged Asset Common Stock Schedule Column (10) Line (0299999)	$0	X	0.2100	=	$0	†
(125)	Stock Reduction - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (19)	$0	X	0.2100	=	$0	†
(126)	Stock Increase - Reinsurance	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (20)	$0	X	0.2100	=	$0	
	Schedule BA Unaffiliated Common Stock/ Equity Interests and Affiliated Non-Insurance Stock (C1-cs), excluding Residual							
(127)	Tranches or Interests/ **Schedule BA Collateral Loans backed by Residual Tranches or Interests**	LR008 Other Long-Term Assets Column (5) **Line (49) - Line (45.1) - Line (45.6)**	$0	X	0.2100	=	$0	
(128)	Total Residual Tranches or Interests/ **Schedule BA Collateral Loans backed by Residual Tranches or Interests**	LR008 Other Long-Term Assets Column (5) Line **(45.1) + Line (45.6)**	$0	X	0.2100	=	$0	
(129)	Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)	$0	X	0.2100	=	$0	
(130)	NAIC 01 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (52.1)	$0	X	0.1575	=	$0	
(131)	NAIC 02 Working Capital Finance Notes	LR008 Other Long-Term Assets Column (5) Line (52.2)	$0	X	0.1575	=	$0	
(132)	Holding Company in Excess of Indirect Subs	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (7)	$0	X	0.2100	=	$0	
(133)	Affiliated Non-Insurers	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (19) + (20) + (21)	$0	X	0.2100	=	$0	
(134)	Total for C-1cs Assets	Lines (123)-(124)-(125)+(126)+(127)+(128)+(129)+(130)+(131)+(132)+(133)	$0				$0	
	Insurance Risk							
(135)	Disability Income Premium	LR019 Health Premiums Column (2) Lines (21) through (27)	$0	X	0.2100	=	$0	
(136)	Long-Term Care	LR019 Health Premiums Column (2) Line (28) + LR023 Long-Term Care Column (4) Line (7)	$0	X	0.2100	=	$0	
(137)	Individual & Industrial Life Insurance C-2 Risk	LR025 Life Insurance Column (2) Line (5)	$0	X	0.2100	=	$0	
(138)	Group & Credit Life Insurance C-2 Risk	LR025 Life Insurance Column (2) Line (12)	$0	X	0.2100	=	$0	
(138b)	Longevity C-2 Risk	LR025-A Longevity Risk Column (2) Line (5)	$0	X	0.2100	=	$0	
(139)	Disability and Long-Term Care Health Claim Reserves	LR024 Health Claim Reserves Column (4) Line (9) + Line (15)	$0	X	0.2100	=	$0	
(140)	Premium Stabilization Credit	LR026 Premium Stabilization Reserves Column (2) Line (10)	$0	X	0.0000	=	$0	
(141)	Total C-2 Risk	L(135) + L(136) + L(139) + L(140) + Greatest of [Guardrail Factor * (L(137)+L(138)), Guardrail Factor * L(138b), Square Root of [(L(137) + L(138))2 + L(138b)2 + 2 * (Correlation Factor) * (L(137) + L(138)) * L(138b)]]	$0				$0	
(142)	Interest Rate Risk	LR027 Interest Rate Risk Column (3) Line (36)	$0	X	0.2100	=	$0	
(143)	Health Credit Risk	LR028 Health Credit Risk Column (2) Line (7)	$0	X	0.0000	=	$0	
(144)	Market Risk	LR027 Interest Rate Risk Column (3) Line (37)	$0	X	0.2100	=	$0	
(145)	Business Risk	LR029 Business Risk Column (2) Line (40)	$0	X	0.2100	=	$0	
(146)	Health Administrative Expenses	LR029 Business Risk Column (2) Line (57)	$0	X	0.0000	=	$0	
(147)	Total Tax Effect	Lines (110) + (122) + (134) + (141) + (142) + (143) + (144) + (145) + (146)	#REF!				#REF!	

Guardrail F	0.0
Correlation	-0.25

† Denotes lines that are deducted from the total rather than added.

LR030 MOD

Company Name
Cocode: 00000

CALCULATION OF AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL

		Source	(1) RBC Requirement
		Details Eliminated to Conserve Space	
	Asset Risk – Unaffiliated Common Stock and Affiliated Non-Insurance Stock (C-1cs)		
(13)	Schedule D Unaffiliated Common Stock	LR005 Unaffiliated Common Stock Column (5) Line (21) + LR018 Off-Balance Sheet Collateral Column (3) Line (16)	$0
	Schedule BA Unaffiliated Common Stock/ Equity Interests and Affiliated Non-Insurance Stock (C1-cs), excluding		
(14)	Residual Tranches or Interests/ **Schedule BA Collateral Loans backed by Residiual Tranches or Interests**	LR008 Other Long-Term Assets Column (5) **Line (49) - Line (45.1) - Line (45.6)**	$0
(15)	Total Residual Tranches or Interests **/ Schedule BA Collateral Loans backed by Residiual Tranches or Interests**	LR008 Other Long-Term Assets Column (5) line **(45.1) + Line (45.6)**	$0
(16)	Common Stock Concentration Factor	LR011 Common Stock Concentration Factor Column (6) Line (6)	$0
(17)	Holding Company in Excess of Indirect Subs	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (7)	$0
(18)	Affiliated Non-Insurers	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Lines (19) + (20) + (21)	$0
(19)	Total (C-1cs) - Pre-Tax	Sum of Lines (13) through (18)	$0
(20)	(C-1cs) Tax Effect	LR030 Calculation of Tax Effect for Life and Fraternal Risk-Based Capital Column (2) Line (134)	$0
(21)	Net (C-1cs) - Post-Tax	Line (19) - Line (20)	$0
	Asset Risk - All Other (C-1o)		
(22)	Bonds after Size Factor	LR002 Bonds Column (2) Line (27) + LR018 Off-Balance Sheet Collateral Column (3) Line (8)	$0
(23)	Mortgages (including past due and unpaid taxes)	LR004 Mortgages Column (6) Line (31)	$0
(24)	Unaffiliated Preferred Stock	LR005 Unaffiliated Preferred and Common Stock Column (5) Line (10) + LR018 Off-Balance Sheet Collateral Column (3) Line (15)	$0
(25)	Investment Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (8)	$0
(26)	Investment in Upstream Affiliate (Parent)	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (15)	$0
(27)	Directly Owned Health Insurance Companies or Health Entities Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (16)	$0
(28)	Directly Owned Property and Casualty Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (17)	$0
(29)	Directly Owned Life Insurance Companies Not Subject to RBC	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (18)	$0
(30)	Publicly Traded Insurance Affiliates	LR042 Summary for Affiliated/Subsidiary Stocks Column (4) Line (22)	$0
(31)	Separate Accounts with Guarantees	LR006 Separate Accounts Column (3) Line (7)	$0
(32)	Synthetic GIC's (C-1o)	LR006 Separate Accounts Column (3) Line (8)	$0
(33)	Surplus in Non-Guaranteed Separate Accounts	LR006 Separate Accounts Column (3) Line (13)	$0
(34)	Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (13)	$0
(35)	Schedule BA Real Estate (gross of encumbrances)	LR007 Real Estate Column (3) Line (25)	$0
(36)	Other Long-Term Assets	LR008 Other Long-Term Assets Column (5) Line (57) + LR018 Off-Balance Sheet Collateral Column (3) Line (17) + Line (18)	$0

